CHC NEWS

For Community Health Councils

October 1979 No. 47

AGM seeks urgent talks with Government

CHCs have sensed a turn for the worse in their relations with Government, and are asking Patrick Jenkin to uphold their right to be consulted over closures. As an alternative to further emergency cuts in the health service, the Association of CHCs has called for increased funding through general taxation and the removal of VAT from NHS spending.

Delegates to the association's Annual General Meeting, held in York last month, listened sombrely as ACHCEW's secretary Mike Gerrard warned: "It would be very easy for the Government, if it wished to do so, to save £3m by axeing CHCs. There wouldn't be many people outside this room who would weep over that, and the situation that develops over the next few months depends very much on all of us".

The association's new chairman Dr Rod Griffiths agreed that difficult times were ahead, but the meeting also had its more positive side. Guest speaker Dr Lionel Kopelowitz, president of the Society of Family Practitioner Committees, called on all FPCs to admit CHC observers and suggested that CHCs and FPCs campaign together for increased spending on primary care. More about this on page 3.

The AGM unanimously passed an emergency motion requesting the association's Standing Committee "to seek immediate talks with the Secretary of State to clarify the rights of CHCs". This wording was the result of discussions in the Standing Committee, which had five emergency motions on the consultation of CHCs before it.

The resolution chosen was based on the first half of a motion from Guy's CHC, but omitted the CHC's call for ACHCEW to take out legal injunctions restraining AHAs from making cuts without proper consultation. The feeling among London CHCs was that the composite motion did not go far enough, and in a separate meeting they decided to keep the situation under close scrutiny.

Kensington, Chelsea and Westminster NW CHC, moving the motion, said that events in its area had shown how so-called temporary and emergency closures could be used to brush aside local opinion and a CHC's rights. West Birmingham CHC, seconding, warned that these problems would not be restricted to London.City and Hackney CHC accused Patrick Jenkin of "leading AHAs by the nose", by announcing his support for temporary closures and his view that RHAs should not fund legal action by CHCs.

Rod Griffiths asked all CHCs to send the Standing Committee details of their consultation problems, and several shared useful local experiences with the meeting. Cambridge CHC described the technique of "closure by stealth", in which a unit is deliberately run down before closure is mentioned. Southend CHC's local authority had helped it obtain a counsel's opinion on two temporary ward closures, and the threat of legal action based on this opinion had been sufficient to restore services.

Apart from the emergency motion, the two-day AGM considered 27 policy and constitutional motions. On RAWP it "strongly deplored any attempt further to delay the already slow progress of levelling up of resource allocations to health authorities", and a related motion called for the costs of teaching hospitals to be assessed individually. The intention is to end teaching areas' need to "use district funds to subsidise the teaching function of these hospitals."

A motion from North Devon and Ealing CHCs proposed in part that payment of maternity grant should depend on attendance at antenatal clinics, but a succession of speakers criticised the motion's "coercive aspect" and questioned its likely effectiveness. This part of the motion was heavily defeated, but the remainder—calling for a substantial increase in maternity grant—was carried. It was also decided that adults should have a right of access to their

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Meetings....

AGM decided that a Special General Meeting to discuss the report of the Royal Commission on the NHS should be held "at a suitable date in the autumn"—though in practice it is not likely to take place before the Government issues its NHS White Paper. The 1980 AGM will be on 12 September, in London, and will hear a report from the Standing Committee on the possibility of a two-day AGM for 1981.

INSIDE....

Your letters

Abortion counselling

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

Mrs Kelly (*CHC NEWS 44* p 2) asks whether, since over 90% of the Pregnancy Advisory Service's clients get abortions, PAS really gives unbiased counselling. The answer is "yes". The object of unbiased, non-directive counselling is to help the person find the right solution for *their* problems. Most of the girls who go to PAS want abortions, that is why they go, and most get them.

Mrs Kelly should ask the anti-abortionists at *Life* about the girls who come to them. According to *Life* administrator Mrs Nuala Scarisbrick, 80% of these girls think that *Life* offers an abortion service, and this illusion is deliberately fostered by making their advertisements resemble those of PAS and BPAS. It also appears that, despite *Life*'s efforts, a majority of these girls ultimately obtain their abortions elsewhere. Mrs Kelly mentions the shortage of accommodation as a reason for which women seek abortion. Is she not aware that reducing demand has caused many councils to close mother and baby homes?

Mrs Chris Kelly, Member, South Birmingham CHC

Thank you for the opportunity to reply to the letter above. David Flint's attack on *Life* and the "anti-abortionists" is shallow. *Life* cares for the mother and her unborn child and is prepared to face with her the long-term and inescapable problems that an unplanned pregnancy may bring. Lack of accommodation *is* one such problem, that is why *Life* houses all over England are full, and more are opening. Mother and baby homes are being closed by social services departments because of lack of funds. *Life* has the grateful support of social services and the probation service in its efforts to alleviate this acute accommodation shortage.

Life's national administrator, Nuala Scarisbrick, has never said, and denies, that *Life* seeks to fool girls into thinking that it offers an abortion service. *Life* offers pregnancy counselling which is non-directive and not conducted in an atmosphere of panic. Some clients do go on to have terminations, but others are amazed when they are given information about positive alternatives.

Ed: This correspondence is now closed.

CHCs and coping with the cuts

Chris Ham and Ruth Levitt, School for Advanced Urban Studies, Rodney Lodge, Clifton, Bristol BS8 4EA

We are organising a workshop for CHC members and secretaries called *Trying to cope with the cuts*. It will be held in Bristol on 5 and 6 December. The aim is for CHCs to share experience, information and skills in coping with cuts, closures, and the effects of RAWP. Please write to us at the address above if you want more details.

A poor turnout

Donald Preston, Secretary, Bromley CHC

Disappointment after what should have been the Bromley CHC's night of the year leads me to ask other councils how they present their annual reports to their communities, if in fact they do so.

Bromley CHC has over the years published its annual report in June, and presented it at a public meeting held in different venues throughout the borough. The second part of the meeting has been devoted to topical health matters, with speakers and audience participation. This year the subject was consumer satisfaction and problems in the NHS.

In a hall that easily accommodates some 200 people, 50 persons tried to fill the first few rows. Naturally this was a disappointment to the CHC members, and the panel of speakers must have wondered why they had travelled so far for so few. We would be most interested to learn of the experiences of other CHCs, before spending any more public money on presenting our annual report in this way.

Befriending the patient

Dag Saunders, Secretary, Salop CHC

I am a little mystified by your Healthline answer concerning service committee hearings (*CHC NEWS 44* p 10). From my experience it is not unusual for a CHC secretary to be asked by a patient to act as the "patient's friend" and for the secretary or indeed a member to speak on behalf of the patient during a hearing. In my own experience the chairman of the medical service committee was careful to explain to the patient that if the person acting as patient's friend — ie, the CHC secretary — represented the patient, then the patient would not have the right to speak openly to the service committee.

Ed: We have heard from one other CHC secretary—Martyn Smith of W Birmingham CHC—who has spoken at a service committee hearing as "patient's friend". The crucial factor seems to be whether the service committee regards the CHC secretary as a paid advocate or not—a person considered to be a paid advocate by the committee could assist the complainant with advice but could not take part in the proceedings or address the committee. A CHC member is less likely to be regarded as a paid advocate than a secretary. Tom Richardson, secretary of Oxfordshire CHC, suggests three ways round the difficulty: (1) the CHC secretary can be the complainant, with the real aggrieved party acting as "friend"; (2) the CHC secretary acting as friend can ask for permission to speak in order to assist the service committee in its enquiry; (3) the CHC secretary as "friend" can advise the complainant during the hearing in a voice loud enough to be heard throughout the room.

Health advice on radio

Dr David Robertson, Bradley Hall, Bradley, Frodsham, Cheshire WA6 7EP

I am conducting a survey of all local radio stations in the UK to determine the extent and character of the health advice offered. The survey results will be published. If any readers of *CHC NEWS* have observations to make about health advice on local radio, I would be pleased to hear from them.

Violence in the family

Margery Taylor, Health Education Council, 78 New Oxford Street, London WC1A 1AH, and David Hobman, Personal Social Services Council, Brook House, 2-16 Torrington Place, London WC1E 7HN

Following a recommendation by a Parliamentary select committee, the Health Education and Personal Social Services Councils have recently formed a joint working party on violence in the family. The object is to create greater public awareness of the extent of violence within the family and to devise forms of action by education both to prevent the incidence of such violence and to intervene when it occurs.

As joint chairmen we invite CHCs to let us have their suggestions on how to tackle the problem from an educational standpoint. Any examples of good practice already being followed would be particularly welcome.

Safety of home births

Nancy Vickery, SRN, SCM, Member, Eastbourne CHC

The National Childbirth Trust, whose leaflet you summarised in your June edition (*CHC NEWS 43* p 11), may be treading on dangerous ground in encouraging expectant mothers to oppose the trend to 100% hospital confinements and promoting "at-home births". Home care wherever possible is of course a worthy objective within the NHS. But the safety of home confinement is now dependent on the recruitment and maintenance of staff who are able, willing,

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CHC NEWS and Information Service Staff:
VIVIAN SANDERS (EDITOR)
DAVE BRADNEY, JANET HADLEY

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Comment

Delegates at ACHCEW's annual meeting in York must have been as surprised as they were pleased to hear the cordial message delivered to them by the president of the Society of Family Practitioner Committees, Dr Lionel Kopelowitz. His firm statement that it was desirable that FPCs should welcome CHC observers at their meetings seems like a direct reversal of the Society's previous policy. Dr Kopelowitz gave no indication that his message represented a change of heart. But he must have expected CHCs to wonder what lay behind it.

What he said was that FPCs, and executive councils before them, were proud of their structure, with its balance between lay and professional representatives. They had found it difficult to accept these new bodies, CHCs, as representatives of the public in the NHS. But now that CHCs have come of age FPCs welcome their interest, on behalf of patients, in the primary care services. By attending FPC meetings CHCs can gain an insight into the working of the committees, Dr Kopelowitz went on, and an appreciation of the independent contractor status. FPCs and CHCs could become allies in the struggle for more resources for primary care.

One explanation for the olive branch may be that FPCs are feeling the cold wind of the Royal Commission's disapproval and think it wise to huddle up to the CHCs for warmth. FPCs may also be worried that the impending removal of AHAs will leave them vulnerably isolated. CHCs—possibly also then thinned out and covering larger areas—could seem useful neighbours to be making friends with.

Perhaps it is cynical to question the motives behind Dr Kopelowitz's gesture of friendship. But a touch of cynicism is understandable in view of the history of FPCs' relationships with CHCs, and in view also of a report (see Health News below) that a BMA working party on the Royal Commission is to ask for the abolition of CHCs or, failing that, removal of their role in complaints. A week after this report appeared in *General Practitioner* the magazine published a leader (14 September p13) backing the call to do away with CHCs and making a series of wild attacks on them. For example, CHCs are accused of latching onto complaints because they lack any other role; of expecting doctors to be infallible; and of encouraging patients to tilt at any alleged lapse by a doctor.

The Royal Commission found little evidence that CHCs were thought by staff to be permanently seeking to find fault. And a look at a few CHC annual reports would show that their work on complaints consists to a great extent of providing reassurance, a sympathetic ear, and an opportunity for letting off steam. Far from pursuing complaints to the bitter end, CHCs in fact tend to absorb them. And by observing the pattern of complaints presented, CHCs can more effectively carry out their main work of representing the interests of the local community in the health service.

Such uninformed comment could easily damage the work that is being done to *improve* relationships between CHCs and the medical profession. ACHCEW had a constructive meeting with the General Medical Services Committee of the BMA not long ago. And the BMA's press office has been most anxious to assure the association that reports giving details of the working party's deliberations were premature and inaccurate. Whatever the speculation in York as to the reasons for the FPCs' about-turn, the offer of friendship is most definitely welcomed. CHCs which have long regretted unhappy relations with their FPC will be looking eagerly for a swift improvement.

Health News

Researchers uncover the "immense potential" of anti-smoking advice

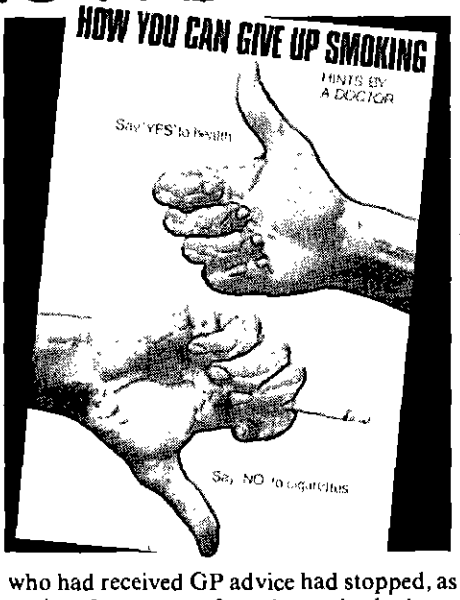
Half a million people a year would give up smoking if only their family doctors took the trouble to advise and encourage them. This crucial message is the outcome of a study* of over 2000 smokers carried out by a research team at the Institute of Psychiatry, in London.

GPs see over 18m of the 20m smokers in Britain at least once every five years. If the doctors all agreed to give "simple but firm" anti-smoking advice at every opportunity "the total yield could exceed half a million ex-smokers a year, and possibly similar results could be obtained for several ensuing years", the researchers conclude.

The potential of this approach is so immense, they believe, that it could produce better results than the creation of 10,000 special smoking withdrawal clinics.

The smokers studied were patients of 28 GPs in five London group practices. The advice strategy that worked best consisted of a one- to two-minute talk about smoking "given in the doctor's own style", an advice leaflet, and a warning that the GP would be in touch again to see how the patient was getting on. The leaflet used was *How you can give up smoking*, issued in 1968 by the DHSS.

Before this consultation 9.6 per cent of the smokers probably or definitely intended to stop — but immediately afterwards 17.8 per cent said they were ready to take the plunge. After one month, 7.5 per cent of the smokers



who had received GP advice had stopped, as against 3 per cent of smokers who had received no advice.

After one year, 5.1 per cent of the "advised" smokers could report that they had stopped by one month and were still stopped. Only 0.3 per cent of the "unadvised" smokers could say this, giving a true long-term success rate of 4.8 per cent. Put another way, on average each of Britain's 20,000 GPs could expect 25 successes a year if they would use this method.

The advice seems to work by encouraging more smokers to try stopping, rather than by improving the success rate amongst those who do. There is also a lower relapse rate amongst smokers who have stopped in the short-term.

**British Medical Journal*, 28 July 1979, pages 231-5.

BMA takes a hard look at CHCs

The future of CHCs has come under scrutiny from a British Medical Association working-party which is studying the recommendations of the Royal Commission on the NHS. But rumours that the working-party would call for the abolition of CHCs (*General Practitioner* 7 September p 1) are not accurate, according to the BMA's press office. At the working-party's second meeting various views on CHCs were put forward. Among them was the proposal that the Government should be asked to clarify the role of CHCs if the NHS were to be reorganised in such a way that health authorities at the lowest level of administration were to be given more power, with greater representation of local interests. The final document could contain such a recommendation. But it might in any case be amended by the BMA's Council before it goes to the Government.

Letting local authorities do their own thing

The first stage of the Government's plans for increasing the autonomy and freedom of choice of local authorities by removing much central Government interference and control has been published in a short white paper*. This is basically a list of various checks on

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Health News

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local authority activities at present operated by central Government departments. It is proposed that all these checks will be lifted when the necessary legislation goes through. The effect will be to reduce the workload of the central departments and to cut expenditure both at central and local level.

The proposals in the white paper are said to be in accord with the wishes of the local authority associations. As a corollary to the removal of accountability to central Government, local authorities are to be made more accountable to the public. Legislation will be introduced later in the year aimed at making local government activities more open to public scrutiny.

It is difficult to determine the effect of repealing the various controls listed in the white paper. They consist for the most part of provision for appeals and notifications to the Secretary of State, and for consent orders and approvals, directives and checks by the central departments. They relate to such things as housing, town and country planning, closure of schools, air and noise pollution, disposal of waste, levels of licence fees, administration of house insulation grants. Various important requirements would also be jettisoned — such as the provision that local authorities with land to sell must offer it to other public authorities before putting it on the open market.

The Government is also currently carrying out reviews of: the statutory duties of local authorities (to see what might be dispensed with); central control over the local authorities' capital expenditure; and the requirement by central departments for various kinds of local statistical information. And future legislation may cover such controversial areas as school meals, milk and transport, and relaxation of the Parker Morris standards for council house building.

**Central government controls over local authorities* Department of the Environment, Cmnd 7634, HMSO 80p. Comments on the proposals should be submitted by 12 October.

Helping the inspectors

A close and fruitful relationship between CHCs and health and safety inspectors is developing in the north Midlands.

Harry Vickers, principal inspector in the Health and Safety Executive's North Midlands Area, has asked all his inspectors to get in touch with their local CHCs, as an additional way of monitoring work hazards in NHS premises.

"Valuable information may be forthcoming from the secretary and members of a CHC", says Mr Vickers. "CHC visits could bring to light things that we wouldn't necessarily see".

Situations the HSE's inspectors would like to know about include, for instance, inadequate heating, exposed hot water pipes in bathrooms, and hospital porters not being issued with adequate protective clothing. Already joint pressure from the North Midlands Area and North Nottingham CHC has identified a problem involving mortuary viewing room conditions which were "distressing and unsatisfactory from a microbiological aspect".

The HSE has issued no central guidance on the relationship between CHCs and its inspectors, leaving this to the individual discretion of its principal inspectors at area level. Inspectors may also have some responsibility for monitoring patient care, since Section 3 of the Health and Safety at Work Act 1974 requires employers not to expose non-employees to work hazards. But on this HSE *has* issued interim guidance — inspectors must avoid interfering with patient-professional relationships wherever possible.

When inspectors do discover health and safety infringements in the NHS the HSE can issue a *Crown notice* (see *CHC NEWS 41*, page 3), which has no legal force but carries with it the implied threat of adverse local publicity and a complaint from the HSE to higher authority.

Vicious circle on overprescribing

Patients and doctors tend to agree that tranquillisers and sleeping tablets are prescribed too much. But while doctors also feel that antibiotics are overprescribed, patients often expect antibiotics for a cold because this is what they have been given before. This is one of the findings reported from a questionnaire study of what patients, doctors and other staff in a general practice thought about drugs and prescribing practice (*Journal of the Royal College of General Practitioners*, July 1979 p 417). The report comments that though doctors know they overprescribe they feel pressurised into doing so by patients' expectations — so "a vicious circle is created which results in an ever increasing number of drugs being issued."

Only 2 per cent of the patients questioned thought it was safe for doctors to prescribe without first seeing the patients, but 80 per cent of the GPs thought that this was sometimes acceptable. Patients were found to be unsure as to what constituted a "drug" — only a third thought aspirin was a drug and only 2 per cent included penicillin and laxatives. The drugs bill might be kept down, the report concludes, if doctors spent more time in educating and explaining rather than prescribing.

AGM seeks urgent talks with Government

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own medical records.

The AGM also supported: improved complaints procedures, an increase in the numbers of chiropodists and foot-care assistants, more flexibility for AHAs to spend accumulated mobility allowance on patients' behalf, and a "clear and comprehensive discharge procedure" for elderly patients. With very little dissent the meeting agreed to oppose any restriction of the Abortion Act 1967.

Welsh delegates were annoyed that for the second year running their two motions on pharmaceutical services had not been put to the AGM. Originally from Rhymney Valley CHC, and this year proposed by the Welsh Association of CHCs, these motions called on the Government to nationalise the drug industry and turn local chemists into salaried NHS employees.

Both motions had the unanimous backing of the Welsh Association, and the Welsh felt that motions with this amount of support should have been debated. They also claim that the 1978 AGM remitted their motions for consideration by a special sub-committee—which never met. ACHCEW maintains that the 1978 motions were discussed by the Standing Committee, and that Rhymney Valley was notified of the decisions taken.

Dr Griffiths promised that the matter would be discussed again by the Standing Committee, but the Welsh were not mollified. It seems likely that the next meeting of the Welsh Association will seriously consider the possibility of Welsh CHCs withdrawing from ACHCEW and dealing direct with the Welsh Office.

Changes to ACHCEW's constitution require a two-thirds majority, and a move to open Standing Committee meetings to the public and press failed to clear this hurdle despite a vote of 122-70 in favour.

In the election for chairman of ACHCEW, Rod Griffiths, chairman of Central Birmingham CHC, was declared "substantially elected" in his contest with Graham Andrews (North Devon) and Alf Mason (Worthing). Dan Merlin Thomas, chairman of Cardiff CHC, was elected vice-charman after two ballots. He was opposed by John Austin-Walker (Greenwich) and Leslie Rosen (Leeds Eastern).

ACHCEW's new chairman Rod Griffiths (left), and the new vice-chairman Dan Merlin Thomas.

The meeting was also addressed by Professor Freddie Brimblecombe, chairman of the Children's Committee. He told delegates that in France there are about two million people who have been labelled "the Fourth World", who for various reasons are reluctant to use the services available to parents and children. A similar group exists in Britain, and services should be adjusted to meet its particular cultural needs.

The siege of Wendover

by Mary Aitchison, Secretary, Frenchay CHC

Frenchay health district has an area of over 200 square miles and a population of over 225,000. In 1978 there were almost as many births amongst Frenchay residents as in Bristol — yet Frenchay has no specialised consultant/GP maternity unit.

Within Frenchay there are just two small maternity units — Chipping Sodbury (12 beds) to the east of the district, and Wendover (16 beds) to the west. Wendover Maternity Hospital — the focus of this article — is managed by the Southmead District Management Team.

Frenchay is too remote from the large maternity units at Southmead Hospital and the Bristol Maternity Hospital. Transport facilities are poor, and the major units are too distant for GPs to attend deliveries. Yet consultant obstetricians have neither helped nor encouraged GPs to send mothers to the small local units.

While recognising the importance of the major consultant units, Frenchay CHC has argued that mothers who wish to have deliveries in small hospitals or at home should have the right to choose their place of birth.

In 1975, prior to the opening of the new Bristol Maternity Hospital, Avon AHA published a consultative document which proposed the closure of *maternity beds in Bristol*. It stated that:

"The Peel Report on maternity services* recommends that wherever possible GP maternity units should be associated with consultant maternity units, which are staffed and equipped to deal with complicated deliveries, emergencies and the special care of new-born babies. The facilities that will be available to GPs at Bristol Maternity Hospital and Southmead maternity unit will provide the improved standard of care . . . recommended by the Peel Report".

After discussion with other CHCs in Avon, Frenchay CHC accepted the AHA's proposals, with the reservation that small units should be retained where there are no large consultant maternity hospitals sited in easy reach of patients and their doctors. We stressed that the Wendover and Chipping Sodbury units must be retained, stating that: "The majority of mothers, given the choice, prefer the friendliness of smaller units". A CHC survey subsequently confirmed the popularity of Wendover as a place of birth for local mothers.

The AHA told us we "would be consulted before any proposals affecting maternity beds in peripheral areas of the Frenchay district were made", but our confidence in this assurance was shaken when seven months later a local GP sent us a copy of a letter he had received from the obstetric registrar at the Bristol Maternity Hospital. This said: "Mrs X would quite like to come out to Wendover for a few days in the early puerperal, but I was not able to tell her at this stage whether Wendover would still be functioning."

We asked the area medical officer for his comments, and he wrote: "There have been no proposals to close . . . Wendover maternity unit. I am sure the Frenchay DMT will always keep you informed of any proposals of this kind."

In June 1978, a mother expecting her second child wrote to Frenchay CHC:

"I have been given the choice of Wendover, Southmead or the Bristol Maternity Hospital for my second confinement . . . In choosing Wendover, where my daughter was born, I was very sorry to learn that there is a possibility of its closure in the near future. I beg you to ask the AHA not to act in haste and do away with a unit which seems to me to employ all the ideals one hears put forward on current 'parenthood' programmes on the media".

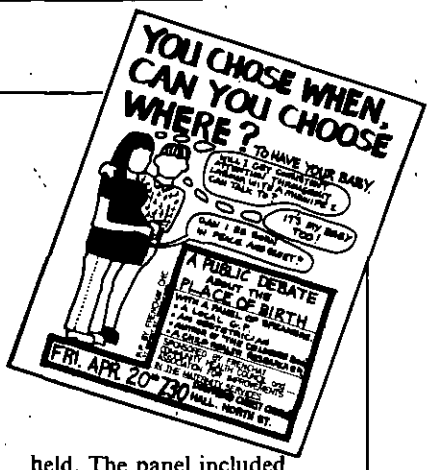
A concerned GP then warned us that a document on Southmead's maternity services — proposing a closure at Wendover — had been circulated, and enquiries with Southmead CHC confirmed this. The document had been circulated by Southmead DMT on 7 June 1978, but had not been sent to Frenchay CHC.

Its recommendation *That to end anxiety and uncertainty among staff, the firm date of 31 March 1979 be approved as from when Wendover Hospital shall cease to be used for maternity purposes* spurred us into immediate action!

Nine months' warning of closure may allow effective democratic consultation for an acute hospital but for a maternity hospital it sounds the death knell, because GPs stop booking expectant mothers in. Mothers too were afraid to insist on Wendover lest they end up with no alternative choice. Nursing staff were advised to seek new employment. In September 1978 local GPs were advised by Southmead that owing to the simultaneous resignation of several midwives from Wendover there was inadequate cover to allow any deliveries to take place there for the next two months, although efforts were being made to recruit new staff.

Frenchay CHC publicly criticised the closure of the hospital for confinements, and protest petitions poured in. We demanded an urgent meeting with the AHA, which gave an assurance that staff would be appointed and the hospital re-opened for confinements. We held a public meeting, and with support from midwives, local GPs and the Association for Improvements in the Maternity Services (AIMS) an action committee was formed.

Another public meeting, to debate "The place of birth", was held. The panel included Christine Beels, author of *The childbirth book*, a GP and an AHA member, but invitations to local obstetricians were not successful.



One speaker blamed the Peel Report* for the sharp rise in hospital confinements. He claimed that the Peel Committee had been weighted towards the views of obstetricians and gynaecologists, with no representation from mothers, paediatricians or epidemiologists. The feeling of the meeting was that Wendover should remain open, and that there should be a period of normal functioning to allow the service to recover.

The hospital re-opened for confinements in November 1978. By Christmas it was recovering from the setback, but there were still complaints from parents that GPs were reluctant to book patients into the unit. The CHC discovered that newly recruited staff had only been given short-term contracts, so we met Southmead DMT and were given an assurance that the staff would be given extended contracts.

When the AHA met last April, its agenda included the recommendation that *Wendover be closed, but retained and brought back into use if this is necessary because of an increase in the birth rate.* We circulated AHA members with information supporting our view that to "mothball" the hospital would be engineering its closure.

Members of the CHC, AIMS and the local trades council lobbied the AHA meeting. The recommendation was hotly debated and not accepted. Instead it was agreed that a working party of obstetricians, GPs, midwives, paediatricians and CHC representatives be set up to consider GP involvement in obstetric services. Wendover had won a reprieve!

Photo Bristol United Press

* *Domiciliary midwifery and maternity bed needs* (the Peel Report). HMSO 1970.

Book reviews

Sociology of health and illness: a journal of medical sociology

Vol 1, no 1 June 1979, Routledge Journals, £8.50 a year (three issues), single issues £3

This is a new international academic journal of medical sociology. In the first issue there are articles on the way casualty patients get labelled as "good" or "bad"; on the relationship between pharmacy and medicine; on the different perceptions of what is normal and abnormal behaviour by working and middle class women in two Texas communities; on decision-making by two Scottish health boards; on what underlies the process of referring patients from one care setting to another; and on the different types of medical social control (including psychosurgery, genetic counselling, and reporting of child abuse). For the non-academic the illustrative material may be more interesting than the analysis, which is sometimes heavily jargonised. But the general reader could well find this a thought-provoking journal to pick from a library shelf if the chance occurs.

New methods of mental health care

edited by Molly Meacher, Pergamon, £5 softback, £12.50 hardback

This book offers a message of hope to sections of the community mostly ignored by the public until some startling scandal hits the headlines. It starts with a cautionary tale of the rise and fall of interest in mental health during the 1960s and continues with well-documented accounts of the new experiments which are designed to carry forward to the 1980s a more positive approach to the mentally ill. Preventive services, hospital admission policies, chronic patients, employment problems and alcoholics are all usefully looked at through the experiences of different caring groups.

More importantly, the need for a change in the role of the social worker is considered. With the growing emphasis on community care, a total family support and crisis intervention system is a must if families are to carry the burden previously discharged between high walls. There is also a heartening and perspicacious look at the needs of the elderly mentally infirm. Altogether, this is a book worth mulling over for everyone who is interested in mental health, especially for those whose administrative and training skills will be needed if the vision is to become a reality.

Mrs B Fitzgerald
Plymouth CHC

Evaluating primary care

by Ewan Clark and M A Forbes, Croom Helm, £10.95

This book is an account of a research project into general practice at Southampton University. The practice was organised in an experimental way, with doctors specialising in covering different age groups; so that both the doctors and methods of practice are not typical of the national pattern. A computer was used to log most significant events in consultation and prescribing, yielding a very detailed analysis of primary care problems. This volume of data is the real value of the book, and study of it would arm CHC members with an insight into many important questions about general practice. The observations by the doctors of their own attitudes to their work and to the study might also help CHCs to build up a dialogue with GPs in their districts.

Dr Rod Griffiths
Central Birmingham CHC

Better lives for disabled women

by Jo Campling, Virago £1.25

This book concentrates on the special problems disabled women face, not just because they are disabled but because they are women. It explores how society discriminates against women in many areas, e.g. benefits for disabled women. There is practical advice about education, employment, clothing, and aids, but the accent is on the preconceived role society portrays of a disabled woman and how to counteract it.

The best sections are those which examine the social and psychological aspects of a physical disability, areas which are not often covered in handbooks. Jo Campling discusses the sexuality of a disabled woman, her problems forming relationships and the image she has of herself.

It is a good book to recommend to disabled women themselves, especially those who have just become disabled. I have just recommended it to a woman who has become incontinent and was totally unprepared for the change in people's attitudes towards her or of the effect it had on her life.

Mary Smith
Liverpool Central and Southern CHC

Issues in social policy

by K Jones, J Bradshaw and J Brown, Routledge, £3.25

This collection of essays is written for students but will be of value to others interested in the welfare state. CHC members will be familiar with many of the subjects — professionalisation, the voluntary sector, citizen participation, community care, and the redress of grievances. The different elements of professionalism are outlined; e.g. altruism versus protectionism, and help to illuminate the posturing of the different professions in relation to the Jay committee's report on mental handicap nursing. We also get a picture of the range of voluntary services and there is a timely posing of the question, "Does that large untapped pool of volunteers really exist?"

The theoretical framework of this book may also prove useful to CHC members who not surprisingly get bogged down in practical and local issues.

Tom Mulvey
North Hammersmith and Acton CHC

Group approaches in psychiatry

by J Stuart Whiteley and John Gordon, Routledge, £6.95

The subject matter is not historical but twentieth-century (although Socrates claimed "the unexamined life is not worth living"). There is great advantage in having co-authors who combine expert knowledge in sociology and psychiatry, the one being vitally dependent on the other. Every aspect of group interaction in psychiatry is covered, including the mental hospital as a small society; the small group and large group; experimental groups (Gestalt therapy, psychodrama, encounter groups); the special application of group techniques, covering addiction, alcoholism, delinquency and the family as a group in treatment; and the evaluation of group psychotherapy — this last chapter being compelling reading.

The authors have tackled a vast and diverse subject in a sensitive and uncluttered manner, making it commendably easy to read. Literature in a highly specialised field, directed to a wide readership, sometimes disintegrates into pure entertainment. This most certainly does not apply here, the writers having respected the seriousness of the content, treating the reality of it with sympathy. This is an invaluable guide for everyone concerned with mental health, and I strongly recommend every CHC to buy a copy.

Dee Heaps
Enfield CHC

Books received

Human milk in the modern world argues that the switch from breast feeding has amounted to an international revolution in infant feeding practices, with nutritional, social, economic and ecological consequences which have been nothing but bad—a very disturbing book (Oxford Medical £7.50).

Health in danger: the crisis in the National Health Service by David Widgery (Papermac £2.95).

Why suffer? Periods and their problems by Lynda Birke and Katy Gardner (Virago £1.50).

The quality of life: the Peckham approach to human ethology by Innes H Pearse (Scottish Academic Press, £6.50).

My body, my health; the concerned woman's guide to gynaecology by Stewart, Guest, Stewart and Hatcher. A professionalised imitation of the self-help women's book *Our bodies ourselves*, the cloth *"clinician's edition"* of this American book contains chapters on patient education and informed consent (based on US law). The cheaper version omits these sections! (cloth £8.60, paperback £3.50).

Prevention of handicap and the health of women by Margaret and Arthur Wynn (Routledge £9.95).

Epilepsy

What does it mean?

*by Shelagh McGovern**

There are 300,000 people in the UK — 100,000 of them children — who are living with a diagnosis of epilepsy. That means they are subject to fits, attacks or seizures. And that is *all* the diagnosis tells us. Other facts we must find out for ourselves — and unless we do find them out we can't begin to understand. We need to know, in each individual case, the type of seizure; how often, or how rarely, they occur; how incapacitating they are — if at all. Above all, we need to recognise that having epilepsy is just a *part* of life, and must not be allowed to overshadow skills, abilities and talents, and the contribution a person can make to the community.

One of the difficulties with epilepsy is that, because it's an umbrella term for many different manifestations, it often causes confusion and embarrassment even as a diagnosis. If we know one person with epilepsy we tend to expect that all epilepsy will be like theirs. If theirs is "mild" and causes no problems, we are at risk of thinking that someone who has incapacitating seizures doesn't really have epilepsy, and may even be malingering. Similarly, if we are familiar with "grand mal" fits, we may overlook any other manifestation and not recognise it as a seizure.

"having epilepsy is just a part of life, and must not be allowed to overshadow skills, abilities and talents . . ."

A man who has an average of two seizures a year, always immediately on waking, is perfectly able to live a full and useful life. But he lives it with the diagnosis of epilepsy. If he applies for a job and the employer's knowledge of epilepsy is based on an experience many years earlier when a work mate was having two or three seizures a week and slowing down production, the applicant will probably not even get to the interview stage.

It is to overcome the problems caused by "not knowing" or, more frequently, by the dangerous "little knowledge", that the British Epilepsy Association (BEA) mounts its programme of education. It aims to enlighten, through the written and spoken word and by film presentations, those whose work or leisure is likely to bring them into contact with the problems epilepsy can cause — which means, in fact, every member of the community.

Talks, courses and conferences always begin with a definition of epilepsy. Once people can be helped to realise that it is a fault in the chain of electrical impulses transmitted by brain cells, their awareness of the complexity of the condition is increased. The brain has ten billion cells, each capable of transmitting impulses, and each sharing responsibility for particular human activities — speech, balance, movement, memory, the senses, thought, emotions, behaviour. This concept makes it easier to understand how a fault can produce a variety of possible external manifestations, dependent on the particular area of the brain that is malfunctioning. Add to that the fact that, in the process of producing impulses, some cells are excitatory and some inhibitory, and the purpose of anti-epileptic medication becomes clearer. In most cases it is designed to increase the effectiveness of inhibitory cells so that there is less likelihood of the impulses becoming spontaneous and unruly.

Quite often it takes many months to find the right anti-epileptic drug and the exact therapeutic dose; quite often, particularly in young people, the change of body weight and the natural alterations in the biochemistry will cause a fluctuation in the effectiveness of the drug regime. All these factors affect the person with epilepsy and add to the unpredictability of the condition.

"epilepsy . . . is a condition which, in itself, is disabling only during a seizure, and not always then"

Medical advances in the last twenty years have achieved total or "adequate" seizure control for 85% of people with epilepsy. In the remaining 15% the seizures prove intractable for varying episodes of time, and about 2% have seizures that do not respond to any known treatment.

"epilepsy . . . often causes confusion and embarrassment even as a diagnosis"

The problem facing the BEA is to bring social awareness into line with medical advances so that everybody with epilepsy is encouraged to live life to the full according to their capabilities — which may take them to the top of their profession, as in the case of Tony Greig, Michael Wilding, George Gershwin and Julius Caesar — or may maintain them as middle-of-the-roaders, like the majority of their non-epileptic peers.

When it is generally accepted that anyone can develop epilepsy at any time, regardless of age, health record, intellectual ability or any other consideration; that the causes of epilepsy can range from hormonal changes to scarred brain tissue, and that in 40 per cent of cases there is no apparent cause; that having epilepsy does not necessarily mean having frequent fits; and that it is an intensely individual condition about which it is impossible, and dangerous to generalise, *then* an enlightened attitude can be said to prevail, and *only then* will epilepsy be recognised for what it is — a condition which, in itself, is disabling only during a seizure, and not always then.

Another aspect of BEA's work is the advice and guidance offered to those with epilepsy and to their families. Often the people most in need of information are the last to receive it, and families cope as best they can. The association helps with social and domestic management, points out the possibility of a shift of emphasis in family relationships, explains benefits and welfare rights, and fights on behalf of the family or individual when the necessary authorisation is given.

The role of a non-medical association is to bridge the gap between social awareness and medical skill. In epilepsy, this means, baldly, improving attitudes and removing the sense of isolation and fear.

In the best of all possible worlds, however, the medical advances would be more readily available to us all. Drug treatment would consist of a single medication (monotherapy), rather than the "cocktail" of drugs still suffered unnecessarily by so many; drug level monitoring would be the order of the day; dental hygiene would be automatically available where necessary, as would shatter-proof spectacles and anti-smother pillows; patients would have continuity of care because they would see the same consultant or registrar at every hospital visit; and the GP would automatically refer the patient to the association that could provide help and guidance in the social aspects of the condition to complement the medical care.

"medical advances . . . have achieved total or adequate seizure control for 85% of people with epilepsy"

In the best of all possible worlds there would be one of the BEA's self-help and mutual support groups within ten miles of anyone with epilepsy, instead of just the 85 that now exist. The frustrating thing is that, in this country, we are only a step away from the best of all possible worlds — the availability of multidisciplinary care for people with epilepsy and for their families, from the moment of diagnosis until the condition is in remission. One wonders why, in the face of the indisputable facts, that step is proving hard to take.

**Shelagh McGovern is assistant general secretary, British Epilepsy Association, Crowthorne House, New Wokingham Road, Wokingham, Berks.*

ALCOHOLICS

What lies ahead?

by William Kilgallon, director, St Anne's Shelter and Housing Action Ltd, Leeds

Although in our society alcohol is culturally acceptable and is used wisely by the majority of those who drink, its abuse is exacting an increasingly heavy toll. A recent Government report (1) has suggested that a figure of half a million people in this country with a serious drinking problem could well be a conservative estimate. In the past 10 years, drunkenness offences have increased by more than 50%, deaths from alcoholism have trebled, those from liver cirrhosis have increased by more than a third, and admissions to NHS hospitals for treatment of alcoholism have doubled. In the same period drinking and driving offences have more than doubled; over a third of all drivers killed in road accidents have a blood-alcohol level over the legal limit. And the loss to industry because of absenteeism and carelessness caused by drinking is very high.

There has never been any concerted strategy for dealing with this problem although in the last century legislation was introduced to restrict the sale of alcohol, to establish "reformatories for inebriates", and to introduce licensing. Although we still have the licensing laws from the last century, the suggested reformatories have foundered because of lack of agreement between central and local government on the financial responsibility.

Alcoholism has been seen at various times as a moral weakness, an illness, or a product of social and cultural conditions. These attitudes have influenced social policy and the provision of services for alcoholics. Public drunkenness has been considered a criminal offence since 1606, and indeed the police, courts and prisons provide the only community response for many alcoholics. As a result of a growing understanding of alcoholism as an illness, facilities were developed within the NHS for the treatment of alcoholics and so there are now some 26 alcoholism units operating at regional or area level. These units can between them accommodate 537 people.

Habitual drunken offenders

Habitual drunken offenders have always been seen as presenting particular difficulties, even though they represent only a minority of those with a serious drinking problem. In the late 1960s, against a background of increasingly overcrowded prisons and a rapid rise in the number of drunkenness offenders appearing before the courts, the Home Office set up a working party to consider what should be done with those arrested for public drunkenness. This working party reported in 1971 (2) and recommended a wide range of facilities, including advice centres, day centres, and hostels for problem drinkers. It emphasised the futility of using the penal system for dealing with public drunks and recommended the establishment of detoxification centres following the example of some American states and East European countries.

In 1972 the DHSS took responsibility for the provision of services for habitual drunken offenders and in the following year issued its circular, 21/73, *Community services for alcoholics*, which encouraged local authorities to provide specialist facilities and to offer the necessary initial finance to volunteer organisations. As a result the number of places in specialist hostels for alcoholics has risen to 650, though this is far short of the minimum requirement of 2000 places recommended by the Home Office working party in 1971 (2).

The 1972 Criminal Justice Act gave police the power to take someone arrested for public drunkenness to an approved treatment centre rather than the cells. The DHSS encouraged the local health authorities to consider experimental detoxification centres in response to this.

Two such centres were established: one in Leeds in 1976, a community-based model run by the St Anne's Shelter and Housing Action — a Leeds based voluntary social work agency specialising in working with the single homeless; and one in Manchester in 1977, which is based at the alcoholic treatment unit at Withington Hospital. A third unit was planned at St Thomas's Hospital in London. This would have been a medical model detoxification unit — based at the hospital and with more medical and nursing than social work staff — but with community based aftercare. However, the plans for this centre were shelved by the DHSS.

The Leeds detoxification centre

The centre's two main purposes are to provide:

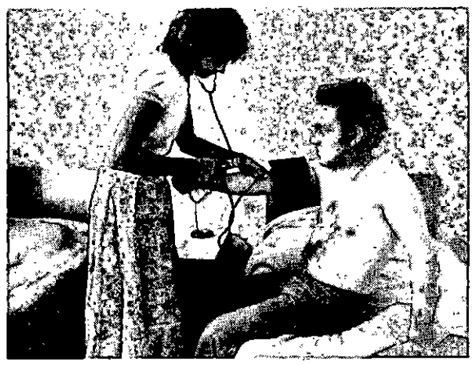
- a constructive alternative to the penal system for dealing with those habitually arrested for offences of public drunkenness; and
- the opportunity for homeless alcoholics to receive the necessary help to escape from their present destructive life-style.

All admissions to the centre are brought by the police following an arrest for drunkenness. The police do not bring every drunk, but only those who are homeless or living in a hostel or other temporary accommodation and who have a previous conviction for drunkenness. Although admission is by arrest only, subsequent residence is entirely voluntary.

The centre offers a ten-day programme of health and social work care and is backed by a network of aftercare houses and a system of follow-up support in the community. The centre is staffed by a team of social workers, nurses, and care assistants. In the three years of operation there have been over 3000 admissions, involving about 800 individuals.

The centre has been researched for the DHSS by a specialist team, the Detoxification Evaluation Project (DEP), and by a research team from Bradford University. Although their final reports are not complete, their interim reports (unpublished) have indicated strong support for the work of the centre. Other agencies involved with the centre have also made their views known. The police reckon to save up to 12 hours with each admission and the DEP research shows that 80 per cent of admissions are completed within 15 minutes of arrest. The Leeds magistrates have noted a decline in the number of homeless drunken offenders appearing before them from almost 1200 in 1975 to just over 200 in 1978, and have no doubt that the centre is diverting a substantial number of offenders from the courts. It is not surprising then that the police and the courts are strongly in favour of the centre. Both of the Leeds CHCs have shown a keen interest in the work of the centre, have visited it and given it strong support.

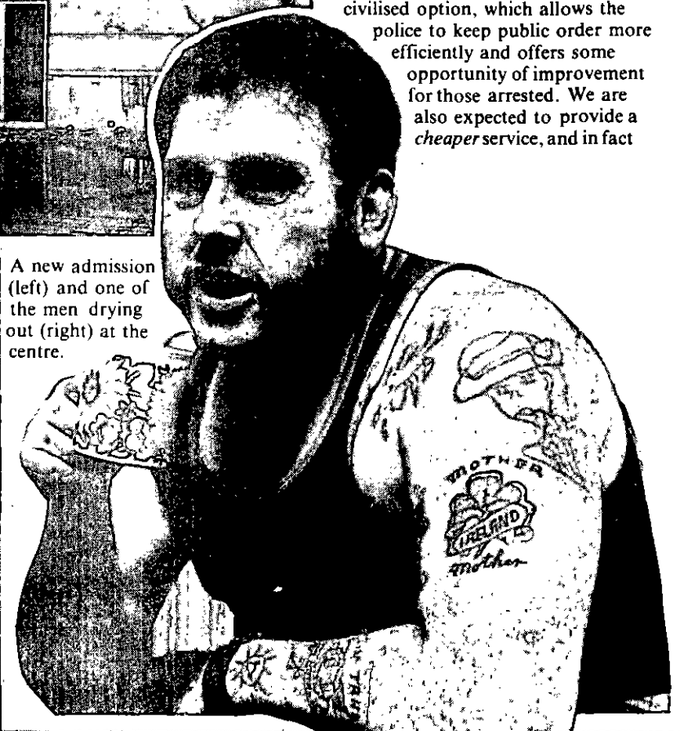
In the detoxification centre the homeless alcoholics are offered access to medical and social work care which they would not normally receive. The provision of good primary health care prevents the likelihood of a later acute admission to hospital and so not only benefits the individual but also the community. The probation service and the social service department have both strongly supported the work of the centre.



The garden of one of the centre's dry houses (above). A doctor at the centre with a man who has successfully dried out (left). And a "skipper" (below) in Leeds where alcoholics congregate.

Photos: Raissa Page

A new admission (left) and one of the men drying out (right) at the centre.



The benefits

The men who are brought to the centre speak openly of the benefits it has brought them. The Bradford research report states that the men talk of the centre as "a place to gather breath, to be sure of a sympathetic environment . . . the centre creates a gap and potentially a way out". It would be unrealistic to expect that a ten-day programme could compensate for years of homelessness and years of heavy drinking. That is why the aftercare houses and the community support offered by the social workers are vital to the centre's work. The researchers identified a group who were brought to the centre and after one admission had not been back and had not been subsequently arrested, and it seems that a positive intervention early in their "drinking careers" has been effective for them.

In the three years that the centre has been opened, 104 men have moved on to aftercare houses and these have often been men with long-established records of drunkenness offences. For other men the centre has helped them to moderate their drinking so that whereas in the years before the centre they might have a dozen or so arrests for drunkenness each year, they now are admitted to the centre two or three times a year. Some men have been able to move from the centre through the aftercare houses into their own accommodation and back to work.

It would be difficult to find anyone who would argue for the imprisonment of habitual drunks. We are offering a more humane and civilised option, which allows the police to keep public order more efficiently and offers some opportunity of improvement for those arrested. We are also expected to provide a *cheaper* service, and in fact we do. We can only measure some of the cost — we know that admissions to the centre run at £165 a time whereas the alternative method of arrest, court appearance, and so on, costs between £185 and £240 a time. This, of course, is only the immediate visible saving. The man who before admission to the detoxification centre was averaging 15 arrests a year and is now down to two or three admissions a year, represents a far greater saving; so do those who have changed from repeated court appearances to a life of sobriety.

A clear Government policy needed

Yet the future of the detoxification centre is in doubt — not because it has been judged ineffective, but because there is no clear Government policy on alcoholism services. The provisions of circular 21/73 are due to come to an end in 1980 and no alternative arrangements have been achieved. Central Government is strongly pursuing the line that alcoholism services should be paid for by the local community at a time when restrictions on local spending are being imposed. As most of the provision for alcoholics, and this is particularly true of homeless alcoholics, is in the non-statutory sector, it is extremely vulnerable in the battle between local and central government.

Community services for alcoholics have been investigated by a working party set up by the Federation of Alcoholic Rehabilitation Establishments (FARE) and chaired by Sir George Young, MP and Helene Hayman, MP. Their report, which has just been published (3), blames bureaucratic muddle, with central and local government passing responsibility from one to the other, for the lack of adequate services for alcoholics.

Alcoholics attract little public sympathy and practically no political support. The services available to them are at a minimum and yet they are faced with a reduction because of spending cuts. The attitude of this Government to the future of the Leeds detoxification centre is important not only for the citizens of Leeds and for the hundreds of people who have benefited from this centre, but also as an indication of their determination to provide an adequate strategy in dealing with alcoholism.

References

1 *The pattern and range of services for problem drinkers* report by the Advisory Committee on Alcoholism, DHSS, 1978

2 *Report of the working party on habitual drunken offenders* Home Office, 1971

3 *Community services for alcoholics* Report of the FARE working party at the House of Commons April - October 1978 (£2.25 inc. post from FARE, 3 Grosvenor Crescent, London SW1X 7EE).

Healthline

Husband's consent

I want to be sterilised for family planning reasons. Will my husband's consent be required?
The *Family Planning Information Service* (Tel: 01-636 7866) says there is no legal requirement for the partner's consent — but doctors rarely proceed without this if the operation is for family planning, rather than medical, purposes. The DHSS and the Medical Defence Union advise getting the partner's consent, though the DHSS confirms that there is no legal requirement for this.

Setting up home after discharge

What is "resettlement benefit", and will I be eligible for it?
RB is paid by the DHSS to some people discharged after a long stay in hospital, to help them with the expense of re-establishing a home. You must have been in hospital over a year, and have been receiving a benefit which currently would give you more than £11.70 a week *out of hospital*. During the second year in hospital, patients without dependants receive only £3.90 personal allowance and have £7.80 deducted towards hospital costs — any excess benefit in that year is set aside for possible payment later as RB. If your benefits during the year were being paid to a dependant, or to someone looking after a dependant, you will not be eligible. You must have been formally discharged, and you must not have moved into accommodation where the local authority or Government is continuing to bear the cost (eg a home for the elderly or disabled). RB is paid weekly, at a maximum rate of £22 pw, never as a lump sum. The total payable is based on the benefit rates which were in force during your second year — *not* on current rates. Excess benefits from your third and subsequent years in hospital do not count. RB is not paid automatically, so apply to your local DHSS office as soon as you get an official discharge date.

For more details see DHSS leaflet N19, and the article *Money matters* in *Mind Out*, March/April 1979, page 5.

Contact lenses

Can contact lenses be prescribed on the NHS?
Not through an ordinary optician. The only way would be if a hospital ophthalmologist were to prescribe them on grounds of medical need.

NHS in new towns

What can we read on the subject of health service planning in new and expanding towns?
In 1969 and 1970 the DHSS organised meetings to consider this subject, and out of these discussions two working groups were formed. Their reports were called *General medical services in new towns and similar communities* (DHSS, 1972) and *Planning health services in new communities: the technical problems* (DHSS, 1974). Also worth reading are *Health service planning in practice: experience in a new town* (Miles and Yule, Health Trends 1977, Vol 9, pages 63-66), and *Diagnosing the new town blues* and *A sense of adventure* (two articles in Health and Social Service Journal, 18 and 25 August 1978).

Life without a larynx

Is there a self-help group for laryngectomees?
There are social clubs for laryngectomees in many parts of the UK. Contact your nearest through the National Association of Laryngectomee Clubs, 30 Dorset Square, London NW1 (Tel: 01-402 6007).

Complaint after death

Who can complain on behalf of a patient who has died?
Anyone at all — not just the next of kin or a legal representative. This applies both to family practitioner and hospital complaints. See also *CHC NEWS 39* page four.

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 two
and have sufficient continuing experience to provide such care. There must also be reliable emergency back-up facilities for unexpected complications.

With the drift away from home confinement a diminishing number of GPs and midwives have anything like a sufficient domiciliary caseload to keep themselves within the requirements of competence. "Let them function in hospital *and* in the community" is the facile answer sometimes given to this problem. But, given the round-the-clock requirements of domiciliary midwifery, it is not surprising that the professionals concerned are less and less willing to do this.

Surely, the best use of resources—instead of home confinement—would be to concentrate all efforts on promoting the antenatal services, which are not nearly enough used. The National Childbirth Trust has a very good relationship with the local maternity personnel, and its members will I hope use their influence in this direction wherever possible.

VAT

Fiona Drake, Secretary, S E Cumbria CHC

All over the country health authorities are struggling valiantly to find ways of making economies in order to manage their local health services within the budget as decreed by the DHSS. One of the principal causes of the current crisis is the unforeseen increase in the rate of VAT. In the Cumbria Authority area alone, if the level of expenditure for 1979/80 is equal to that of last year then an additional £340,000 will be needed within a full year from the introduction of the new rate. The authority already paid VAT in 1978/79 amounting to approximately £450,000.

Would other CHCs agree that a case should be made to Government for the exemption from payment of VAT of NHS bodies in their capacity as charitable institutions? An exemption was made from the payment of SET some years ago, and cars bought under the Motability scheme have now been exempted from VAT. Are other CHCs thinking along these lines?

Unannounced visits

Sue Beatty, Secretary, South Hammersmith CHC

At a recent meeting we discussed the requirement to inform a hospital of an intended visit by the CHC. Although we felt this was reasonable when a large number of members visited a department, our members have often felt that wards had been "tidied up" for the occasion, and that we were perhaps not seeing the true picture. Some members felt that we should be able to visit unannounced when only one or two people wished to visit a department or clinic, rather in the way that members of hospital management committees and boards of governors used to visit without warning. We would like to know if any other CHCs have found this to be a problem.

Half-way houses

Mrs M T Adams, Member, Burnley, Pendle and Rossendale CHC

There is a good deal of interest in Burnley health district in the idea of half-way houses for geriatric patients, as a bridge between hospital and community. But there appears to be considerable argument about whether half-way houses "work" or not, and they do not seem in any case to be very widespread. I would be glad to hear from any CHCs which have a half-way house in their district and could pass on their knowledge of these facilities and let me know if their value has been assessed.

Ultrasound scans

Rose Echlin, Convenor, Working Party on Maternity Services, Islington CHC

This CHC's working party on maternity services would be interested to hear from other CHCs about their knowledge of ultrasound scanning in maternity departments in their district. We would like to know whether scans are carried out "routinely" on all, or most women; how many scans women are likely to have during a pregnancy; who carried out the scans; and the numbers of scans compared with the number of deliveries in the district. Any other information or "feedback" from the woman would also be appreciated.

WHAT SHOULD AHA MEMBERS DO?

*by Philip Hunt**

"I have no doubt whatsoever who is responsible for managing the local (health) services. It is you, the members of RHAs and AHAs. It is your legal duty to do so. No one else can . . . If you fall down in getting to grips with local management responsibilities, the whole future of health in the local context will also fall down."

That is what Patrick Jenkin said at this year's AGM of the National Association of Health Authorities, when he emphasised the crucial responsibilities of health authority members. And he was right to do so, for not only are members responsible for the expenditure of millions of pounds and for taking important decisions about the way local health services are run, they also carry the layman's viewpoint into the management of the service.

At present, the chairmen and members of RHAs and the chairmen of AHAs are appointed by Health Ministers. AHA members are appointed by RHAs (in Wales by the Secretary of State for Wales) and by local authorities. The detailed composition of authorities varies but roughly one third of members come from local government; one third from the professions (mainly doctors and nurses) and the universities, and the remainder from other sources after consultations with a variety of organisations including the TUC, CBI and voluntary bodies with an interest in health.

Whatever their origins, as the DHSS has repeatedly stressed, members are not expected to represent particular interests but to contribute their experience and knowledge to corporate decision-making. Though the practicality of this view has been questioned most members accept it.

One other important requirement of the member is that he or she commit a considerable amount of time and energy to the job. It is not just a case of attending formal authority meetings and meetings with the staff, CHCs and local authorities. There are also visits to be made, disciplinary and appointments committees to be sat on and many other duties. Very often such a workload is shared by too few people on each authority, and the burden on them can be great.

The role of the member is a continually evolving one and there are many aspects to it. Two areas of particular importance are making decisions and visiting health care premises. Another aspect, of course, is the relationship members have with CHCs.

Formal decision-making. It is at the formal meetings of authorities that members are seen in their central role of questioning officers and taking decisions. For many members, however, this is is not as easy as it sounds. Meetings attended by large numbers of officers, press and public are not always the best place for a member to discuss matters in detail.

In addition, some members may feel that they do not always receive the sort of information and range of choice they need to make effective decisions. This in turn presents an undoubted difficulty for officers in attempting to strike a balance between members' desire for the fullest information and for the suppression of unnecessary and sometimes confusing detail.

A further problem is that some members are inhibited at authority meetings because they feel remote from what is happening at the "coal-face". Officer management teams, planning teams, professional advisory committees and CHCs have all tended to add to this feeling of remoteness. Indeed members' interest in the operational level of the health service—as opposed, for example, to the planning system—is deprecated.

This is a pity, for surely the member will be better able to understand the administrative problems of the service if he or she has some knowledge of the way in which the operational field works and the way in which authority decisions affect it?

One way in which authorities have tried to overcome some of these problems is to set up member sub-committees or working groups, which enable officers to put over the sort of detailed information that is necessary if decisions are to be soundly based. This has been the cause of some misunderstanding by some CHCs.

It should not be seen as diminishing public debate of policy but as a way of making that debate more informed, and of involving members more closely by giving them a chance to "think aloud" and to question officers closely. CHCs often set up not dissimilar bodies themselves, for similar reasons.

Visiting is a very important part of the members' role, though some uncertainty probably exists amongst some members about what it is meant to achieve. There may be a feeling that visits are all too often concerned with broken windows and the plumbing, rather than with the way the unit is run and what patients feel about the service. What seems to have been lacking, though there are encouraging signs of change, is a general philosophy about visiting.

Members' visiting would be much more firmly based if it took as its starting point and its prime purpose the discovery by lay people of what a unit sets out to do and how it goes about it. As a result, members will have a sense of the reality behind the decisions they make and they will create amongst staff an awareness of the employing authority as a body which is not remote and unapproachable, but which is anxious to understand the needs of members in the field.

Relations with CHCs. Relations between members of authorities and CHCs vary from good to bad depending mostly on local personalities and circumstances. Various opportunities exist for close contact between AHA and CHC members including statutory meetings, joint visits and seminars, CHC observer status at AHA meetings and the receipt by both AHAs and RHAs of CHC reports and papers. There would seem little to gain from any formal changes in these arrangements.

Most members of health authorities recognise the help a "consumer view" can give them in managing the service. They should be wary, however, of letting the existence of CHCs deflect them from establishing their own relationship with the general public. Health authorities have a widely drawn membership and should not be too bashful about their ability to interpret public need. One of the central responsibilities of management in any sphere is to keep in close touch with its customers.

*Philip Hunt is Assistant Secretary of the National Association of Health Authorities, and a former Secretary of Edgware/Hendon CHC.

Consultation: *Closing the loopholes*

by Geoff Waine, Secretary, Stockport CHC

"... Those who really believe in consultation in the NHS will often find themselves engaged in an uphill struggle and fighting on many fronts."

This quotation, though it comes from the McCarthy report, *Making Whitley Work*, seems to me to express very well. CHCs' experience of consultation on health service developments. Despite the initial obligation placed by Statutory Instrument 1973 no 2217 on AHAs to consult CHCs on proposals which will either substantially develop or vary local health provision, and despite this receiving a two-fold strengthening and amplification of the role of the CHC by the issue of HSC(IS)207 in 1975 and the NHS Planning System Manual in 1976, one has only to be a cursory reader of *CHC NEWS* to realise that many difficulties are still being encountered.

There are, of course, a number of loopholes available to AHAs whereby formal consultation procedures can be avoided. The most widely used is the classification that any closure or change of use is to be temporary. In Stockport we have a hospital which has been "temporarily" closed for nearly four years, but no doubt there are instances of even longer "temporary" closures. A more subtle approach was reported by Ken Henderson in *CHC NEWS* this April (no 41 p 5), where a health authority "relocated" facilities as opposed to closing a hospital. Most recently the let-out clause in SI 2217, which allows an authority to bypass consultation if a decision has to be taken too quickly for the procedure to be followed (section 20(1)), has been put to prominent use.

We are aware of these tactics, but this CHC came upon another problem. Most closure proposals originate from an AHA and relate to services managed by them. It is the AHA which is responsible for initiating both informal and formal consultation with the CHC. But not all services affecting a health district are managed by the AHA — many such decisions are made by either the RHA or the DHSS.

HSC(IS)207 covered, or at least tried to cover, the eventuality of the DHSS initiating a proposal for closure or change in use. No mention was made of the procedure to be followed when proposals originate at RHA level. Since the CHC has a statutory duty to keep under review the operation of the whole of the health service in its district, should not all proposals be subject to full consultation?

Stockport has a case in point, for in 1976 the CHC learned through the local press (an often-used consultation medium) of an RHA decision to withdraw access by local consultant psychiatrists to 64 beds contracted by the RHA from a local private hospital. The AHA at that time was opposed to the decision, which went against the agreed pattern of development for local psychiatric services. The CHC protested at the failure to consult and lodged an objection to the proposal until such time as full consultation took place.

For the next twelve months, the RHA and AHA each contended that the other was responsible for initiating consultation. The RHA based its argument on the provisions of the Statutory Instrument, whereas the AHA contended that since the RHA held the contract for the beds, and had originated the proposal, it was the RHA's duty to consult the CHC. Having patiently watched this buck-passing exercise, the CHC referred the matter to the DHSS.

Eventually, the DHSS replied that responsibility for initiating consultation rested with the AHA, although it suggested that both authorities should liaise in the presentation of the issue. The area administrator, clearly unhappy with the DHSS decision, declined to take the initiative, arguing inter alia that for all practical purposes the RHA decision was a fait accompli. Further pressure has brought the attendance of the area administrator and area treasurer at a meeting of the CHC in closed session (at their insistence), but no formal public consultation. My members are now contemplating referring the matter to the Health Service Commissioner.

Whilst there are a number of lessons to be learned locally from this particular case (although, of course, we are not at the end of the road), a few more tentative general conclusions are put forward.

- The DHSS views HSC(IS)207 as only a "framework for consultation" and not as "precise arrangements to be followed in every case. It should be interpreted flexibly." This lack of precision suggests a very strong need for agreed local consultation procedures, definitions of terminology, time scales and so on. Preferably such agreement should be reached at a time when actual proposals for closure or change of use are not in the melting pot.
- Further ways of sharing experiences on consultation and planning exercises should be explored by CHCs. This is particularly important where locally agreed terminology (such as "temporary closure" and "substantial variation") has been clarified.
- Whilst ACHCEW has sought member CHC views on the subject and, I understand, approached the DHSS, a great deal more thought and effort, particularly by the Department, should go into clarifying existing guidelines. After all, even the Royal Commission suggested that "further guidance" is needed.

To what end, you may ask. Simply to foster the "continuing and constructive exchange of ideas between AHAs and CHCs" envisaged as far back as HRC(74)4.

SECRECY AND CONFIDENTIALITY

by Arthur Harman, Secretary, Cuckfield and Crawley CHC

Cuckfield and Crawley CHC earlier this year found their observers excluded from "confidential" parts of West Sussex AHA meetings. "Open government" may be almost mythical, but the Public Bodies (Admission to Meetings) Act 1960 does constitute at least one measure designed to secure it. CHCs also derive rights from:
(1)The NHS Act 1977, especially Schedule 7;
(2)Statutory Instrument 1973, no 2217;
(3)DHSS Circular HRC(74)4;
(4)*Democracy in the Health Service* (1974);
(5)DHSS Circular HSC(IS) 194.
CHCs have also built up a corpus of practical guidance from advice, exhortations, protestations, shared thoughts, and recommendations, notably from the Secretary of State.

Yet West Sussex AHA ill-advisedly relied on the final phrase of Section 21(1) of SI 2217. This says that "an area authority may refuse to disclose to a Council any other information which the Authority regards as confidential". The AHA's stand was that "We cannot accept that another organisation should have the right to deal with our confidential matters as they think fit". So, out went our observer at "Part II" (an often crudely used procedure). Out, too, went Chichester and Worthing CHCs, though they were not involved in the dispute. History was made, for we know of no other such exclusion, however hostile relationships elsewhere between CHCs and management.

A brief article cannot adequately trace the events which led, over many months, to an impasse which I believe the AHA itself later regretted. But the authority's actions seemed to be dominated by anxiety to preserve secrecy, which — as is usual — proved impossible. A document at issue was "leaked" elsewhere, and the information officially denied to our council came from other sources — through members and myself "wearing different hats", and receiving more trust than the AHA reposed in the CHC.

In public life information is never difficult to secure, and this was not the fundamental issue we faced. The CHS was entitled to information to enable it to carry out its proper functions. There was no foundation for any AHA claim that in our hands the information would be used in a fashion other than befits a body of men and women which has been statutorily constituted.

Getting tough

by Elise Davies, Secretary, Warrington CHC

In January of this year members of the mental health sub committee of Warrington CHC visited "F block" in Warrington General Hospital. They were appalled by the conditions in the unit and ended their report ". . . the building is in such a state of dilapidation and neglect that it seems inconceivable that, in 1979, it can still be used to accommodate mentally handicapped patients".

F block is a unit for 96 mentally handicapped adults within the grounds of Warrington General Hospital. It is an old three storeyed ward block about seven miles from the large mental handicap hospital by which it is administered (Newchurch Hospital - 444 beds). F block has long been acknowledged as being completely unsuitable for the care of mentally handicapped patients and the accepted solution has been to transfer the patients to new ward units at Newchurch Hospital. This move has been talked about for at least 10-15 years but because of lack of resources and perhaps lack of commitment, the new units were never built.

The CHC first visited F block in September 1975. Members commented then on the unsuitability of the building for the care of mentally handicapped people and the need for upgrading. On subsequent visits members made similar comments and the replies from the district management team were full of the assurance of better things to come—but always in the ill-defined "near future".

The council was persistent in its attempts to bring about an improvement to F block and discussed the problem at the annual meetings with the area health authority in 1976, 1977 and 1978. Each year the AHA listened with sympathy but nothing was done. In 1977 the CHC met members of the National Development Team for the Mentally Handicapped and the first gleam of hope appeared when, in its report published 18 months later, the team recommended the closure of F block.

The council was however still very concerned about present conditions in F block and again visited the unit in January this year. Members were appalled by the deterioration in conditions there:

- there were loose and missing tiles in the hallway which were both unsightly and dangerous
- the walls above shoulder height were covered with a thick layer of dust
- the conditions of the toilets were appalling—some of them had no doors, no toilet seats and no heating
- there was a large hole in the floor caused by dry rot
- no physiotherapist, occupational therapist or chiropodist made regular visits to the unit
- fewer than half of the patients attended the school, the remainder had no form of education or occupation
- there had been a marked deterioration in the unit over the past year or so, both in patient care and the physical state of the building.

Prior to the CHC's visit, the AHA had published its mental handicap development plans which included the eventual closure of F block and, in the meantime, the allocation of £100,000 for immediate improvements to the unit. There was criticism of the CHC's decision to publish its report *after* details of the allocation were known, but the council wanted to ensure that "immediate" improvements did not become long term especially as previous allocations to F block seem to have been used for other purposes. Also future plans for the unit could not excuse the neglect of these patients over past years and the CHC chairman therefore decided that the matter was one of public concern.

The DMT also criticised the CHC for "so vigorously publishing" its report—it was sent to members of the AHA (from whom not one reply or comment was received), to Members of Parliament (who have since visited the unit) and to the press. There was criticism that the report had upset staff and caused distress to patients' relatives. There was however no criticism of the report itself—no-one claimed that it was unjustified or exaggerated—which would appear to be sufficient reason for its publication.

The latest information is that the upgrading of F block is scheduled to start in mid-November.

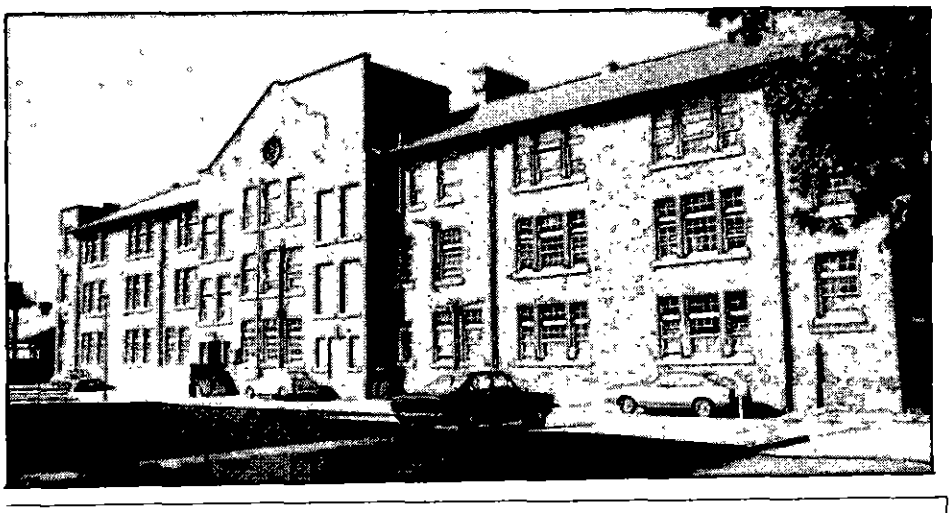


Photo: Warrington CHC

Fighting for the right to know

The CHC has never sought, as the AHA seemed to suggest, " . . . confidential information about the diagnosis and treatment of individual patients or any personnel matters relating to individual officers . . ." (SI 2217). But we believe that this is the only type of information that the CHC can properly be refused.

We protested, loudly and vigorously. We complained to: the MP, Mr P M Hordern, who gave us magnificent support; the RHA, which kept "a low profile", but was not inactive; and the DHSS — Dr Gerard Vaughan himself intervened. Newspapers within our health district focused interest on the issue (and one in particular gave us sustained help). Representations were made to ACHCEW, but personally I was unhappy that the association appeared not to realise that the dispute was crucial to all CHCs.

The AHA tried to rule that information passed to the CHC's observer would be on a personal basis, and was not to be discussed with the rest of the council or the secretary. In response the CHC resolved that information given to an observer would be regarded as having been passed to the CHC to be dealt with responsibly as they saw fit. Ultimately, the CHC decided to rescind the words "as they think fit" from the resolution. This resulted in a situation where the AHA accepted that information passed to our observer would be deemed to have been passed to the council as such, and would be dealt with responsibly.

The Minister of State welcomed this solution, stating in a letter that "CHCs' involvement in AHA meetings is an important factor in strengthening the links between the two bodies. It was envisaged in the Departmental guidance on this matter that, when confidential issues were raised at AHA meetings, the CHC observer would normally be present and could discuss such matters with his CHC. But it is also expected that CHCs would respect the Authority's confidentiality on such occasions, and hold their discussions in private". This succinctly states my members' objectives.

Brighton's *Evening Argus* headlined their report on the outcome "Watchdogs win battle on secrecy". It went on to say, "The CHC has not moved an inch from its original position. It is thought to be the first time any CHC in the country has taken such drastic action to secure its right to know what goes on in the NHS". In a subsequent leader, the newspaper extended congratulations to the CHC and ended with the words, "Eternal vigilance is the price of freedom. Well done!" We do not seek to score points. But we learned long ago that determined, patient persistence is the name of this CHC game.

Not just a matter of weeks:
The Abortion (Amendment) Bill

The Abortion Act 1967 clarified the existing law on termination of pregnancy. Abortion was and still is illegal by virtue of the Offences Against the Person Act 1861. The purpose of the 1967 Act was to allow exceptions to the 1861 Act in certain specified conditions. Thus a doctor carrying out an abortion would not be guilty of an offence if, in the opinion of two registered medical practitioners, to continue the pregnancy "would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or if there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped."

The present 28-week time-limit for abortions derives from the Infant Life Preservation Act 1929. This makes the killing of a child capable of being born alive illegal unless it is necessary to save the mother's life, and says that evidence of a pregnancy having lasted for 28 weeks or more is *prima facie* proof that the child would be capable of being born alive.

John Corrie's private member's Bill, which passed its second reading in the House of Commons on 13 July by 243 votes to 98, seeks to amend both the grounds and the time limit for abortions. Abortion would be legal only up to 20 weeks' gestation and if the continuance of the pregnancy involved "grave risk to the life of the pregnant woman; or substantial risk of serious injury to the physical or mental health of the pregnant woman or any existing child of her family." Thus the wording on the degree of risk to mother or children is strengthened and the clause regarding the relative risk of continuing or terminating the pregnancy has been removed.

Abortions would be allowed between the 20th and 28th weeks of pregnancy if two doctors certified that from the evidence of tests it appeared to them that the child would be born severely handicapped. The case of the foetus possibly damaged by rubella would thus not be covered, since this does not show up on tests. Risk to the mother's life appears not to be a ground for abortion under the Bill after the 20th week.

Very few abortions are at present carried out after the 20th week. In 1977, 0.89% of all abortions in England and Wales were carried out at 20-23 weeks' gestation, and 0.18% at 24 weeks or over. Women having late abortions tend to be the very young, women in the menopause (or those with irregular periods), where diagnosis of pregnancy is difficult, or those subject to delays caused by unsympathetic doctors or lack of NHS facilities—no more than half the abortions carried out in England and Wales are done under the NHS.

According to the DHSS, the earliest period of gestation at which an infant has survived is 24 weeks, but this is extremely rare. In fact doctors already effectively operate a time-limit of 24 weeks to allow themselves a margin of error within the 1967 Act, because of the difficulties of establishing accurately the duration of a pregnancy. Amniocentesis (sampling of the fluid surrounding the foetus) to detect Down's syndrome (mongolism) and spina bifida and anencephaly cannot be carried out before the 16th-18th week of pregnancy, and the results may not be through for another four weeks.

Mr Corrie's Bill seeks to tighten the existing legislation in several other ways. Amendments would require all premises used for the provision, for payment, of consultation with a view to abortion, of an advisory service in relation to abortion, or of pregnancy testing, to be licensed. Licences would be refused if there was any "financial arrangement or other relevant agreement" with places approved for carrying out abortions under the Act. This would mean that the abortion charities would not be able to refer a woman opting for an abortion to one of their own clinics.

The Bill would also strengthen the "conscientious objection" clause of the 1967 Act. No-one with a conscientious objection to abortion "on religious, ethical or any other grounds" would have to participate in a termination, and the proviso that in any legal proceedings the burden of proof of conscientious objection would rest on the person claiming it, would be removed.

Doctors' groups, including the BMA, have objected to the fact that the Bill does not clarify what is meant by "substantial risk of serious injury", and they also oppose the new wording on the grounds that it would interfere with the doctor's power to exercise clinical judgement. The Bill is at present in the hands of a Parliamentary Select Committee of 17 members, whose composition reflects the second reading voting. The committee will have its second meeting on 24 October. It seems likely that the wording of the Bill will be revised, some of the apparent anomalies removed, and the time-limit extended—perhaps to 24 weeks—before the Bill goes back to the Commons for its third reading (which will probably not be before February).

Parliament

Capital spending down

Hospital capital expenditure in England, at 1978/79 prices, declined from £502m to £312m over the period 1973/4 to 1977/8, recovering to £341m (provisional) in 1978/79 (David Knox MP, Leek, 23 July).

Meeting in secret

Dr Gerard Vaughan would like to see all family practitioner committees admit the public and press to their meetings, because "the sweeping away of unnecessary secrecy will improve relations between the public and the NHS". But he believes that open meetings "can most sensibly be achieved by local arrangement" (Dr Roger Thomas MP, Carmarthen, 24 July).

A and E criteria

Major accident and emergency departments should serve a population of at least 150,000, and in the main urban areas this figure will often be much higher (Tim Renton MP, Mid-Sussex, 24 July).

Foot care assistants

In September 1977, 30 foot care assistants were employed in England, by ten AHAs. Assistants' current salaries range from £2375 to £2811 (Dr Roger Thomas MP, Carmarthen, 25 June).

Vaccine damage claims

In July 1979, 2471 claims for compensation under the Vaccine Damage Payments Act 1979 had been received. 247 of the 1790 claims decided had been upheld —including claims of damage by whooping cough, diphtheria, polio, measles, rubella and smallpox vaccines (Malcolm Thornton MP, Liverpool Garston, 24 July).

The costs of smoking

In 1977 it was estimated that tobacco companies spend £25m a year on advertising, and £45m on other forms of promotion. In 1978/79 the Health Education Council spent £325,000 on smoking and health campaigns (Alfred Dubs MP, Battersea South, 4 July).

In 1970/71 it was estimated that the treatment of smoking-related diseases was costing the NHS £36m a year. The cost in social security payments cannot be reliably estimated (Ken Eastham MP, Manchester Blackley, 9 July).

Drug side-effects

The DHSS will not issue a circular on prescribing practice, following a survey showing that drug side-effects are a contributory factor in about 10 per cent of all admissions to geriatric units. It expects that the relevant professional bodies will take note of this research (Dr Roger Thomas MP, Carmarthen, 5 July).

Maternity policy

It is the Government's policy "to maintain maternity hospitals wherever possible, and to enable women who wish to have confinements at home to do so" (Clement Freud MP, Isle of Ely, 26 June).

Dogs and diseases

Fifteen cases of *Toxocara canis*—the worm infection of dogs which can also be transmitted to humans*—were reported in 1977 and 1978. The Health Education Council's leaflet *You and your pet* gives advice on de-worming dogs, and explains local authorities' powers to exclude dogs from childrens' play areas (Tony Marlow MP, Northampton North, 18 June).

* See *CHC NEWS 36*, page five, for more details.

Scanner

Hospitals can harm children's health

Nightmares, loss of bladder and bowel control, and panic caused by reminders of doctors, nurses or instruments are among the signs of emotional disturbance resulting from a young child's stay in hospital. Yet the professionals are still slow to modify their own behaviour or the hospital's regime—"children are often treated as if they were only miniature adults and are expected to be reasonable", says Dr Dermod MacCarthy in *The under fives in hospital* (£1.10 inc post from NAWCH, 7 Exton Street, London SE1). The booklet describes the causes and manifestations of stress and the various ways in which the emotional wellbeing of children in hospital can be safeguarded.

Boost for private health insurance

Following three years of decline or standstill in the number of subscribers to private medical care provident schemes (of which BUPA is the largest), there was a record annual growth in 1978. By the end of 1978 almost 2.4 million people in the UK were covered by the three major provident associations, though the growth has been in group insurance schemes, not individual subscriptions. These are among the figures to emerge from the latest of the annual surveys of provident schemes, which are commissioned by the DHSS (*Provident scheme statistics 1978* £2 inc post from Lee Donaldson Associates, 21-24 Bury Street, London SW1).

Reporting on drugs

Despite the "yellow card" system, many suspected adverse drug reactions still go unreported, the Committee on Safety of Medicines says in its annual report (HMSO £3). The same volume carries the annual reports of several other bodies, including the Medicines Commission, which sets out its comments on the Pearson Commission on civil liability (see *CHC NEWS 40* p 4). The Committee on the Review of Medicines reports that 22,000 products have still to be reviewed, while recommendations have been made on substances contained in 1300 products, including aspirin, paracetamol and phenacetin.

Community health project

Meetings on rheumatism and the menopause, relaxation sessions for pensioners and a keep-fit group for women were among the activities undertaken as part of the first year of the Waterloo health project, described by the project worker, Jane Miller (report 30p from Waterloo Health Project, 14 Baylis Road London SE1 7RE). She includes useful details of the "less visible" aspects of the work involved in the project.

A handful of trouble

Even minor lacerations of the hands from carelessly discarded sharps can put hospital workers at severe risk because of the possibility of infection. And contact with detergents, drugs, bleaches, acids and other chemicals can cause dermatitis—a general term which covers all kinds of irritation and inflammation of the skin. Hospital hand hazards *is a 4-page leaflet produced by the Hospital Hazards Group of the British Society for Social Responsibility in Science (20p inc post from Trade Union Book Service, 265 Seven Sisters Road, London, N4).*

Transport and sport for the disabled

Photo: Diane Olsen

Disabled people trying to use public transport have to make do with suitable vehicles available only at restricted times for restricted purposes and/or unsuitable vehicles more frequently available. Yet public transport *could* be geared to disabled people at no disadvantage to the rest of the community. This is the message of an illustrated "action report" of a study of public transport provision in Greater Manchester*, funded by the Job Creation Programme and the Spastics Society. It calls for central government commitment to the provision of *standard* public transport which is accessible to the less severely disabled, and the creation of a special *complementary* system for the severely disabled. **Can I get there?* £1.50 inc post from Spastics Society (N W Region) 62 Bridge Street, Manchester M3 3BW. *Sports centres and the disabled* gives details of facilities accessible to wheelchair users in sports centres in England (75p inc post from Royal Association for Disability and Rehabilitation, 25 Mortimer Street, London W1N 1AB).

Specialised health visitors?

The case for and against *specialised* health visitors (HVs) to help parents with handicapped children is examined in the report of a study initiated by the Disabled Living Foundation*. The evidence collected from parents and health visitors convinced the two doctors connected with the project that specialised HVs were a necessity.

**The specialised health visitor for the handicapped baby, young child and school child* £2.50 inc post from Disabled Living Foundation, 346 Kensington High Street, London W14 8NS. .

What future for community associations?

Community associations developed between the wars to draw people together in a common effort "to advance education and provide facilities in the interests of social welfare for recreation and leisure time occupation". Their relevance today is investigated in the report of a working party set up by the National Federation of Community Associations*. The report also discusses the future of the NFCA itself.

* *Tomorrow's community: the development of neighbourhood organisations*

Bedford Square Press, £3.20 by post from Macdonald and Evans Distribution Services, Estover Road, Plymouth.

Cartoon: Liz Mackie

GPs working in hospitals: HC(PC)(79)5 and HC(79)16

A uniform system has been agreed for paying GPs who provide inpatient care or casualty services in community and cottage hospitals. As explained in HC(PC)(79)5, GPs doing casualty work will receive an on-call as well as a sessional payment, and payments for inpatients will usually be based on average bed occupancy. HC(79)16 describes new arrangements for the employment of general medical and dental practitioners as part-time members of the hospital team headed by a consultant. These posts will from now on be in the grade of hospital practitioner.

Directory of CHCs: changes

An updated version of the Directory of CHCs came out last October, and each CHC was sent a copy. Further single copies are available from the *CHC NEWS* office—please send a large stamped addressed envelope (11p). Changes will continue to be published monthly in *CHC NEWS*. A 1979 edition is now in preparation. Please notify us of any alterations in address, telephone number, chairman or secretary.

Page 4: North Derbyshire CHC Secretary: Mrs Elizabeth Bratton
Page 4: North Nottingham CHC 4 Leslie Road, Forest Fields, Nottingham. Tel: Nottingham 704811
Page 9: South East Kent CHC Chairman: Coun. J F Setterfield
Page 12: Southampton and SW Hampshire CHC Secretary: K M Woods
Page 20: South Gwent CHC Chairman: Mrs Pamela Purnell
Page 24: South Western Regional Association of CHC Secretaries c/o West Somerset CHC, Flook House, Station Road, Taunton. Chairman: Peter Coleman. Secretary: John Churchill. Tel: Taunton 71618.

News from CHCs

☐ Joe Hennessy, secretary of **Durham CHC**, turns TV programme presenter this autumn. *Helping hand* is a series of programmes from Tyne Tees TV for the physically handicapped, their families and those who work with them.

☐ *To mark the help given by the CHC in the development of services for the elderly mentally ill and infirm, Mrs Margaret Ross, secretary of* **Hastings CHC**, *was invited to open the admission assessment unit at St Helen's Hospital.*

Photo: Hastings CHC

☐ **Bath CHC** stepped in to avert drastic suppliers' cutbacks of heating oil to hospitals and other health buildings in the district. As a result of publicity given to the CHC's protest, the oil company met the district management team, agreed to restore the 20% cut in deliveries and to maintain supplies at the 1978 level. But the council is still worried about winter supplies and also about the rise in fuel bills which the district faces. It wants a DHSS subsidy to health authorities to enable them to meet the increased oil costs.

☐ Northamptonshire AHA auditors aroused protests from some members of **Kettering CHC**, when they requested to see car insurance documents from council members claiming motoring expenses. Some CHC members who work for local authorities or the DHSS said their employers had never demanded such checks. Other members however did hand over their documents and in two cases were found to be incorrectly insured. They had no cover for other than "social domestic or pleasure purposes". An accident occurring while giving a lift to a fellow CHC member to a council meeting or hospital visit would not have been insured against.

☐ No more than a few hours' warning is given by **North Staffs CHC** of the fact that a visit is planned to the 800-bed St Edward's mental illness hospital in Leek. The CHC used to give about a week's notice, but now, apart from a courtesy call to senior hospital staff, members make "spot" visits in groups of up to five. There have been no objections from DMT or hospital staff.

☐ **Hillingdon CHC** has a report on family planning services in its district, and **Dartford and Gravesham CHC** has distributed copies of a four-page illustrated booklet about its activities. *Healthy centres* is a survey report on patients' views of health centres, carried out by **Salford CHC**. Other recent CHC publications include a report on outpatient ambulance transport **(Islington CHC)**; disabled people in hospital **(Hounslow CHC)**; and a report on services for mentally handicapped people **(Kensington-Chelsea-Westminster South CHC)**.

☐ **The North Western Regional Association of CHCs** organised a conference about accident and emergency services. A summary of the conference, published by the King's Fund (joint conference organisers), highlights the continued trend towards centralising accident services, the need for better career prospects for doctors, and for educating the public in the proper use of the service. **The Yorkshire Regional Association of CHCs** held a meeting to discuss *Helping mentally handicapped people in hospital* and a meeting on hospital at home has been held by **Waltham Forest CHC**.

☐ In a lightning 10-day campaign, **Haringey CHC** joined with other local groups to collect 19,000 signatures for a petition protesting at the AHA's decision to save money by closing Wood Green and Southgate Cottage Hospital temporarily and restricting the accident and emergency service at the Prince of Wales Hospital to the hours of 9am to 6pm, Monday to Friday. The decision, taken on 18 July, went against previous assurances that there would be no change in the A and E service at the Prince of Wales until extra provision could be made at the North Middlesex Hospital. The CHC has been opposing long-term plans for the two closures, and felt that the AHA was trying to bypass formal consultation procedures. A letter explaining the CHC's position was sent to Health Minister Dr Gerard Vaughan. He met the CHC, league of friends and staff at Wood Green, but said he could not intervene in a temporary closure. The story has a happy ending, however—at least for the time being. At a special meeting on 3 August the AHA rescinded its decision to make the two closures. But Haringey has been seriously overspent for two years, and more cuts will doubtless be needed.

☐ *Bowthorpe Hospital will remain open, said Health Minister Dr Gerard Vaughan after a visit to this 48 bed maternity unit in Wisbech, Norfolk and representations from Wisbech Hospitals Action Group,* **King's Lynn CHC** *and others. Outside the hospital 2000 assembled to voice their support for the hospital and Dr Vaughan acknowledged the strength of local feeling. In a statement later he said he had been impressed by the "thoughtful and admirably researched evidence" of the hospital action group and their argument that closure would have far-reaching implications for the local Fenland community. The CHC had narrowly voted to oppose the closure and it*

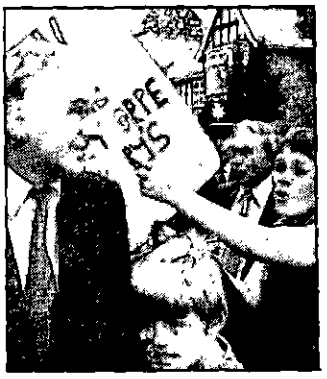


Photo: Eastern Daily Press

assisted the action group with information for a 38-page counter-proposal A better answer. *"However, the action group", said CHC secretary John Holden, "did the spadework which we should have done". The price of keeping Bowthorpe open will probably be not using beds at the new King's Lynn district hospital which is due to open in 1980.*

☐ **High Wycombe CHC** has joined the ranks of CHCs who have published guides to local health services. And its campaign to re-open the casualty unit at Amersham Hospital, closed "temporarily" two and a half years ago, has prompted the AHA to coin a brand-new closure category—"formal" closure. This, it seems, is neither a permanent nor a temporary closure. It is the subject of a 1½-page consultation document, issued by the AHA in response to CHC protests that the closure could no longer be deemed temporary. The CHC's campaign has received massive local support from the public, local authorities and MPs.

☐ **North West Herts CHC** turned a public somersault on its decision to support the proposal for a new district general hospital in St Albans with a supporting role for Hemel Hempstead's hospital. When it was discovered that the RHA intended to provide only a GP-run 9-5 casualty unit for Hemel, the CHC voted to reverse its position and demanded two medium sized acute hospitals, one in each town. This option had emerged as the favourite during the CHC's public consultation in 1978, and the CHC had been accused of ignoring public opinion (see *CHC NEWS 38*, p4).

☐ Children at St Mary's primary school, Strood, raised £500 towards **Medway CHC**'s "Health Development Year". The fund-raising year reaches its half way stage this month and so far £30,000 has been found by local people for specific health projects on a list drawn up by the district management team and the CHC. Diana Porter, assistant CHC secretary, commented "It looks as if we shall reach the £50,000 mark quite comfortably. Now we are going to concentrate on interesting the pubs and clubs, which by tradition are good fund raisers." The bulk of the money is going to child care and maternity services, and because it is earmarked, is not being affected by any cutbacks.