CHC NEWS
For Community Health Councils
July 1979 No. 44

This neglect must stop

CHAR tells Dr Vaughan

Many Family Practitioner Committees are indifferent to the medical needs of homeless people, according to the Campaign for the Homeless and Rootless.

CHAR makes this accusation in a letter to the new Health Minister, Dr Gerard Vaughan. Despite much concern and activity since 1974, CHAR says that improvements in medical care of the homeless "have been confined to a few isolated areas" where voluntary organisations and a few conscientious GPs have taken initiatives. Many hostel users and other homeless people are still unable to find themselves a doctor.

CHAR is asking the new Government to do three things:

INSTRUCT FPCs "to ensure that all residents of hostels and lodging houses and other single homeless people in their locality are registered with a GP".

INSTRUCT AHAs "to review their hospital admission and discharge procedures affecting homeless people".

ENCOURAGE AHAs in inner city areas to take into account the special needs of single homeless people when planning primary health care services.

CHAR notes that "homeless people are too often discharged straight from hospital — both general and psychiatric — to unsuitable and in many cases sub-standard hostel and lodging house accommodation with no after-care". It also points to a case in Hull last year, in which an elderly homeless man was refused admission to a hospital and later froze to death in the hospital car park. Humberside AHA's inquiry into the case concluded that the man "was regarded throughout as a vagrant rather than a patient".

AHAs can improve the present system, says CHAR, by helping with the development of hostels, group homes and halfway houses; by making sure that relevant hospital staff understand the responsibilities of local authority housing departments under the Housing (Homeless Persons) Act 1977; and by ensuring that adequate after-care is provided "for *every* vulnerable patient on discharge".

CHAR has also written to junior health minister Sir George Young, urging him to declare "a long-term commitment by the DHSS to promote and resource" services for homeless alcoholics.

CHAR's address is 27 John Adam Street, London WC2. Tel: 01-839 6185.

Photos: Maria Bartha

Royal Commission on the NHS

Members of the Royal Commission on the NHS expect their report to be ready for publication by the end of this month. However, it is possible that the Prime Minister will delay publication until the end of the summer period.

OMBUDSMAN TO RULE ON AHA MISMANAGEMENT

A complaint about area health authority mismanagement has been made to the health Ombudsman by Hartlepool CHC.

Last December the Cleveland AHA agreed to spend the whole of a windfall capital allocation on a £180,000 blood analyser for one of its pathology labs. When he queried this at the AHA meeting, CHC secretary Douglas Allan was told that area advisory committees such as the scientific advisory committee had been consulted and that the lab was the only one in the region without this facility. The CHC remained concerned that the machine had never appeared as a priority item in area plans.

Further investigations revealed that the type of machine, an SMA(C), was the "Rolls-Royce" of analysers and the AHA had not considered any alternative purchases. The CHC then discovered that the area's scientific advisory committee had not been formally consulted and that some of its members were appalled. Also, the whole country contained only 15 machines of this particular type and there were none at all in the Northern region. When the AHA was again challenged to justify the decision the CHC was accused of mischief-making by the chairman of the AHA.

Now the machine has been bought and the CHC does not oppose the decision to purchase, but the manner in which it was made. "We are very loth to do it, but we are going to the Ombudsman because we are alarmed that AHA members can take decisions without knowing the options and we consider the whole affair to have been badly handled", said Douglas Allan. "We want an assurance that this type of thing won't happen again."

Your letters

Compulsory admissions

A H Harman, Secretary, Cuckfield and Crawley CHC

Mr Hanvey's article *Compulsory care (CHC NEWS 42* p 14) was interesting but not entirely accurate. In fact what he terms an emergency order under Section 47 of the National Assistance Act cannot be made by the "proper officer" (district community physician). The duty is laid firmly on the "appropriate authority" — ie, district, London borough, Common Council of the City of London, and so on. The relevant circular of 1948 states: "Application to the Court must be made by the local authority and not by the medical officer of health".

I think it borders on the impertinent to suggest that a court would make such an order without proper consideration, and that any sort of "patient's advocate" is required. My own extensive experience in this field convinces me that such orders are only made after very thorough consideration by the court and when there are no alternatives.

CHCs may be interested to know that it is also possible to secure compulsory admission under this section to private establishments, thus supplementing NHS provision.

Dr Muir Gray, community physician, Oxford AHA(T), is doing research into this legislation (see *Health and Social Service Journal,* 18 August 1978 p 942). A letter from me on this subject was published in the same journal on 1 September 1978 (p 995).

Finally, I think Mr Hanvey's suggestion falls very much within the CHC activities which were the subject of the scathing criticisms so justifiably made by Mr Bowling of Ipswich CHC in your same issue.

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Nurse recruitment

Arthur Steer, Member, West Dorset CHC

Cyril Gumbley's article on nurse recruitment (*CHC NEWS 41* p 13) does not really offer any solution to the problem. In the first place, if only 100 nurses are being trained each year and there are vacancies for 200, it would appear to simple souls that the training programme needs to be stepped up.

If wives have such difficulties in continuing as nurses, then perhaps there ought to be more emphasis on men for the career. Their wives will naturally follow them, and may even provide another pair of hands for the hospital.

Lack of housing is a major cause of labour immobility. In the past the large psychiatric hospitals built houses for the staff. Is it not possible for the DHSS, if they are really concerned at the lack of trained staff in certain areas, to build or acquire housing for staff?

For years we have heard of the shortage of staff in hospitals and have recruited far and wide overseas in an attempt to make good the deficiency. I would suggest that the time has come when other methods of recruitment and retention must be explored.

Hearing therapists

I R Kershaw, Member, St Helens and Knowsley CHC

In health circular HC(78)11 the DHSS, in response to the Secretary of State's Advisory Committee on Services for Hearing Impaired People, created a new class of worker — the hearing therapist. In order to get this new post established the DHSS provided funds in the form of an additional revenue contribution to cover salaries, secretarial support and so on.

But, from discussions with colleagues (I am a principal social worker for the deaf), I get the impression that area health authorities have been slow to take up this offer. I would be glad to hear from CHC members with any information on the appointment of hearing therapists in their area, or indeed any information connected with this matter.

Abortion counselling and accommodation

Mrs Chris Kelly, Member, South Birmingham CHC

David Flint (*CHC NEWS 41* p 2) is opposed to pro-life voluntary organisations seeking public support for their counselling and caring activities. He also opposes their attempts to provide homes for women with unwanted pregnancies. He seems unaware that again and again it is the problem of accommodation that "drives" the pregnant woman to opt for termination. She has no alternatives offered to her except by organisations involved in caring, eg *Life.*

The Pregnancy Advisory Service, which Mr Flint commends as an unbiased counselling agency, arranges for over 90% of its clients to have their pregnancies terminated. Is this unbiased counselling?

Letting the public in

Dr Alan Berson, Member, South Camden CHC

I was stunned to read (*CHC NEWS 39* p 2) that the Kingston, Richmond and Esher CHC voted "by a large majority" not to allow members of the public to speak at CHC meetings. The method of election of CHC members is already so ludicrous that it is almost impossible for actual local community members to become members of the "community" health council, unless they are connected with a local authority or official voluntary body. One wonders what community the CHC is supposed to be speaking for.

Our CHC does allow a few moments at the end of CHC meetings for members of the public to bring up subjects that concern them, and in addition they are allowed to speak on any item on the agenda. In fact I attended my first CHC meeting several years ago as a member of the public to speak on a specific local issue, and in my capacity as secretary of a residents' association and chairperson of our neighbourhood association. I continued to attend meetings, and was eventually co-opted to the CHC. Other members of the public attend regularly and often serve as catalysts for CHC action, and to my knowledge none has been an extremist or crank. To use this as an argument is to express a fear of democracy itself, and to make a mockery of the whole concept of *community* health councils.

Ed: This subject has drawn a large response but we feel that it has now been well enough aired in these columns for the time being.

Homoeopathy

Anne Forrester, Secretary, Greater Glasgow Western District Local Health Council

Does Healthline's Information Service stop short of north of the Border? In *CHC NEWS 40* (p 6) hospitals providing homoeopathic treatment within the NHS were listed. But there was an omission — the Glasgow Homoeopathic Hospital. Homoeopathic services are also available in the Children's Home Hospital, Mount Vernon, and in the Dispensary, Lynedoch Crescent, Glasgow.

Ear piercing

Mrs I M Watson, Secretary, Hull CHC

I would like to thank Mr Gumbley, East Dorset CHC, for his clarification of the various types of hepatitis (*CHC NEWS 41* p 2). He is obviously better informed than the Hull environmental health officer, who, through Kingston upon Hull City Council, raised this matter with Hull CHC.

The degree to which the public has expressed interest and concern with this matter has surprised even the Hull CHC, and a number of CHC secretaries and others have sought information on it. On

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Comment

The decision not to close the Elizabeth Garrett Anderson Hospital in London's Euston Road has national implications. Secretary of State Patrick Jenkin announced that the hospital will be preserved as a place where women can be treated by women, although it will no longer be a multi-specialty hospital. There will be beds for about 40 gynaecology inpatients with around 18 day-hospital beds and outpatient services. The running costs will be met from the region's revenue allocations but Mr Jenkin made it clear that the capital costs of repairs and improvements, "can and should be met in partnership between Government and voluntary contributors".

The reversal of the previous Government's decision to approve the AHA's closure proposals runs contrary to the policy of resource reallocation, since the area is relatively well-endowed with beds and the hospital is considered by the AHA to be too small to run economically. But of more immediate interest is the issue of voluntary funding.

Until the establishment of the NHS in 1948, hospital services were provided either by the local authority hospitals, the descendants of the old Poor Law infirmaries, or by voluntary hospitals, which owed their origins to charitable endowments. The public hospitals had to try and fill the gaps left by the charitable hospitals. The system had developed in a haphazard way and rational resource planning was unheard of. The opportunity to improve the quality of care by means of more effective planning was one of the main arguments for central Government funding, across the board, for the new NHS.

In the case of the "EGA", it would seem the Government is encouraging a reversal of this — expecting "public subscriptions and other voluntary sources" to plug a gap in NHS funding. It is unclear to what extent the Government regards the EGA as a special case. The hospital provides a national service, but if similar arguments are applicable to local hospitals, there could be startling results. After all, it is not only in "over-provided" areas that the NHS is seeking to rationalise services, and shortage of resources is a commonplace.

Shall we be seeing campaigners against hospital closures and administrators of small hospitals anticipating the axe, searching around for charitable funding as part of their efforts to persuade AHAs to grant a reprieve? And if NHS hospitals are to be funded partly from private sources, will the donors insist on a say in how their money is spent?

Clearly if the Elizabeth Garrett Anderson solution were to be extended, it could drive a coach and horses through the objectives of RAWP. The decision brings a little nearer the possibility of a future NHS divided by affluence — one type of service for those in prosperous parts of Britain where charitable funds are easier to come by, and a decidedly inferior NHS in the poorer areas left with whatever the Government of the day is prepared to pay for.

As we teeter at the top of this slippery slope, we should ask ourselves whether we shall be sliding forwards into the future or back into the past.

Health News

BMA ruling threatens the growth of patients' committees

Publicity for patients' committees (PCs) could lead to GPs being disciplined for advertising, a committee of the British Medical Association has warned.

The BMA's Central Ethical Committee claims that any publicity which could be interpreted as encouraging patients to defect from practices *without* PCs could justify a complaint of unprofessional conduct to the General Medical Council. It would be no defence that the doctor concerned had not originated the publicity, nor that he or she was not a member of the PC.

If PCs must avoid infringing this ruling, they will lose several valuable methods of publicity. They would no longer be able to:

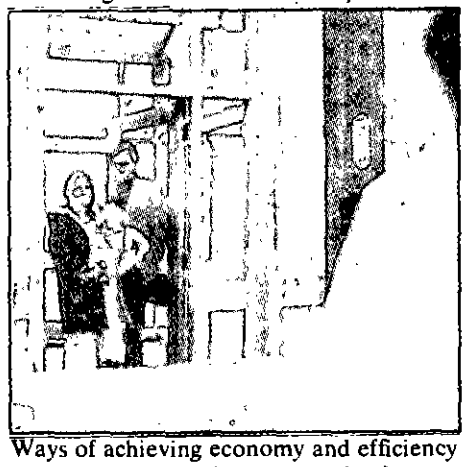
- Use posters and announcements in the press to advertise their meetings;
- Have their meetings reported in local papers;
- Distribute a newsletter, to spread the word about the advantages of patient participation to the patients of other local doctors.

The CEC has asked the GMC to confirm that its interpretation of the GMC's rules on advertising by GPs is correct. Doctors involved with the National Association for Patient Participation in General Practice plan to meet representatives of the BMA to clarify the situation.

Design of health centres

The first example of the new style of health building notes (HBN 36) — in fact a hefty, inch-thick volume — is on health centre design. It has been issued by the DHSS in an interim edition along with HN(79)24. Circulation is limited and CHCs will not be getting a copy, but ACHCEW is among the bodies invited to submit comments.

Among the general design considerations stressed are ease of access (especially for mothers with young children and the handicapped), privacy, and the need for health centres to be "simple and unassuming in character" and to provide a reassuring environment for the public.



Ways of achieving economy and efficiency are also emphasised. For example, the note says that specialised accommodation should be kept to a minimum and that space should wherever possible be designed to contain more than one function or to be used for different activities at different times (it suggests that speech therapy and child health assessment could double up).

Detailed guidance describes the size and nature of the space required for all the various health centre functions and facilities. For instance, the note says that pram shelters should be sited where they can be overseen from the waiting area. And, assuming an appointment system, it specifies that waiting areas for GPs should be on a scale of five seats for each consulting suite (giving a total of 7 square metres exclusive of circulation space). Flow charts, diagrams and photographs illustrate many of the points. The building note should be published in its final form towards the end of the year.

Eyes right

A mobile vision screening service for pre-school children in rural Oxfordshire greatly improved the rate of early detection of visual disorders. The service accepted referrals from doctors and from health visitors and was run quite cheaply. It reduced considerably the number of inappropriate referrals to the specialist hospital. A total of 4544 children were seen in the first 18 months of the mobile orthoptic unit. The majority were under one year, but anxious parents also brought four- and five-year-olds to the van and, in many cases, their suspicions were borne out and these children needed specialist help. The authors of the study, described in the *British Medical Journal*, 14 April 1979, page 994, stress that if visual disorder is suspected, "No child is too young for referral, and the 'wait and see' attitude may be disastrous".

Now and then

A survey which enables us to compare conditions and attitudes now with those in

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Health News

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the past is especially welcome as most only give us a snapshot view. *Patients and their doctors** compares information from surveys of GPs and patients, carried out in 1964 and 1977. During the period, practice organisation has changed, with a trend towards group practices, appointment systems, deputising services and primary care teams. There are fewer home visits.

Comparisons of patients' views must be made with caution — does a more critical attitude mean the service has got worse or that expectations have increased? Patients' estimation of the time it would take them to reach the surgery had increased (in spite of the fact that more said they would use private transport). Once there, more people thought they had to wait an unreasonable length of time to see the doctor. The authors' tentative conclusion is that "a number of the changes — the increase in partnerships, in appointment systems, in ancillary help, in deputising services — have made working conditions more acceptable to general practitioners, but have not increased patients' satisfaction and have sometimes been detrimental to this".

*Occasional Paper No 8, from the Journal of the Royal College of General Practitioners, by Ann Cartwright and Robert Anderson, for the Royal Commission on the NHS (from 14 Princes Gate, London SW7 1PU, £3).

Assessing acupuncture

One of the first scientific trials of acupuncture as a technique for pain relief is under way at Poole General Hospital, in Dorset.

The Poole Acupuncture Research Unit is treating 100 patients suffering from osteoarthritis of the knee — 50 receiving acupuncture and 50 conventional physiotherapy — and is comparing the degree of pain relief in the two groups. The unit is based on the hospital's rheumatology department but the work is being financed by a charity, the Sir Halley Stewart Trust.

If acupuncture can be shown to be at least as effective in relieving pain as physiotherapy, the unit's research team hopes that it will become available through the NHS. "Respectable" NHS acupuncture clinics would make it easier for GPs to refer patients for this form of treatment.

Not everyone responds to acupuncture, but the team points out that for patients who do find it effective no drugs are needed and there appear to be no side-effects.

Primary care in Wales

The Welsh Consumer Council has published a companion study* to the recent research paper of the National Consumer Council on access to primary care (see *CHC NEWS* p 1 April). The study was conducted in Merthyr and Cynon Valley health district with help from the local CHC. The findings of the two studies are quite similar — the report notes that chemists and GPs' receptionists have an "integral role in providing primary care beyond the scope of their formal job definition". *Getting primary care on the NHS* from Welsh Consumer Council, 8 St Andrews Place, Cardiff (£1 inc. post).

Small will be beautiful, says Jenkin

Broad hints about the future of the NHS under the new Conservative Government have come from Social Services Secretary Patrick Jenkin, speaking at a dinner of the British Medical Association.

Mr Jenkin revealed that he wants the NHS to become "far more of a local service than it is at present", that the DHSS will be issuing much less detailed advice in the future, and that what he described as the "vendetta" against private medicine will be ended.

On the question of NHS structure he said: "It is wrong to treat the NHS as though it were — or could be — a single, giant, integrated system. Rather we must try to see it as a whole series of local health services serving local communities and managed by local people, and I accept that different arrangements will be found appropriate in different parts of the country. The management structure is too elaborate and must be simplified."

Patrick Jenkin, Social Services Secretary

On DHSS advice: "I believe that my Department has come to concern itself much too much with detail. Of course, we must seek to achieve national standards of care, and of course proper accountability must be safeguarded. But I also believe that doctors and other professional people in the NHS are trained to take professional decisions off their own bat, and do not need the torrent of advice to which in recent years they seem to have been subjected."

Better drug surveillance on the way

A new way of scrutinising the safety of drugs as they come on to the market is being evolved by the Committee on Safety of Medicines — which admits that its present "yellow card" system detects only one to ten per cent of all adverse reactions to drugs.

A pilot project has been proposed to test out the "recorded release" scheme which the CSM first suggested in February 1978, and the General Medical Services Committee of the British Medical Association has accepted on behalf of the GPs whose cooperation will be crucial to the success of the project. Arrangements still have to be agreed with hospital doctors and Local Medical Committees.

To pilot the scheme, a single new drug will be chosen and the first 10,000 to 100,000 patients to receive it will be traced through the Prescription Pricing Authority. Each patient's GP or consultant will then be asked to supply details of his or her medical history since the first prescription, on a special follow-up form. There will be no provision for the direct reporting of adverse reactions by patients (see *CHC NEWS 43, page 4*).

Experience gained through the pilot project will help to decide how long monitoring of a new drug should continue, what kind of central monitoring body is needed, and how much a permanent scheme covering all new drugs would cost.

Private hospitals

Intervention by the Government caused the Health Services Board to postpone its decision on the proposed expansion of the Wellington Private Hospital. Early in May the Board held a public hearing on the hospital's application to build a 99-bed annexe to its establishment in St John's Wood, a prosperous neighbourhood of London. The scheme was vigorously opposed by more than a dozen London CHCs and several AHAs. They argued that the hospital would draw staff, especially trained nurses, away from the NHS, which is already experiencing "serious staffing shortages" in central London.

The board was due to announce its verdict on 1st June, but before then it received a letter from the Secretary of State, Patrick Jenkin. Mr Taggart, Secretary to the board, told *CHC NEWS* that the board was requested to "modify its activities a little" — and not to phase out any more pay beds in the light of the Government's intention to change the law. It was decided to defer judgement on the Wellington until further consideration had been given to the Minister's letter. On 13th June, the board agreed that the hospital should go ahead.

After a public hearing in March, the board refused an application for a 152-bed private hospital near Ascot, Berks. The main reason given for the refusal was the detrimental effect on the supply of nurses to NHS hospitals in the locality.

Nursing research

A new research unit to study the effectiveness of nursing care has been set up by the DHSS, at the Northwick Park Hospital and Clinical Research Centre in Harrow. Its director is Dr Rosemary Crow, formerly lecturer in the Department of Nursing Studies at Edinburgh University.

CONSULTATION OR..

by Jeannette Mitchell, Secretary, Brent CHC

Over the past year it has become clear that there is a growing disillusionment amongst CHCs about their capacity to influence the decision-makers. In particular, many CHCs' experience of the consultation procedure over hospital closures has left them feeling frustrated and powerless.

During the twelve months beginning in October 1977, CHCs took their opposition to a hospital closure to the Secretary of State on 37 occasions, but their objections were upheld only three times.

So must CHCs resign themselves to a ritualistic role as the official opposition? What are the alternatives to drifting into cynicism?

Many people take the view that CHCs were a tokenistic afterthought built into the NHS to add a measure of democracy to what was otherwise a highly centralised and "top down" management system. After five years of CHC activity, however, we would all probably agree that despite some of the trappings of democracy CHCs cannot offer NHS users any more control over the actions of doctors or administrators than existed in the past.

This is of course hardly surprising. The DHSS circular which established CHCs, HRC(74)4, carefully set out where the power lies in its second paragraph: "In the reorganised NHS management of the service and representation of local opinion will be distinct but complementary functions, entrusted to separate bodies".

The DHSS would argue that CHCs are not about control but *consultation*. If we are concerned about what lies behind our current sense of powerlessness, we need to assess the benefits and disadvantages of the introduction of consultation into our communities.

The idea of consultation implies that in the past health authorities have failed to meet local people's needs because they have not known what these are, and that information provided in the course of consultation will lead to *action* by the authorities. How far this is from a reality in which every CHC suggestion is met with a shake of the head and the magic phrase "resource constraints"! For most CHCs consultation has brought swift action on small matters like improved hospital signposting, but has made little impact on more fundamental questions like the centralisation of health care services and the closure of small hospitals.

While many people would now agree that consultation has brought very limited benefits, it is sometimes even suggested that it has proved to be a step *backwards*. While prior to reorganisation NHS users had not been particularly noted for their militancy, it was not difficult for the Government to predict in the early seventies that its plans to close small hospitals on an unprecedented scale over the coming decade would be met with resistance. The introduction of the formal consultation procedure has ensured that these battles take place on ground which is familiar to health service managers but alien to most local people — including CHC members.

We may be experts on our needs, but when it comes to the language of norms, ratios and occupancy rates it is the health managers who appear the experts, reducing our problems to complex technical questions and limiting the options.

So it is not surprising that CHCs find it hard to keep local community needs clearly in focus. Yet it seems that the Royal Commission is likely to respond to CHC demands for "more teeth" by tying CHCs even more closely into the management system.

While superficially this seems attractive, CHCs need to consider seriously whether the prospect of more long words, heavier documents, more tightly defined options and even more meetings at which the lay person feels out of his or her depth will give us the kind of control we seek. It should perhaps make us wary that at the last ACHCEW conference David Ennals advocated the much closer involvement of CHCs in the planning process, stressing that one reason why there had been so much conflict over hospital closures was that CHCs had not been involved early enough in planning and did not understand why local hospitals had to be closed!

Critics of CHCs have argued that they are not an antidote to the NHS management system but an essential part of it — channelling potentially disruptive dissent into manageable forms. Clearly this argument is difficult to dismiss. But what the critics sometimes forget is that CHCs have a wide brief and considerable freedom of action to interpret their role as they choose. They have access to information and are in a position to investigate needs and raise issues of concern with the wider community. They can act as a focal point to synthesise the opinions and perspectives of local people, and can provide an overall view of what is happening to the local NHS.

On their own, attempting as thirty individuals to represent the needs of local people to the health authorities, CHCs may be powerless. But by feeding information *out* to the community as well as *up* to the authorities, by refusing to talk the language of priorities, by helping community groups organise to articulate their own needs, CHCs may find that they are able to assist the communities they serve to make their voices heard.

It may be that CHCs are constrained as much by their *own* failure to challenge the assumptions involved in the "consultation" way of thinking as by the inherent limitations of their position. The key contribution of CHCs may lie less in their role as representatives of local people than in their capacity to act as a resource for autonomous community activity on health issues. However easy it is for the health authorities to ignore the letters and documents of CHCs, it may prove more difficult for them to resist more broadly-based community activity.

COMMUNITY ACTION?

Photos: Joyce Agee

A problem shared is a problem

*by Penelope Mullen**

The RAWP report has been with us for nearly three years. Its proposals and their implementation have had considerable impact and have generated much controversy.

The Resource Allocation Working Party was set up in May 1975, following increasing concern at the perpetuation of inherited inequalities in the health service. These are usually demonstrated by unequal expenditure per head, but are also revealed in the unequal distribution of facilities and staff, and by inequalities in the level of health of different population groups. The working party presented its main report (1) in September 1976.

But can changing the method of resource allocation achieve equality? This depends, of course, on whether we are seeking equality of health or equality of health service provision. Since health depends on a wide variety of factors such as environment, pollution, socio-economic status and housing, in addition to the contribution made by the health services, it is extremely unlikely that any resource redistribution in the health services alone could achieve equality of health between different population groups.

Equality *in health service provision* can, of course, be achieved through resource redistribution. The RAWP's terms of reference were "to establish a method of securing . . . a pattern of distribution responsive objectively, equitably and efficiently to relative need". It interpreted this brief as giving it an underlying objective to "secure . . . that there would eventually be equal opportunity of access to health care for people at equal risk".

Thus RAWP aims to achieve equality of health service provision given equal "need", and is not aiming to achieve equality of health. It must also be added that equality of opportunity of access does not preclude differential take-up of services by different population groups.

The use of the word "objectively" in the terms of reference has caused some problems in the RAWP debate. Clearly there can be no objective, "correct" way of distributing health service resources independent of value judgements. It is possible, however, to establish criteria for distribution which incorporate value judgements and then to apply these criteria objectively.

RAWP has been seen by some as synonymous with cuts in the NHS. The working party made it clear that it was concerned only with how the available resources were divided up and not with the adequacy of the total resource availability — it was concerned only with how the "cake" is cut up and not with the size of the "cake". Thus RAWP itself should have no effect on the total resources made available to the NHS. However, factors which have led some to equate RAWP with cuts include the almost simultaneous introduction of cash limits on NHS spending, and the tendency to label regions and areas whose current allocations exceed their RAWP targets as "overprovided". There is no evidence that such authorities have too many resources, they are merely relatively better off than the below-target regions and areas.

RAWP proposals

With minor variations, RAWP proposed that revenue allocations be based on the population of each region or area, weighted by its age/sex structure and the national bed utilisation rates for 17 different *condition groupings* (ie groups of diseases). However, since it is considered that there are variations in "need" over and above those caused by differences in age/sex structure, the weighted population is further weighted by the Standardised Mortality Ratio (SMR) for each condition grouping, according to the now famous RAWP formulae. An SMR is a measure of the relative death rate adjusted to allow for the age/sex structure of the particular region or area. SMRs are included as substitute indicators of morbidity (the amount of illness), which is itself intended to be taken as an indicator of "need".

Mortality data may not be a good indicator of the amount of illness, especially for chronic, non-fatal conditions

The working party demonstrated some relationship at regional level between mortality rates and morbidity rates, as measured by sickness absence rates and self-reported illness in the General Household Survey. However, in a developed country mortality data may not be a good indicator of the amount of illness, especially for chronic, non-fatal conditions.

Below the regional level, additional problems may occur with the use of SMRs. There is little evidence as yet that the general relationship between mortality and morbidity demonstrated at the regional level also holds for smaller geographical areas. Also, since some condition groupings account for a very small percentage of all deaths, the SMRs for these groupings in some areas and districts are based on very small numbers.

However, it must be acknowledged that the direct measurement of need is extremely difficult, if not impossible, and that the available information about morbidity is unsatisfactory for this purpose.

RAWP proposed that allowance be made for inpatients who cross NHS boundaries to receive treatment. The method proposed adjusts the allocations of the importing and exporting authorities by the average cost per case within broad specialty groups. Thus, where the actual cases transferred are below average cost for their specialty group the importing authority will be over-compensated, and where they are above average cost it will be under-compensated. This has little effect at the regional level as net patient flows are small and, except in a few specialist cases, there is no reason to believe that overall the cases are non-average.

However, below the regional level, some patient flows can amount to 100% of all the cases within a particular specialty group occurring in a district. Also, especially in the case of teaching hospitals and regional specialties, cross-boundary flows are unlikely to consist of average-cost cases. Due to lack of information no adjustments for cross-boundary flows of outpatients are to be made at the regional level, but the working party does suggest that some allowance be made sub-regionally.

Targets and allocations

Regional targets are calculated by dividing up the total "cake" in proportion to each region's weighted population, calculated from the formulae and adjusted for cross-boundary flows. These targets are then compared with the present allocations to determine by how much each region is above or below target. It should be noted that a region's target depends not only on its share of the "cake" but also on the cake's *total size*, so that if the total allocation is increased each region's target will also increase. This has the effect, when these new targets are compared with existing allocations, of making below-target regions appear even more deprived and above-target regions appear less "overprovided".

Below regional level, most regions have calculated targets

for their areas, most commonly using a form of modified RAWP method, with some omitting or simplifying the use of SMRs and some giving special treatment to regional specialties. The working party recommends that targets for each area be calculated by aggregating district targets.

If there is sufficient growth overall, the movement of regions towards their targets can be carried out either slowly by "levelling-up" through differential growth rates, or more rapidly by reallocation from the above-target to the below-target regions. For the past three years, within overall NHS growth rates of between 1.4% and 2.26%, movement by regions towards their RAWP targets has been by "levelling-up", by means of differential growth rates ranging from 0.25% for the most above-target region to 4% for the most below-target region. Thus, no region has actually had its allocation cut as the result of RAWP implementation. However, if cash limits have been set too low, and/or if there are demographic changes such as an increase in the proportion of the elderly, the low rates in the above-target regions may not provide sufficient growth even for "standstill".

The low rates of growth in the above-target regions may not provide sufficient growth even for 'standstill'

Below the regional level, the above-target regions face a very different problem from that facing the below-target regions. Because of their significant real growth rates, the below-target regions have the choice between "levelling-up" and reallocation. However, above-target regions with little or no growth do not have this choice, and they must *reallocate resources from their* above-target areas if they are to move their below-target areas towards their targets.

Should RAWP be implemented?

Some have argued that RAWP should only be implemented at a time when there is significant real growth in the health service, while others feel that whatever the size of the "cake" it should be cut up fairly as soon as possible. In addition, it has been suggested that the implementation of RAWP should be halted until the technical problems have been ironed out. At the regional level, especially with the present policy of equalisation by "levelling-up", and because many of the technical difficulties with RAWP cancel out, there is little argument for delaying its implementation.

Below the level of the region the case is not so clear. Large cross-boundary flows can exaggerate inequalities, small numbers and inadequate data can distort calculations and a variety of factors such as socio-economic structure, the level of social services provision, population density, housing conditions and location of facilities can affect the need for health services or the cost of providing them.

The RAWP report states that such factors should be taken into account in determining the speed of movement towards target. But it could be argued that some of these factors should be taken into account in the calculation of the targets themselves, particularly since published targets — especially where a single figure is given rather than a range of figures — tend to be treated with considerable reverence. Because of the necessity of taking such local factors into account, it would seem desirable for the application of RAWP to be related closely to the NHS planning system. Most regions have set up working parties to study these and related questions, and these factors may be considered by some to justify caution in reallocation until more is known.

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(2) See circular HN(78)153.

**Penelope Mullen is a lecturer at the Health Services Management Centre, University of Birmingham. She is author of* Reflections on RAWP *(HSMC Occasional Paper No. 13, 50p).*

Books

When I went home . . . a study of patients discharged from hospital

by Pat Gay and Jill Pitkeathley, King Edward's Hospital Fund for London, £3

Having been involved in setting up a day centre in conjunction with a hospital community ward, in which volunteers and discharged patients were brought together, the authors set out to discover what patients discharged from four general hospitals and one psychiatric hospital thought of arrangements for their discharge and care in the community. The book is a report of the survey undertaken and its findings, with comments by patients, and concludes with seven short case studies.
Doreen Sinstadt
Plymouth CHC

The wheelchair child

by Philippa Russell, Souvenir Press, £4 paperback

Although Philippa Russell opens by saying that no one study is definitive of "the

Photo: G D Clark

problems, possible pleasures — and potentials — of a wheelchair life", she has provided a wealth of information for parents of handicapped children.

The book opens with some causes of handicap, and outlines help that should be available. It goes on to discuss the statutory and voluntary bodies set up to aid the disabled child and adolescent. As well as giving practical and sensitive advice to parents, *The wheelchair child* provides a valuable and comprehensive collection of information, which should be useful to all involved with the handicapped. The advice given should be assimilated and adapted to individual needs.
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Action with the elderly

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The author of this handbook "for relatives and friends" is a consultant psychiatrist in Scotland. He shows a sensitive insight into the feelings and needs of old people, and describes the available services. This is set out in short paragraphs interspersed with cartoons and photographs. Useful addresses are also supplied. After a first reading, the good index will make further quick consultation easy.
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Understanding ageing: Facing common family problems

by Melissa Hardie, Hodder and Stoughton, £1.25

Publications about old age seem to proliferate in direct ratio to the increase in the number of people aged over 75 in the community.

This paperback is intended for direct consumption by the elderly, as well as by their carers. Again, available services are described — perhaps optimistically. Some NHS regions may not have all the services mentioned. Useful addresses are given, and there is a good index.

Like *Action with the elderly*, this is aimed at the articulate middle class, rather than at those who form the inarticulate bulk of the clients of the voluntary bodies, and indeed of the CHCs. New CHC members and volunteer recruits will find both books helpful.
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Medicines for the year 2000, proceedings of a symposium held at the Royal College of Physicians, London, in September 1978, by the Office of Health Economies, ed George Teeling-Smith and Nicholas Wells (£5 inc post from OHE, 130 Regent Street, London W1).

THERAPEUTIC COMMUNITIES

*By Raymond Blake, Secretary of the Association of Therapeutic Communities**

The concept of the therapeutic community evolved in the late 1940s, out of the treatment of soldiers suffering from war neuroses. Pioneering psychiatrists, some of them psychoanalysts, sought an alternative to the rigid hierarchical methods of the military psychiatric hospital. These hospitals based their treatment on what is called the *medical model* — the patients were considered as "having a mental illness", and this "illness" was to be treated and "cured" by the medical staff.

These psychiatrists believed that this approach created dependency in the patients, and worked against their ability to take responsibility for themselves. It undermined the possibility of patients realising their own inner strength — which they needed to work through their personal and social problems.

The alternative which began to be explored was to examine the hospital from a therapeutic viewpoint — to delegate responsibility to the patient in a more realistic and more democratic manner, so creating a *partnership* between staff and patients and involving patients actively in their own rehabilitation. Patients' attitudes of dependency changed to those of participation and responsibility. The staff, by allowing patients to take responsibility for their own living areas, for their day-to-day activities, and for their interpersonal relationships, found that patients responded positively.

Through working together and helping each other, patients discovered their own abilities and self-respect, both individually and socially. This approach is now known as *social therapy*.

New types of organisational structure evolved within the hospital. The *community group*, a daily ward meeting of all patients and staff together, began to take decisions on how the unit should be run. It examined current events in the unit — eg a disturbance at night — and explored their causes and implications. Such meetings were a time for thinking about how the community worked and for taking decisions about improvements. The second structure was of small *work groups* or activity groups, to maintain the unit and organise art projects and entertainment for what was becoming an identifiable community. This sharing of activities and decision-making encouraged verbal participation and interaction between the patients. They became more spontaneous, vital and responsible.

The staff then introduced groups to discuss personal and social interactions — *talking groups*. By mutual identification and observation of each other's behaviour, members of these groups, led by staff, were able to help each other with very personal issues. Through these personal interactions the group and its individual members gradually became much stronger.

Those three group structures — community, work and talking groups — are still the main elements of what are now called therapeutic communities (TCs). From the talk groups the approach known as *analytical group psychotherapy* gradually developed, based on social and psychoanalytic concepts.

There are two principles at the core of the TC approach: honesty and responsibility. In the early years the word "permissiveness" was used, meaning that within the limits of community acceptance various types of behaviour were permitted. This enables disturbed or anti-social behaviour to be revealed by TC members.

The community responds to such behaviour by confronting the person with its effects, in a clarifying, firm and yet supportive way. This response leads the patient to recognise the effects of his or her behaviour, and to consider how alternative and more constructive responses could be developed. For example, the patient might come to see how bad time-keeping sets up angry responses, or how fear of rejection is a cause of loneliness. Equally, repressed abilities can be discovered, such as sensitivity or a capacity for leadership.

Letter to a therapeutic community

I left the project nine years ago, and since than I can honestly say I haven't felt better. At times I've been in situations that in the past I would have run away from, by taking an overdose or getting drunk, anything to avoid it. The difference now, and this to me is the most important thing, is that I have a choice. I have to decide, take responsibility for myself, my actions. Before my time at St. Luke's I was not aware of that choice. I was an expert at blame, at passing the buck instead of taking responsibility.

Looking back I see St. Luke's as a sort of second family, a second chance to make right those things that went wrong with my emotional development in my own family. I feel that my own daughter benefits tremendously from my experience. Before the project I resented her, felt bitter and blamed her for my feelings and behaviour. I was unable to show her much love or affection. Now our relationship is secure, happy and enjoyable — not perfect, just a normal relationship between mother and child. At St. Luke's I learned giving and taking — sharing — something which until then I was terrified of.

The work of staff in a TC is to help patients explore the effects of their behaviour, socially and personally. Disturbed behaviour is seen not as an illness which the patient has but as a pattern of behaviour which he or she can understand and change. The staff and senior patients in the TC help to create a culture favourable to such exploration and change.

Often disturbed behaviour turns out to be rooted in the patient's early experiences. Patients will unconsciously re-create the disturbed dynamics of their family and other social relationships, especially in psychotherapeutic groups, by treating particular members of the group as if they were their parents or other figures important to them. In this way patients can recognise their reactions, and try to develop more constructive responses, first in the small groups, then on a larger scale in the TC as a whole, and later in the outside world.

There are of course limits to the TC approach. TCs work best for people who can see that there are few simple answers to personal and social problems. They are not as effective for obsessional or very rigid personalities, neither are they suitable for very brittle personalities needing much individual attention, at least until such people become strong enough to cope in a group setting.

Treatment in a TC can be combined with many other types of treatment. Drug treatment is essential in many TCs, but in these cases the aim is to replace the control of drugs by a process of personal integration, ie the gradual development of personal exploration, control and responsibility. Many other therapies may also be part of the patient's overall treatment programme, for instance family therapy or the action therapies of drama and art, which develop the expression of those parts of the personality previously repressed for various reasons.

Research and observation have shown, however, that the deepest changes tend to take place in the intimacy of the small psychotherapy groups, where negative and positive behaviour can emerge and healing experiences may lead to changes in attitudes and personality. The other major experience is in the community group, where the social power and responsibility of the community is exercised through its collective voice, and ultimately by sanctions. For example, if the community's expectations have been broken by abuse of drugs or undue aggression, the community may debate and decide on discharge.

Photo: Raymond Blake

The community group is the touchstone of the morale, strength and values of the community as a whole. Here, as in the small groups, the example of the senior members helps new members to learn. Support from fellow patients and relationships with staff are the most powerful elements in a TC.

It is often suggested that there is still a medical hierarchy within TCs, and if this is the case it becomes important to ask what form this hierarchy takes. Is it a version of the medical model which allows doctors to continue to give orders in a concealed way, or is there a genuine attempt, through exploration of the issues with members, to achieve consensus on decisions affecting the community?

There undoubtedly *is* a hierarchy, for the ultimate responsibility lies with trained staff and the staff leader — psychiatrist, social worker or warden. Where TC principles operate, however, staff explore the issues with members, sharing the facts, options and responsibility for decision-making. A good community will debate. This model of consensus management — management by the community of the community — applies also to the psychotherapy groups, in which staff lead or enable the psychotherapy by the group of the group.

There is, understandably, a rather ambivalent image of TCs in many people's minds. They are often seen to be in conflict with the more orthodox psychiatric approach, particularly in the UK. TCs are often places where human behaviour which would be unacceptable in a mental hospital ward can be seen. Anxiety, responsibility, anger, pain and play are all expressed in varying degrees at various times. Alternatively, it may be the high degree of independence of TC patients which visitors find surprising. TCs will vary in appearance and atmosphere according to morale or the particular phase they are in. Physically they will be cleaner and tidier at times and not so clean and tidy at others, though of course it is the ultimate responsibility of staff to maintain reasonable limits.

It is usually difficult initially to distinguish staff from members. Staff do not wear uniforms, and their authority is exercised through skill and personality rather than by rank. Staff are a multidisciplinary team, perhaps including psychiatrists, art therapists, social workers and psychotherapists. Senior patients may appear to visitors to be similar to staff members, for instance during a community meeting.

The few research findings yet available show that TCs are effective in most cases in enabling patients to live more independent lives. They are effective in breaking cycles of hospitalisation, as well as having a preventive function. There are about twenty TC units in the NHS, and they are also being developed in the social services — day and residential — and in the voluntary sector. They are applicable in the fields of mental health, education and the care of the elderly, and in the rehabilitation of drug addicts and prisoners. To be effective TCs require well-trained staff, and this is a major factor in developing the TC approach.

Treatment in a TC is not a quick cure for patients. It requires a year or two in most cases, with further group therapy thereafter. Though no panacea, it is a treatment for a wide range or personal problems or diagnoses. It is demanding on staff and members, but it makes for a better quality of life for the patients.

A drama therapy group at work in a Glasgow psychiatric day hospital

Photo: Nursing Mirror

**The Association of Therapeutic Communities can be contacted at the St. Luke's Project, Chelsea Town Hall, King's Road, London SW3. The views expressed in this article are not necessarily those of the ATC.*

Healthline

Health centres and private practice

What are the rules governing private practice from health centres?

GPs working from health centres must apply to the Secretary of State, usually through their FPC, for permission to have private patients. So far consent has never been refused. Circular HC(77)8 (Appendix B, fifth schedule) sets out the conditions under which such permission is given: the number of private patients shall not exceed the number of NHS patients, and arrangements must be such that NHS patients receive "full and proper attention". Permission given to a GP also covers locums, partners, deputies and assistants acting on his or her behalf. Circular HC(79)8 (paragraph 57) allows health centre dentists to practise privately for up to 10% of their time at the centre or 150 hours annually, whichever is the less, provided they hold at least six NHS sessions per week at the centre. Also see Section 72 of the NHS Act 1977.

Housing and health

Is there a book discussing the links between poor housing and ill health?

Yes — *Health and housing*, by Peter Lane (Batsford, 1975).

Lupus group

Systemic lupus erythrematosus is an immunological disorder causing skin rashes and also affecting other parts of the body. Is there a self-help group for SLE sufferers?

Yes. Write to Mrs Cheryl Marcus, Joint Chairwoman, Lupus Steering Committee, 25 Monkhams Drive, Woodford Green, Essex. The group has just launched its own newsletter.

Hospital definitions

How does the DHSS define the terms District General Hospital and Community Hospital.

There is no simple answer to this question — you'll have to do some reading! The concept of a hospital providing the population of a health district with most types of specialist medical and surgical care arose in 1962, in *A hospital plan for England and Wales* (HMSO, Cmnd 1604), and was developed in the Bonham-Carter Report *The functions of the DGH* (HMSO 1969). A community hospital, broadly speaking, is a small hospital for patients *not* requiring specialist care, where responsibility for patient care is taken by GPs. The key document here is the guidance memorandum *Community hospitals: their role and development in the NHS*, issued with circular HSC(IS)75. Also see the article on community hospitals in *CHC NEWS 41*, and have a look at *The way forward* (HMSO 1977) and circulars DS 85/75 and HC(78)12.

Befriending the patient

Do you know of any CHC secretaries who are allowed to speak during FPC service committee hearings, while acting as the "patient's friend"?

We don't know of any secretaries who are normally permitted to do this. If any secretary *has* been allowed to speak during one of these hearings, would he or she please let us know?

Advice on asthma

Is there something that asthma sufferers could read about what causes the disease, how to treat it, and how to cope with it in everyday life?

Try *Coming to terms with asthma*, 25p inc post from the Asthma Research Council, 12 Pembridge Square, London W2 4EH.

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

Your letters

Continued from page 2

the rare occasions when the public's view is available, it should be allowed to decide the priorities, and I make no apology for stating the obvious. ACHCEW has a difficult task in its role of accountability to all CHCs, and it is a task which I think it is meeting incredibly well.

Availability of FPC lists

Shirley McCarthy, Secretary, North West Herts CHC

As initiators of work on the availability of professional lists, the primary care group of this CHC is concerned that the impression given by the joint letter from the National Federation of Consumer Groups and the National Association of CABx (*CHC NEWS 43* p2) may not reflect the main concern of this CHC.

Our efforts have been aimed at having reinstated the statutory duty which executive councils had to supply up-to-date information on lists of doctors, dentists, pharmacists and opticians to libraries and crown post offices. We agree that this information should be more widely available and hope that CHCs will work with their FPCs to this end. But it would seem premature to press for more complex information to be presented when FPCs appear to find it difficult enough to produce regular basic lists.

Regarding content, in Hertfordshire and I believe nationally the Medical List does contain more than "just names and addresses", giving branch surgery details and denoting which GPs supply contraceptive and maternity services. But even this information is of little use unless readily accessible and up-to-date, and the priority should therefore be to reimpose the statutory duty.

Insulating the patient

J W Corbett, Secretary, Barnet/Finchley CHC

Kate Truscott of *Fightback* was dismayed to hear of the resolution passed by South Tyneside CHC deploring strikes in the NHS (*CHC NEWS 40* p 2). This CHC passed a similar motion with the vital proviso that any restriction on the right to strike should be as a direct *quid pro quo* for index-linked salaries.

Ms Truscott would have us believe that wholehearted support for NHS strikers would eventually lead to the rooting out of the cancer and a better health service for all. Admirable stuff, if it *did* actually achieve this.

We live in a society where conflict has been formalised at every level, but can we not insulate the patient? NHS workers may well have an excellent case, but please let us attempt to create an oasis of calm around the patient, where properly considered and maintained conditions and salaries can make industrial strife such as we have recently witnessed obsolete.

IYC and mentally handicapped children

Peggy Jay, Convenor, Mental Health Care Group, North Camden CHC

I was immensely pleased to see that the Association of CHCs for England and Wales had decided to concentrate its contribution to the International Year of the Child on the theme of getting all mentally handicapped children out of hospital, in accordance with the resolution passed at the association's AGM last year. I was, however, disappointed to see that the letter from the association inviting CHCs to join in this effort stated that there would still be "a number of children remaining in need of medical and nursing supervision". Maureen Oswin's research has shown that only too often it is precisely this medical and other specialist care which is lacking in the long-stay hospital wards.

I think all CHCs should look urgently at their long-stay children's wards with a "child care eye", and report on conditions, with a view to making representations to their AHAs and local authorities.

I would like to add that it is vitally important that no parent of a mentally handicapped child in a long-stay hospital should feel in any way pressurised to receive that child back home. What these parents require is a small, local unit where they may share in the care of their child, supporting and being supported by the staff.

for their areas, most commonly using a form of modified RAWP method, with some omitting or simplifying the use of SMRs and some giving special treatment to regional specialties. The working party recommends that targets for each area be calculated by aggregating district targets.

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Below the regional level, the above-target regions face a very different problem from that facing the below-target regions. Because of their significant real growth rates, the below-target regions have the choice between "levelling-up" and reallocation. However, above-target regions with little or no growth do not have this choice, and they must reallocate resources from their above-target areas if they are to move their below-target areas towards their targets.

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PERSONAL SOCIAL SERVICES COUNCIL

by Malcolm Johnson, Secretary (Policy and Research) of the Personal Social Services Council, and former Vice-chairman of Leeds Eastern CHC

The task of the Personal Social Services Council (PSSC) is to advise the Secretaries of State for Social Services and for Wales on policy issues over the whole range of personal social services. Advisory bodies to the government are by their nature a hybrid species. They are neither pressure groups nor civil service, but sometimes adopt the advocacy role of one and sometimes the diplomacy of the other. In some ways the relationship is akin to that of CHCs to area health authorities — one which I call "critical friendship". Just as CHCs are made up of people who represent a wide range of interests in health matters and of different political persuasions, the same could be said of members of the PSSC, although they are in the social services field.

In practice our area of interest covers all of the work of social services departments, but also overlaps with health and social security. Indeed PSSC has specific obligations to advise on the care of physically handicapped people and on child care. In addition its work encompasses policy on older people, mental handicap, mental illness, residential care, the voluntary sector, alcoholism, the practice of social work and collaboration between health and social services. Like CHCs it has a special brief for consumers. The *Good neighbour campaign* and the *Children's committee* (arising out of the Court Report) both operate from the PSSC and the latter is a joint committee of the PSSC and the Central Health Services Council.

The origin of the Personal Social Services Council lies in a recommendation of the 1968 *Seebohm Report on local authority and allied social services* — that a single new advisory body should be set up to advise ministers on policy on the personal social services.

Advisory bodies all work on roughly the same principle, ie gathering together a balanced group of experienced and creative individuals who are leaders in their fields. From such a group it ought to be possible both to draw out the concerns and feelings of the community of interest they represent and to learn of ways in which their field can be advanced. The council is made up of 29 unpaid people all of whom are appointed by the Secretaries of State to serve for a limited period. Half are drawn from local government, directors of social services, British Association of Social Workers, Central Health Services Council and CCETSW. The others are from the universities, directors of national voluntary bodies, medicine, research and social welfare generally.

The council meets four times a year and its many policy working groups have at least one major meeting each month. The considerable expertise of council members is supplemented by non-council members and by the PSSC's small staff. Funding is provided jointly by local and central government, with smaller amounts available from charitable trusts.

Issues arrive on the agenda of policy groups because they are referred directly by a Minister, arise from local authority concerns, are raised by voluntary bodies, professional bodies, public debate and from within the council itself. Most of the working groups require some kind of research to add information and insight. This may involve the research staff in work of a few weeks, or may mean a major piece of policy-related research. The PSSC has also adopted more participative forms of consultation and will soon be inviting those who are interested to submit "evidence" in the manner of parliamentary committees.

In this way experience and research get distilled in reports which contain policy advice to the government and to our other audiences of local government and the voluntary sector. The reports are always published whilst the specific advice is discussed at senior civil servant and administrative level.

The research and policy aspects of PSSC should be apparent by now, but development is a less tangible notion. At one level it is evangelism — putting across the message of policy advice to members of parliament, councillors, professionals, volunteers and researchers through conferences, seminars and meetings. At another level (and one which is about to be extended) it is the active promotion of new initiatives in practice. It means working in collaboration with voluntary and statutory bodies to try out, say, new forms of "intermediate treatment", boarding out for mentally handicapped people or providing residential care which provides for the sexual needs of older and handicapped residents. These joint ventures are evaluated and reported on.

Having been a researcher who has published and hoped the decision makers were listening and also a pressure group representative hoping the policy makers were aware, I feel that PSSC offers the opportunity to work closer to the cutting edge of policy construction. But PSSC is not just for the council members and its staff. It is and must be open to influence by all those who provide and consume social services. So much of our work is concerned with maintaining extensive networks and keeping in touch with diverse fields.

CHCs have played little part in PSSC's activities in the past, no doubt because of the fairly strict division which has existed between health and social services. But PSSC does share common interests with the NHS. And the consumers of personal social services are almost the last group in Britain without a formal consumer body. CHCs might like to keep the PSSC informed about local concerns and the need for some equivalent body in its territory. The council would take very seriously any representation made to them by CHCs and would welcome the opportunity to build more bridges across the divide between health and social welfare services.

Personal Social Services Council, Brook House, 2-16 Torrington Place, London WC1E 7HN (01-323 4757).

Photo: Maria Bartha

Enterprise for the elderly

by David Delaney, Chairman, North Camden CHC*

Three years ago this mo... ...e Garrett Anderson Maternity Ho... ...Hampstead was closed by the Camden and Islington AHA as it had ceased to be viable. By December squatters had moved in. Two years later the AHA issued a consultative document on its proposal to redevelop the site for staff accommodation.

North Camden CHC has long maintained that several health buildings in the district, used for non-health purposes, are ideal for the priority care groups who are so poorly served. The CHC resolved to spare no effort to persuade the AHA to change its mind about demolishing one of these buildings.

The area's strategic plan records the need for 24 geriatric and 24 psychogeriatric day hospital places in North Camden. The maternity home seemed to be an ideal building for a day hospital. The CHC agreed, however, only to go ahead with a counter-proposal if the conversion could be done at an economic cost. Any surplus space could be used for staff accommodation.

We were most fortunate to obtain the voluntary services of a firm of architects with considerable experience in designing health buildings, including day hospitals. The CHC formed a project team which visited several day hospitals for the elderly and discussed the staffing and operation of a unit in North Camden. Then we briefed the architect on our requirements. We did further research into the need for a day hospital. The health statistics on length of hospital stay, cross-boundary flows, discharge and death rates provided supportive evidence. Camden Borough Council surveys on demographic trends and the social deprivation of the elderly confirmed the pressing need for day hospital services for geriatric and psychogeriatric patients within our health district. The DHSS guidance on *Services for mental illness related to old age (HM(72)71)* and a Medical Research Council report on senile dementia confirmed our opinion that it was not only feasible but positively desirable to have some common facilities for geriatric and psychogeriatric patients.

When the architect had done the initial sketches, we went into a further round of consultation with professional staff. We encountered difficulties in arranging meetings with consultants in the short time left to complete the counter-proposal. After a final briefing, the architect began the finished design and the quantity surveyor estimated the costs. We decided to follow the standard NHS procedures for development projects as closely as we could. This meant using the NE Thames RHA *Outline brief for capital projects*, elements of the *CAPRICODE* procedure for project control and the DHSS *Cost form 4* stating the revenue costs of day hospitals.

We obtained cost statements for several other day hospitals and used them as a guide for estimating the general services costs and the medical staffing levels. Nurse staffing levels were based on regional guidelines and the recommendations of nursing staff themselves. We asked the area works officer to estimate the estate management costs. We then costed a high cost, ideal arrangement and a low cost, economy service. We chose the high cost option for our final submission.

Since the AHA's consultative document gave no cost estimates for its own plans, the CHC had to do the estimates instead. According to cost yardsticks for residential accommodation, the AHA's development proposal would cost £960,000. The net cost of the CHC's plan for a 40-place unit, after the sale of the adjoining property, would be £210,000. The SE Thames RHA's strategic plan showed that a new, 40-place unit would cost £660,000. To meet the anticipated criticisms that the scheme would create ambulance transport difficulties, we approached the London Ambulance Service direct. They told us that the AHA could employ its own drivers and the service would supply vehicles and pay all the costs.

The greatest problem was how to finance the counter-proposal as the capital and the revenue costs would have to come out of internal savings within the AHA. It is very difficult for CHCs to find out about waste of resources. But we calculated that about 13 inpatient beds could be closed, which would finance about 68% of the day hospital. But as these would be beds at Friern mental hospital, this would not help AHA funds. Eventually we revalued the original operating cost of the former maternity home to 1978 prices and found that this comfortably exceeded the running costs of the day hospital.

Our proposal, complete with architect's drawings, showed that the AHA owned a valuable building, entirely suitable for conversion to a much-needed day hospital for the elderly. The capital cost of the CHC scheme would be only a third that of building a new unit, and would also provide some staff accommodation. The revenue costs would be well below the cost of the old maternity home which the AHA had closed.

The area health authority rejected the CHC's counter-proposal.

**David Delaney is also a planning officer for Lambeth, Southwark and Lewisham AHA.*

There are already two recognised points at which community health councils become involved in the NHS planning process. First, the district management team (DMT) — or, in single-district areas, the area management team (AMT) — is obliged to consult with its respective CHC on the content of the district plan (short-term, *operational* planning). Second, a representative of the council is present at meetings of the area health authority at which any plans will be discussed (*operational* and long-term, *strategic* planning). In fact, however, the solutions to problems have already been debated within the planning groups, with district planning teams (DPTs) and by DMTs, and it is only the final plan for which approval is being sought that is put forward.

Consultation ought to mean participation in planning *before* the final stages. This in turn means that all the participants should be kept abreast of relevant background information and should have a wide knowledge of existing needs and services. In practice, for CHCs there is usually only time within the planning cycle for comments on the final plan. Getting alternative ideas incorporated into the final plan is very difficult, however, especially if these ideas have already been considered by planning groups and, for reasons unknown or unexplained to the CHC, dismissed. So in

All day hospital visiting

by Liz Haggard, Secretary, South Nottingham CHC

This summer we started a new type of hospital visit. Members of a study group arrange to cover a ward day on a rota basis with each member on the ward for three hours from 7 a.m. to 9 p.m. We have done six of these visits, four in a large rural mental illness hospital and two in a smaller hospital for women. The visits have worked because the hospital staff have encouraged them and been helpful to us.

Before a visit the CHC secretary and nursing officer agree which ward should be visited. The nursing officer discusses the visit with the ward staff — we do not feel that visiting without staff support would be useful. The study group members have a pre-visit meeting with the ward staff. We have found that these visits are best held on the ward. At this meeting staff and members meet, discuss difficulties which staff want us to know of, emphasize that we expect and need to be guided by ward staff on our visit and agree that members will each write up a diary account of the visit. These diaries will

Participation in planning

by Chris Wolvin, Secretary, Crewe CHC

order to comply with the time limits of the planning cycle, CHCs tend to be working in parallel with, but in isolation from, the management teams and planning groups, inserting their ideas only when formally consulted.

I would like to put forward a number of suggestions of ways in which this isolation can be overcome.

● *Formal meetings with the DMT (or AMT)* could be held on a regular, if infrequent, basis. By necessity such meetings would tend to be held towards the end of the planning process when DPTs have reported to the DMT. The CHC would therefore be unaware of all previous discussion, and might have difficulty in getting the DMT to accept new ideas. But the meetings would at least be useful as a means of discussing district priorities.

● *Informal meetings with DMT and planning officers* could be held more frequently and could be a useful forum for discussing the major issues that have arisen from DPT discussions. For the discussion to be of value much of the background information must be supplied to the CHC.

● *Membership of DPTs* would allow the CHC to feed its own ideas, and ideas from the community, in at the lowest planning level. Even if these ideas are not accepted, the council would know that they had at any rate been properly considered.

● *Supply of DPT minutes, reports and other information to the CHC* would enable the council to discuss proposals in the context of relevant background information and to comment on the issues at a very early planning stage. The disadvantage is that, as many ideas will not be viable, the whole council may be involved in much fruitless discussion.

● *Supply of reports from DPTs on major issues* would allow CHCs to comment on and contribute to the decisions taken prior to the formulation of the final plans. However, the need for the relevant background information is again imperative, and time limits may be an important factor if public debate is thought necessary.

● *Supply of final reports of DPTs* is clearly necessary if CHCs are to comment formally, but the question arises of whether the council can make a contribution or whether, at this stage, decisions have already been taken.

This list is not exhaustive, and the suggestions clearly have disadvantages as well as benefits. But these and other ideas could be combined to produce a mutually acceptable means by which CHCs can participate more fully in the planning process. Participation will only work, however, if CHC members understand fully the nature of the services provided and the role of the professionals, and if the professionals appreciate that there may be another point of view which should receive the same consideration as their own opinions.

An article on CHCs and the NHS planning cycle was published in CHC NEWS 35, p 8.

Photo: Liz Heron

then be brought back for a post-visit discussion with the ward staff. The understanding is that the diaries are an informal private record to be shared by the CHC study group members and ward staff.

On the day of the visit members go direct to their ward and take over after a short briefing from the member already on duty. During their time on the ward, members participate in the general life of the ward, dividing their time between talking to patients and staff. We do not formally take up issues arising from these visits without further discussion among CHC members. Issues are then raised in the normal way through the unit administrator, senior nursing officer or with the district management team as appropriate.

The advantages of these visits are that individual members have more involvement and responsibility and find the visit more rewarding. Ward staff, although initially a bit apprehensive, have enjoyed the visits. We have all found the post-visit discussions interesting and useful. Obviously these visits give us more information than we could gain in a short group visit and we have time to talk to patients and staff. The great value of the visits is that we build up a vivid picture of life on the ward and feel we have shared the experience of patients and staff. Busy members can choose a slot in the rota that fits in with their own routine.

There are disadvantages too. It would be naive to minimize the element of risk involved in these visits for staff and members. A member might well be tactless, upset a patient, be involved in an incident or be in the way at a critical time. Here we have to rely on guidance and help from staff and so far there have not been any problems. The fact that these visits enable us to share staff's experience could lead us to over-identify with the staff point of view. Certainly we are now more aware of what the nursing day involves. Another possible disadvantage is that the information we collect is less systematic than on a visit planned to look at specific aspects.

Visit administration apart, the follow-up after a day-long visit is more complex for the secretary and study group chairman. It can be difficult to identify key issues among the wealth of detail. There can be problems in following up information traceable to particular members of staff.

We have only done six visits but we hope to do more. Members who have taken part in one of the day-long visits would not like to return to the former group visiting pattern which sometimes resembled rather too closely the hospital management committee "grand tour".

SICKLE-CELL ANAEMIA

*by Elizabeth Anionwu, Member, Brent CHC and Brent branch of OSCAR**

Sickle-cell anaemia is so called because the red blood cells change their shape to a farmer's sickle, when they lose a certain amount of oxygen. It is an inherited condition mainly affecting people of African origin, eg West Indians in this country. Roughly 1 in 400 West Indians are affected, as are some people from Mediterranean and Asian countries. It is thought that carriers of sickle-cell *trait* have some natural protection against malaria, which may be why its occurrence is limited to people originating from certain parts of the world.

A person with sickle-cell anaemia has inherited two sickle-cell genes, one from each parent. The parents are either healthy carriers of the sickle-cell *trait*, or themselves have the disease. Babies rarely have symptoms before six months and these could be painful swellings of the hands and feet, infection and anaemia. The illness may cause severe anaemia with jaundice, pains in the joints and other parts of the body. These episodes of pain are called *crises* and are more likely during infection, pregnancy and as a side-effect of anaesthesia. The pain is caused by the red blood cell changing to a sickle shape and blocking the small blood vessels. Between crises it is possible to lead a fairly normal life, and symptoms vary very much from one person to another. There is no cure but treatment can relieve the symptoms.

A person with sickle-cell *trait* has inherited one sickle-cell gene and one normal gene. There is no illness and people are usually quite unaware that they are carriers of the disease, until their blood is specially tested or a child is born. If both parents have the sickle-cell trait there is a 1 in 4 chance that each child will inherit sickle-cell anaemia, a 1 in 2 chance of being a carrier and a 1 in 4 chance of having normal blood cells.

Sickle-cell anaemia and the trait often go undetected, but screening is very simple. All newborn babies of mothers who are carriers should be tested. Early diagnosis is important as symptoms are often mistaken for arthritis, rheumatism or "growing pains". All patients admitted to hospital who are of Afro/Asian/Mediterranean origin should be routinely screened, in case they need anaesthesia. Children at dental clinics and pregnant women should also be tested. When a test is positive, the rest of the family should be offered screening.

Screening to detect sickle-cell trait should be available to interested people on a voluntary basis following education and should not be offered on a mass scale, causing stigma and confusion. All screening should be backed up with education and counselling facilities by trained health workers but very few health districts offer such services; Brent health district has started to develop a small programme.

Health workers and the public need much more information about this condition. I am alarmed at the poor level of awareness among health workers about the health needs of minority ethnic groups and sickle-cell anaemia is a case in point. A leaflet about the condition will soon be published and people wanting more information can contact me at Brent CHC.

**OSCAR stands for Organisation for Sickle Cell Anaemia Research, 200a High Road, Wood Green, London N22 4HH.*

Parliament

Mentally handicapped children

At the end of 1976 there were about 4500 children under 16 resident in English mental handicap hospitals and units. The number of mentally handicapped children in local authority homes was about 1600. Local authorities have a general duty to provide such accommodation, but the DHSS accepts that such care would be inappropriate for the "small number" of severely mentally handicapped children who need the specialist services of a hospital. It is not known how many mentally handicapped children could be discharged from hospital if adequate alternative facilities were available. HC(78)28 asked AHAs to review the needs of all children who have been in hospital for more than three months, at six-month intervals (Jack Ashley MP, Stoke-on-Trent South, 13 March).

In March 1977, 44 English local authorities provided no direct residential accommodation for mentally handicapped children (Robert Kilroy-Silk MP, Ormskirk, 12 March).

Mental handicap hospitals

In 1977/78, 5.8% of hospital revenue expenditure in the NW region was spent on mental handicap hospitals, as against 6.1% in 1974/75. The figure for England in 1977/78 was 6.4%, and the planning guideline for 1981/82 is 6.6%. Roland Moyle said he was not satisfied with this, and had asked the RHA to make improvements (Robert Kilroy-Silk MP, Ormskirk, 12 March).

Distinction awards

Wide disparities in the numbers of distinction awards made to the various medical and surgical specialties have been revealed in figures published by Roland Moyle. At the end of 1977 only 13% of community medicine specialists in England and Wales were receiving awards; 23% of consultants in geriatrics; 25% in mental health; and 26% in rheumatology and rehabilitation. In contrast, 73% of consultants in thoracic surgery had awards; 67% in neurosurgery; and 64% in cardiology. Awards were worth between £2000 and £10,600 pa to recipients (Laurie Pavitt MP, Brent South, 9 March).

Inpatient costs

The following provisional estimates of average weekly costs per inpatient in England have been released for 1977/78: geriatric hospitals £107, orthopaedic £224, mental illness £95, mental handicap £82, acute with over 200 beds (eg DGHs) £276 (David Price MP, Eastleigh, 27 March).

Hotel charges

A charge of £5 per week to all hospital inpatients in England would raise about £80m gross. If exemptions were made for children, pregnant and nursing mothers, psychiatric patients, the chronically sick, patients from families receiving supplementary benefit or FIS, and those in hospital for less than one week, the £5 charge would produce £30m. But still to be offset against this would be "considerable" administrative costs (Ralph Howell MP, North Norfolk, 21 March).

Cannabis, nicotine and alcohol

Lord Houghton of Sowerby asked why the Government "continue to be oppressive and repressive about cannabis and so lukewarm about curbing the greater evils of nicotine and alcohol", and wondered if "considerations of revenue, commercial interest and employment lie at the root of this difference in attitude". Lord Wells-Pestell replied that the Government did not accept that there were "simple parallels between the use of cannabis, nicotine and alcohol". Cigarettes were controlled through voluntary agreements with the industry, and a consultative document on the misuse of alcohol was being prepared. Reduced penalties for cannabis offences were under consideration (15 March).

Nursing numbers

The number of whole-time equivalent nurses employed in the NHS rose from 278,000 to 319,000 from 1973 to 1977. In 1977, 168,000 of these were registered or enrolled nurses (John Forrester MP, Stoke-on-Trent North, 21 March).

Scanner

Chronic mental illness

Working with people who are sufferers from chronic mental illness "imposes strains and frustrations on the caring professions, who must rise to the challenge with an ability to sustain activity and interest without the satisfaction of progress". This was one issue discussed at a DHSS symposium in Worcester last year. The meeting focussed on the experimental Worcester Development Project. *Report of a symposium on chronic mental illness*, free, from Mental Health Division A, Room C401, DHSS, Alexander Fleming House, London SE1.

Smoking

A total ban on all forms of tobacco promotion is called for by a World Health Organisation report on smoking control. A committee of experts, chaired by Sir George Godber, former Chief Medical Officer to the DHSS, condemns the international tobacco industry as "irresponsible" and blames massive advertising campaigns for a "substantial number of unnecessary deaths". A summary of the WHO report is available from ASH Action on Smoking and Health, 27-35 Mortimer Street, London W1N 7RJ.

Sickness and invalidity benefits

New DHSS leaflets explain the rules on eligibility, making a claim, and other complexities affecting payment of sickness benefit (NI.16) and invalidity benefit (NI.16A). Sickness benefit is claimed for up to 168 days, after which invalidity benefit takes over. This is made up of invalidity pension and invalidity allowance (paid with invalidity pension if claimants were under 60 (men) or 55 (women) when they became incapable of working).

Housing disability

An investigation of the effects of inappropriate housing on physically handicapped people living in the community was carried out in 1977/78 by the housing and disability subcommittee of Rochdale Voluntary Action. The report* is valuable both as a study of "housing disability" and as a model for research projects undertaken by self-help consumer groups as opposed to external researchers.

**Housing and disability* (full report £3 inc post, summary £1 inc post, from Rochdale Voluntary Action, 157 Drake Street, Rochdale OL11 1EF).

Abortion figures

Abortion statistics 1976 (Office of Population Censuses and Surveys, HMSO £2) contains tables on legal abortions in England and Wales, covering information such as statutory grounds for abortion, gestational age, place of residence and operation, complications and deaths, and numbers of NHS and non-NHS abortions.

Home sweet nothing

Is the title of a discussion paper on the plight of sufferers from chronic schizophrenia and the lack of support for them in the community. Published by the National Schizophrenia Fellowship (60p + 10p post from 78/79 Victoria Road, Surbiton, Surrey KT6 4NS), it calls for the development of experimental "campus communities", offering sheltered housing, occupational opportunities, and provision for continuing assessment of individual needs.

Geriatric care programme: HN(79)35

Districts are being asked to set up programmes to improve standards of care and quality of life for inpatients in hospital geriatric departments. A DHSS/NHS working group has prepared guidance and training aids for the programmes. One of the aims is to get nurses to re-examine their own actions and attitudes. For example, staff are asked whether they themselves have ever tried to balance on a bed pan, what they would do if they saw an elderly person crying.

Look after yourself!

A new package of information on diet, exercise and giving up smoking is available as part of the Health Education Council's 1979 campaign Look after yourself. *Last year 1¼ million people wrote for information to Health Education Council, London SE99.*

Health in retirement

Loss of occupation, income and status on retirement from work combine with the natural process of ageing to pose special health problems for retired people. A booklet entitled *Third age health*, produced by the Pre-Retirement Association (50p + 15p post from 19 Undine Street, London SW17 8PP) offers guidance on health topics for speakers involved in education for retirement.

Home helps

A choice for pensioners between having their cleaning or shopping or laundry done is one of the effects of cuts in the home help service, which are being kept under review in London by the Task Force Cuts Monitoring Group. A recent report (available from Task Force, 1 Thorpe Close, off Cambridge Gardens, London W10 5XL) shows how the cuts are seriously reducing the levels of home help provision which in few boroughs have ever reached even the arbitrary (low) figure set by the DHSS.

Appointments to AHAs: HC(79)1

This circular for the most part repeats guidance on arrangements for appointing members of AHAs given in HC(76)55, which it supersedes. Members are appointed partly by RHAs and partly by local authorities. One third of the membership is to be drawn from local government. The circular lays stress on the corporate responsibility of AHA members, on the need for younger members, and on members having adequate time to devote to AHA duties (2-4 days a month). RHAs are to consult CHCs on appointments, and are reminded of the advantages of appointing people with CHC experience to AHAs. An appendix lists national bodies that RHAs might appropriately consult about AHA appointments. This contains fewer voluntary organisations than the 1976 list, but does now include the main health service trade unions and the three major political parties. Subject to the approval of Parliament, the tenure of office of half the present AHA members, due to expire on 31 July, will be extended, and new appointments will be made on 1 October.

Tenant or licensee?

The second edition of a pamphlet from the National Association for the Care and Resettlement of Offenders* offers guidance for managers and residents of hostels, group homes and similar accommodation on how Rent Acts and related legislation affect them.

**The "rights" of residents in hostels and similar accommodation*, from NACRO, 169 Clapham Road, London SW9.

Directory of CHCs: changes

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

Page 2: South Tyneside CHC 131 Westoe Road, South Shields, Tyne and Wear, NE33 3PA. Tel: unchanged
Page 3: Leeds Western CHC Chairman: John Tyler
Page 4: South Lincolnshire CHC Council Offices, Eastgate, Sleaford, Lincolnshire. Tel: Sleaford 303241 ex 117
Page 4: Central Nottinghamshire CHC Chairman Mr A Hopkinson
Page 11: Roehampton CHC is now called **Roehampton, Putney and Barnes CHC**
Page 12: Wandsworth and East Merton CHC Chairperson: Ms Susan Poston
Page 20: East Glamorgan CHC Chairman: Coun. J C Anzani

News from CHCs

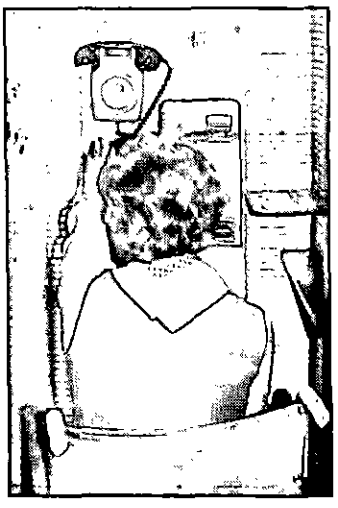
☐ A one-month kidney donor campaign organised by **North Herts CHC** has generated massive publicity. The aim was to distribute 40,000 donor cards throughout the district — but this figure was exceeded within ten days. A press conference featuring a transplant recipient and a DHSS representative launched the campaign, and local shops, firms and girl guides helped with distribution. A film about donation was shown, and kidney machines and publicity material were exhibited widely. Even "Batman and Robin" — two "caped crusaders" from the local Council of Voluntary Service — helped to whip up public support.

☐ The help of **Burnley, Pendle and Rossendale CHC** has enabled the village of Crawshawbooth to keep its GP services. When the village doctor retired, the incoming GP had to find new surgery premises, but was refused vital planning permission. Loss of the surgery would have also meant losing the pharmacy. The CHC went into action and now the planning decision has been reversed. GP retirement in a country area has led to **Durham CHC** challenging an FPC decision not to advertise the practice vacancy. Now the CHC is discussing the ethical issues involved in asking villagers, most of whom have registered elsewhere, if they would register with a doctor who is willing to run a branch surgery in the village. **Scunthorpe CHC** is also in dispute with its FPC, this time about the need for a surgery in a "pocket" of increasing population. It will conduct a survey of 1 in 10 households, with the help of Hull University. Finally, the campaign to retain a surgery in the Lake District village of Grasmere was taken right to the top by **South East Cumbria CHC**. The council appealed to the Minister of Health to ask the Medical Practices Committee to think again about dispersing the Grasmere patients to other practices. It argued that summer tourism and the special problems of a rural area had not been fully considered. But the decision was confirmed.

☐ Rural transport problems for patients and their visitors have been taxing **Southend, Northallerton** and **Worksop and Retford CHCs** recently. The rural transport experiment (RUTEX) funded by the Department of Transport comes to a close in North Yorkshire this month. The county council and the AHA have refused Northallerton CHC's request that they take over the DoT's £3000 a year subsidy. A decline in the use of RUTEX has been a major factor in this decision. Unused services have also been a problem affecting the future of a community bus scheme in North Nottinghamshire (see page 3, *CHC NEWS* June 1978). The bus will run for another year, but hospital visitors and day-patients have not used the bus as expected. John Kitchen, the CHC secretary, said, "However carefully you plan a service, practice does not always go hand in hand with theory. Our survey showed a need for the service, but those people aren't using it." In Southend, the CHC is banking on an intensified publicity campaign for a bus route from outlying villages to the hospital to boost demand. If this fails the bus company will axe a service for which the council won a reprieve last year.

Cartoon: Children of Tatchbury Mount School for the handicapped

☐ *An information booklet describing services for parents of mentally handicapped children has been produced by the* ***Southampton and SW Hampshire CHC****, in collaboration with social services, housing and education departments and local voluntary organisations. The project became possible when the Hampshire Joint Care Planning Team recommended it for joint finance support. A thousand copies have gone out to parents and professionals, along with a questionnaire asking how the booklet could be improved. There are no copies left of the "pilot" booklet, but when the revised edition is published the CHC will be happy to send copies to enquirers.*



Photos: High Wycombe CHC

☐ ***High Wycombe CHC****'s chairman Eileen Collins rolled into Wycombe General Hospital on a fact-finding mission recently. She encountered problems with heavy doors, steep slopes and thick carpeting, found it difficult to reach the buttons in the main lifts, and was quite unable to use the toilets in the physiotherapy department. The low-backed seating in waiting areas looked as though it would cause agony for some handicapped people. On the plus side, staff seemed helpful and aware of the needs of wheelchair users. The CHC has also found access problems in some GP premises – and has been told that patients who can't cope can always be visited at home!*

☐ A survey to find out what services are required by deaf people is being carried out by **West Surrey and North East Hants CHC**. And parents of children in schools for the educationally subnormal and mentally handicapped will be asked for their views on community services in a survey organised by **Huddersfield CHC**. About 1000 families will take part in the survey.

☐ Outpatient departments have been closely studied by **Plymouth CHC** which has published a report. **Hillingdon CHC** has written up its study of services for the mentally handicapped in the district.

☐ The Tyne and Wear CHCs, **Gateshead, Newcastle, North** and **South Tyneside,** and **Sunderland** banded together to mount a conference on *Occupation and health.* Death and illness rates in the North-East are noticeably higher than elsewhere in the country. Doctors with a special interest in occupational disease, local industrialists and trade unionists met together with CHC members to discuss the hazards of work and preventive measures.

Meetings

☐ Smoking, alcoholism, adverse medical side-effects and sexually transmitted diseases were among the topics discussed in **Worksop and Retford CHC's** seminar on "man-made diseases". An audience of 100 included teachers, nurses and other professionals.

☐ **The North East Thames regional group of CHCs** arranged an International Year of the Child conference, *Focus on the under-fives.* The meeting, organised jointly with the RHA, took prevention as its theme and considered immunisation, accidents and surveillance.

☐ A packed meeting to launch a local self-help group for women who have had breast surgery (mastectomies), was held with support and practical help from **Plymouth CHC**.

☐ **Swindon CHC** is planning an autumn seminar on the care of the district's elderly, especially those who are mentally ill.