CHC NEWS

For Community Health Councils

December 1979 No 49

Consultation should carry on, *says Vaughan*

Steps must be taken to stop health authorities bypassing consultation with CHCs by misuse of the "urgency" loophole in the Statutory Instrument and the "temporary" closure device, the Minister for Health, Dr Gerard Vaughan, told a deputation from the Association of CHCs for England and Wales on 16 November. The meeting was described as "helpful" by ACHCEW's chairman Rod Griffiths, who gave an account of what was said to *CHC NEWS*. It was arranged as a result of the emergency resolution passed at the association's AGM, though as instructed ACHCEW had asked for the meeting to be with Secretary of State, Patrick Jenkin.

Dr Vaughan agreed with virtually all the points made by the ACHCEW representatives. The "urgency" proviso in SI 2217 (clause 20(1)) was intended to be used only in cases of genuine emergency, such as fire and flood, he asserted, and he accepted that there was a pressing need to define "temporary" closure and "in the interests of the health service". Dr Vaughan promised that he would shortly be seeing Mr Jenkin in order to sort out some new guidelines on temporary and urgent closures, and he invited ACHCEW to submit proposals for changes. The Minister stressed that he valued the contribution of CHCs in providing an independent, widely-based and well-informed view of the health service. He offered to meet the association again, for example, to discuss the consultative document on the NHS (promised at the latest by the third week in December), and to present the AGM motions.

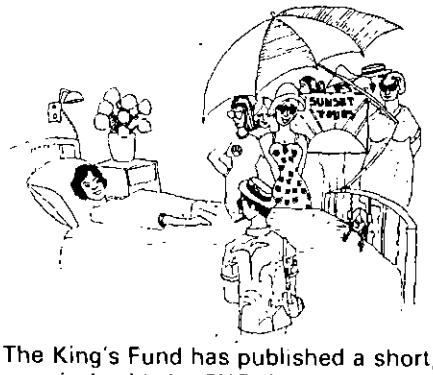
Dr Vaughan accused health authorities of making the "wrong cuts" — closing hospitals by pleading financial necessity instead of pruning waste. He agreed that many decisions to cut services were taken on poor information.

The long-awaited meeting can be hailed as a success for ACHCEW. But it leaves a number of worrying questions unanswered: how do Dr Vaughan's assurances on consultation square with Patrick Jenkin's letter to Betty Paterson, which virtually invited health authorities to take advantage of the SI loophole in the present financial difficulties; will the new guidelines make any difference, since the SI will still provide the only *legal* requirements on consultation; and what are CHCs to make of Dr Vaughan's geniality in the face of Patrick Jenkin's apparent avoidance of any contact with ACHCEW?

Dr Vaughan said that the recent court hearings were useful in clarifying several points, such as what constitutes a substantial variation in service. Patrick Jenkin's view that RHAs should refuse CHCs funds for legal action was apparently ignored when the SE Thames RHA gave Guy's CHC £150 to seek a legal opinion on its case against the Commissioners for Lambeth, Southwark and Lewisham. In court the judge ruled that the commissioners had no practical alternative to closing the inpatient services at St Olave's Hospital temporarily, and that the CHC had been properly consulted. The CHC claimed that its detailed counter-proposal had not been considered, since the commissioners announced their decision on the hospital a few hours after receiving the CHC document.

The DHSS appears not to be monitoring the effect of cuts in the health service. The Minister was very interested to learn that so far in 1979 around 2300 beds have been lost in London. This figure was supplied by the group of London CHCs which has just issued a press release summarising the results of research which it commissioned on cuts in London. The survey found that in the last 4½ months decisions had been taken to close ten hospitals. One casualty department is to close altogether, eight will be providing a restricted service, and others are under threat. The release points out that hospitals in the poorer parts of Inner London are being hardest hit, with the elderly and mentally ill bearing the brunt of bed closures and other sorts of cuts.

CHC VISITING



Cartoon, Anita Sutton

The King's Fund has published a short, practical guide for CHC visits to hospitals, with long-stay hospitals in mind. Its aim is for CHC members to use their right to visit to full advantage, and it draws on discussions by CHC members and secretaries. Topics covered include homework before a visit, getting to know a hospital, questions to ask staff and patients, writing a report and getting things done. It also discusses visits useful and not so useful, such as the "Cooks Tour" style of visiting and how to get beyond this formal and superficial set-piece.

CHC Visiting, King's Fund Project Paper 23, 50p + 25p post, from King's Fund Centre, 126 Albert Street, London NW1 7NF.

AHA censured in Cowley Road report

Cowley Road Hospital, Oxford, is to close next year. The final fate of the hospital has been accepted by Health Minister Dr Gerard Vaughan following consideration of the inquiry report submitted by Professor Arthur Willcocks (see *CHC NEWS 48* p16). The report reluctantly agrees that the hospital should close, but also recommends that the Oxfordshire AHA(T) should review its consultation procedures urgently.

The AHA was in dire financial straits, and given that the new John Radcliffe Hospital had fully opened, the report concludes the closure of Cowley Road was required by the logic of the situation. But Professor Willcocks questions the wisdom of the AHA's decision to press ahead with opening the John Radcliffe, and says that in different financial circumstances his recommendations might well have been different. The anxieties expressed by Oxfordshire CHC about the effect on Oxford's geriatric services of the hospital's closure were legitimate, and its scepticism over the financial element of the proposals well justified. The AHA is sharply criticised for presuming on the Minister's eventual decision by having already transferred 30 beds from Cowley Road to the John Radcliffe.

Your letters

Rampton special hospital

John Kitchen, Secretary, Worksop and Retford CHC

Special hospitals such as Rampton are under the direct jurisdiction of the DHSS and do not form part of the NHS. CHCs therefore have no right of access (see *CHC NEWS 45*, p6). This has not prevented the Council from doing what it sees as its duty to the patients in Rampton.

Initially unaware of any TV programme, CHC members paid a full day, comprehensive visit to Rampton Hospital. They were actively encouraged to speak to the patients without nursing staff eavesdropping or interfering. The overriding impression gained was of a caring attitude shown by staff and a respect, not to say in some cases affection, which some patients showed for individual staff members. Over a period the whole hospital has been visited.

As a result of the Yorkshire T.V programme "The Secret Hospital", the CHC chairman and I met the chief nursing officer and the administrator to express our concern particularly as the programme presented only one viewpoint. An invitation was extended to us to visit the hospital on any day, at any time during 24 hours without prior announcement and ask to be taken anywhere we chose. This invitation was put to the test in August 1979. On evidence of identification the senior nursing officer on duty escorted us to the male maximum security wing and a villa chosen at random. We intend to repeat this exercise.

Whilst realising among the 640 nursing staff who work at Rampton there may be some rotten apples, and given the fact that so many of the patients are and can be very violent, it follows that untoward incidents must happen from time to time. We are equally concerned about violent attacks on staff by patients and we have seen evidence of this.

We feel the Yorkshire TV film was somewhat sensational and whilst not dismissing out of hand allegations of individual cruelty, do not believe that a policy of systematic ill-treatment against patients is pursued — the impression the film presented to us. Our involvement is welcomed not only by patients, nursing, medical and administrative staffs, but also by the DHSS. Our standing invitation surely demonstrates a policy of open management and full co-operation. Our experience has shown that if approached correctly, entrance to special hospitals should not present any particular problem to CHCs.

The need for compulsory care

Arthur Harman, Secretary, Cuckfield and Crawley CHC

I daresay I have had more experience of Section 47 of the National Assistance Act 1948 — and the Act of 1951 — than Mr Hanvey (*CHC NEWS 46*, page two) has had hot dinners!

He pays no regard whatever to the suffering which old and other persons involved endure during the period leading up to compulsory removal. Nor does he consider the health hazards; nor the distress, worry, frustration and despair of relatives, friends and neighbours (and of domestic pets!)

Mr Hanvey is unconcerned that the health and social services simply cannot cope with domiciliary support. Like most people who claim a monopoly in the interpretation of rights and human liberty, he is writing idealistic rubbish.

Ed: This correspondence is now closed.

Can fluoride cause cancer?

Margaret Barnett, Member, South Derbyshire CHC

It is disturbing to read the categorical statements made by the Royal Commission on the NHS on the subject of fluoridation. They even go so far as to say that legislation should be brought in compelling water authorities to fluoridate their water supplies at the request of the health authorities.

Apparently they reached their decision without consulting any anti-fluoridation organisation. Nor did they take into account the evidence which was established last November, under oath in court hearings in the USA, and which I believe has not been disproved, that artificial fluoridation of water supplies in American cities has led to a substantial increase in cancer death rates. This must be considered to be highly irresponsible action on their part.

Centre for the disabled

Emlyn Davies, Senior Regional Officer, Wales Regional Office, The Spastics Society, 45 Park Place, Cardiff.

As an avid reader of *CHC NEWS* I was interested in the article *Let's back the disabled*, by Pat Saunders (*CHC NEWS 46*, page five).

Mr Saunders suggests that every area should have a permanent advice centre for over-the-counter, telephone and written enquiries. We in the Wales Regional Office of The Spastics Society recognised this need three or four years ago, and in June 1978 we opened a very effective Disabled Persons' Information Centre at the above address, Tel: Cardiff 398058.

We receive many enquiries and many visits from the disabled themselves — the centre was designed to be completely accessible for even the most severely handicapped, and incorporates specially adapted toilets. There is no doubt that such centres have a tremendous role to play in disseminating information to the disabled, but they must have the ability to answer specific queries and to offer alternative forms of information to the handicapped in general.

Sickness benefit

Mrs W E Shelton, Member, Mid-Essex CHC

I read with interest your Healthline in September *CHC NEWS* (no 46, page 10), concerning eligibility for sickness benefit. I am keen to sound out support for making representations to Government for a change in policy regarding sickness and unemployment benefits.

I was prematurely retired for medical reasons after 23 years service with the Post Office. I have back injuries and a disabled hand. Since then I have been classified as unfit for employment by my general practitioner and fit for employment by the Regional Medical Service of DHSS, alternately.

In my view the situation is ludicrous when benefit is stopped by one section of the Department and immediately restored by another. But what is more sinister is the anxiety caused to an individual, already below par health wise, by having to complete, daily, application forms for unemployment benefit, in the full knowledge that he is unable to compete with able-bodied and healthy persons. A nervous breakdown is usually resultant from the strain.

Annual general meeting protest

Cllr Catherine Gerrard, Chairman, Halton CHC

I am writing to register my strong dissatisfaction with the way some of the business was handled at the AGM of the Association of CHCs in York. I was particularly interested in motion 15 (opposing any restriction to the 1967 Abortion Act). There was reasonable expectation from the papers circulated before the meeting that this would be most likely to come up on the second day. Because of heavy commitments, I could attend for one day only and therefore made plans to come on the Thursday and of course, missed the discussion on motion 15. However, I

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

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Comment

Early in 1978 the pay confrontation between dentists and the Government was in full spate. The British Dental Association had withdrawn from official pay negotiations, and was recommending to its members a policy of "selective acceptance" — a refusal to carry out some types of NHS work. David Ennals wrote to all the dentists in England, asking them not to make patients suffer. The Association of CHCs wrote anxiously to the BDA, which replied that "a bankrupt dentist is of no use to anyone".

Now things seem calmer. The "target average net income" for NHS work done by general dentists is £11,128 pa, and from April next it will be at least £12,368 — plus "updating as necessary". To this must be added the £1000-plus pa (net) that the average dentist earns privately.

But no-one should imagine the problems have gone away. As many CHCs know, dentists are continuing to hold back, particularly from complex work such as crowns and bridges where they consider that NHS fees still do not recompense them adequately. While researching its new report on dentistry (1), *Which?* magazine talked to 550 dentists and found that over half were withholding some forms of treatment from NHS patients. About 10% were refusing to see new NHS patients at all. The National Association of Citizens Advice Bureaux analysed enquiries made to 20 CABx in north London during April and May 1979, and found 34 people who had been refused some form of NHS treatment by a dentist (2).

When dentists decide that the NHS fees don't suit their pocket, it becomes a simple question of "your money or your teeth". As one dentist explained on TV recently: "In the same way as people can't afford to buy a Rolls Royce, the patient is faced with the prospect of not being able to afford the dentistry which he wishes to have done". The basic conflict between dentists' entrenched self-employed status and the needs of patients is plain for all to see.

Then there is the manpower and maldistribution problem. If dental care is elusive in north London, how much more so in other parts of England and Wales? In the NW Thames region there are about 2500 people for every dentist, but in badly-off regions the figures range from 4500 (East Anglia) to 5400 (Northern).

The Royal Commission put it this way: "Given the present level of disease and methods of practice, regular dental care can be given to considerably less than half the population. The fact that, in general, demand is much lower than need saves the service from breakdown". Dental manpower is increasing gradually — in England by about 17% over the last ten years — but the main hope for reduction in dental disease must be through fluoridation.

Beyond that all suggestions for major reform begin to look frustratingly utopian — though a capitation system, as is used to pay GPs, would seem to be a reasonable compromise between the radical demand for a salaried service and the small-business outlook of most dentists. The Royal Commission suggested that "how far the gap between aspiration and performance is closed will depend on the political will". Perhaps that means we shall all have to get a lot angrier before anything really important is changed.

1 *Which?*, Nov 1979, pages 641-644.
2. *Survey on dental treatment*, 25p inc post from NACABx, 110 Drury Lane, London WC2.

Health News

The health of the prison service

Strong support for secure units and better services for alcoholics has come from the report of the inquiry into the UK prison service*. Two of its recommendations are of particular relevance for CHCs:

•On regional secure units: "It is wrong.... to imprison mentally disordered offenders, and the DHSS should take urgent steps to ensure that the NHS lives up to its proper responsibilities".

•On detoxification centres and hostel projects for alcoholics: "Prison should be avoided wherever possible for ... drunkenness. More determination should be shown in dealing with alcoholism, and local voluntary schemes should be encouraged, where appropriate, with Government grants, both to start and maintain them".

But despite its comment that "closed institutions above all require open, well-informed discussion", the report fails to tackle the thorny question of whether drugs are used to control prisoners' behaviour.

Yet more evidence on this has appeared in *Mind Out* magazine (September/October 1979 issue), in an interview with Joan Broster, an ex-prisoner who for ten months worked in the sick bay of a small prison for women near Stoke-on-Trent. According to Ms Broster, 95% of the inmates were on tranquillisers, antidepressants or sedatives, drugs were adminstered by nurses without proper medical supervision, drugs were used by staff "to cope with every problem" including prison disturbances, and some women became addicted to these drugs

because of their over-use. The Home Office has denied these allegations.

* *Committee of inquiry into the UK prison services*, Cmnd. 7673, HMSO £6.

Legislation on fluoride?

According to a story in *The Observer* newspaper, the Government is preparing legislation which would oblige all Britain's water authorities to fluoridate public drinking water.

A DHSS spokeswoman dismissed this as "speculation", but Geoffrey Lean, who wrote the *Observer* piece, says: "I'm absolutely happy with what I wrote. I've had it confirmed word for word, twice, by my source, who is the sort of source you would expect to get this sort of information from.

"Civil servants have been preparing this legislation following the Royal Commission's report, but it has not yet been decided by Ministers. My reading is that it is thought that Patrick Jenkin and George Young are in favour of it, but that Dr Vaughan is a bit less sure".

A reversal by any other name

The Government has elaborated on its policy of cutting back on money for new health centres, reported in *CHC NEWS 46* (page one) as a "reversal of policy". Junior health minister Sir George Young wrote to Tony Smythe, director of MIND, in response to his expression of grave concern as to what such a switch would mean for the future of community based mental health services. Sir George's reply was that the new policy was not a reversal but a shift in priorities aimed at introducing flexibility. He told MIND, "All too often, in our experience, the provision of a health centre has been regarded as the only solution and the consequence sometimes has been a very large centre totally lacking the domestic atmosphere one finds in the surgeries of general practitioners. We believe that it is a mistake to have a vast proliferation of services in health centres".

CHCs could go west

CHCs have come under scrutiny from a South Western RHA working party, following several district mergers in the region, which have already affected six out of the 14 CHCs. The working party's report calls for the CHCs to be reduced to the number of districts or area teams, and a curtailment of CHC activities which do not strictly conform to the guidelines of the establishing DHSS circular HRC(74)4. The report is rather disparaging about CHCs' pleas for additional help to do research

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work and says that neighbouring secretaries or the CHC's chairman should be drafted in to cover gaps caused by sickness or holidays. *Report of the review working party on CHCs*, from South Western RHA, 27 Tyndalls Park Road, Bristol BS8 1PJ.

"Real" growth for the health service?

An increase of 3% over the latest estimate for this year's spending is the Government's plan for health service gross expenditure in 1980-81. The 3%, says the public expenditure white paper*, will restore the 2½% squeeze this year and add a further ½% "real growth" — the growth figure fixed by the previous Labour Government.

Some NHS charges are to go up from 1 April: prescription charges from 45p to 70p, dental charges in line with rising costs (figures to be announced later), and hospital charges for road traffic casualties recoverable from vehicle insurers. £2m a year will also be saved by restricting entitlement to free welfare milk and vitamins. However, revenue from charges will still contribute a minute percentage of the total cost of the NHS.

The personal social services will have to suffer what Patrick Jenkin describes as an "unpalatable reduction" in expenditure of 7% over this year's spending. But, as he pointed out in commenting on the public expenditure plans, the Government gave no undertaking in its election manifesto to protect the personal social services. The planned growth in joint funding will continue.

Social security expenditure is set to rise by about 1% to £19.3 billion in the next financial year. The increase has to take account of rises already made this year in social security benefits, child benefit to single parents, and fuel benefits, as well as the expected rise in the numbers of pensioners and unemployed. Intensified efforts to curtail abuse of the social security system, involving the employment of 600 extra staff, are expected to bring in £40-£50m.

How real will the ½% growth for the health service turn out to be? The Government's estimate of the inflation rate for next year is not known, but it will presumably be as low as possible in an attempt, among other things, to discourage high wage demands. When the actual cash limits are decided next year, health authorities may find they have little if any "extra" money to spend — even though Patrick Jenkin promises that cash limits will be "realistic". Moreover, the DHSS admits that 1% growth is needed simply to cope with demographic changes (particularly the growing numbers of very old people) and medical advance. Faced with the possibility of an ever larger wages bill, and the certainty of fewer social services to provide back-up care, health authorities may well think themselves lucky if they can manage to bring forward in 1980-81 any of the developments they had to defer in 1979-80.

**The Government's expenditure plans 1980-81* Cmnd 7746, HMSO 70p

BMA rules for patient committees

The BMA's central ethical committee has drafted guidelines for GPs whose practices have patient participation groups (PPGs). Issues which worry the BMA include advertising and breaches of confidentiality, which both infringe the doctor's code of professional conduct. After discussions at the BMA's general medical services committee, the guidelines have been drawn even more tightly. The rules stress that GPs are professionally responsible for the practice and for the actions of the PPG "where such actions come into conflict with accepted professional standards". Doctors must take this into account when the constitution of the PPG is being constructed. Any services set up by self-help groups of patients should be restricted, in case they amount to an inducement to patients from other practices (which, it is implied, do not have such services). Finally, if any breaches of confidentiality occur as a result of visitors *such as CHC representatives* attending PPG meetings, it is the doctors who will be held professionally responsible. In the GMSC's discussion, reported in the *British Medical Journal* (3 November 1979), several members expressed hostility to PPGs. Others felt that if they existed the GMSC ought to "steer them in the right direction". Dr Mike Thomas, chairman of the central ethical committee, said the CEC did not advocate PPGs but could not ignore the ethical problems which they raised.

The less asbestos the better

A new approach to controlling cancer-causing substances in the workplace has emerged in the final report of the Advisory Committee on Asbestos (ACA)*.

The ACA says that "there is no apparent threshold below which the exposure to asbestos dust entails no risk to human health", and that it is therefore "inappropriate to continue to control exposure levels in terms of 'hygiene standards' ... since they imply levels of exposure below which exposure is safe".

Instead the ACA proposes the introduction of "control limits" — levels of airborne dust "above which no person should be occupationally exposed". For asbestos these limits should represent "the concentration of asbestos dust in the workplace at which further expenditure of effort to lower that level is out of all proportion to the reduction achieved in the risk of contracting asbestos-related diseases".

The ACA rejects a complete ban on all types of asbestos because it believes that control over any useful but hazardous material is better than prohibition, and because some asbestos susbstitutes are also potentially harmful to health (see *CHC NEWS 48*, page 14). But it recommends a legal ban on blue asbestos (crocidolite), and tighter controls over white (chrysotile) and brown (amosite) asbestos.

On hazards to the general public the report concludes that "no appreciable mortality from lung cancer can be associated with any degree of contamination by chrysotile (white asbestos) to be encountered in the UK, either in the air or in buildings not under active construction or repair". So there is no recommendation to remove white asbestos from existing buildings. But tighter controls should be applied to prevent the release of dust from asbestos works, and existing legislation should be used to reduce the levels of asbestos in food, drinks and public water supplies.

The report will now go to the Health and Safety Commission, which will issue draft regulations for comment.

**Asbestos: Volume 1* and *Volume 2*, £5 each from HMSO.

Sparks fly in fuel debate

The Government's new scheme to help people pay their heating bills this winter, announced by Patrick Jenkin in the House of Commons on 22 October, aims to give larger amounts of money to a much smaller number of people that those helped under the scheme operated by the Labour administration. The following people will *automatically* receive, from 12 November, a basic-rate heating addition of 95p a week: families on supplementary benefit (SB) with a child under 5 or a dependant who is over 75; and supplementary pensioner householders who are over 75 or who are under 75 but have a dependant (eg wife) over 75. Heating addition at the three rates (now 95p, £1.90 and £2.84) will continue to be paid to people on SB whose claim has already been or is in future accepted, but they will not of course then get the automatic payment. The second part of the Government's scheme is payment of an additional £1 a week to families in work receiving family income supplement (FIS). An estimated 340,000 people will benefit from the scheme, which will cost £16½m this year.

The Government has been attacked in and out of Parliament for restricting help to a small number of people, and particularly for deciding not to continue the electricity discount scheme. Under this scheme, people receiving SB, FIS, rate or rent rebate or rent allowance could get a discount of 25p for each £1 of one winter electricity bill over £20. The Opposition claimed in the Commons that 5 million families benefited from the scheme last winter, at a cost of £45m; meanwhile electricity charges had gone up by 18.9%.

Elderly people under 75, families with children over 5, and other poor people would receive no help this year. Mr Jenkin said that he entirely defended the priorities of his scheme.

Failure to introduce a simple comprehensive fuel benefit, based on need and not tied to the social security system, is criticised once again by the Supplementary Benefits Commission in its latest annual report (Cmnd 7725 HMSO £4). The report's general conclusion is that the level of SB is still too low to keep many of the people who depend on it out of poverty.

Views from the shop floor

Arrangements for the delivery of NHS services need major adjustments to meet the needs of factory workers and other residents in working-class areas, according to research carried out by South Tyneside CHC. Here we publish edited extracts from the CHC's report*, which is based on interviews with workers and management in 12 Tyneside factories.

Very strong objections were made to the **GP appointment system** by the majority of workers, and this was always the first matter raised by each group. There was an overwhelming wish to return to open surgeries where they could see their doctor on the day they got ill, even though they might have to wait a long time . . . usually 3-7 days, before an appointment could be obtained were quoted.... by the time they got to see the doctor they were "either better or dead"....

Great frustration and fear were expressed, particularly with sick children, when they could not get an immediate appointment in acute illness unless they made a "terrible fuss"....

There should be some form of priority appointment for workers early in the morning surgeries, as they were losing pay....

The subject of **charges for sick notes** came in for a lot of discussion in all factories. Firms require a sick note for any employee who is off work three days or less, either with a minor ailment or to visit an outpatient department or GP's surgery.... Workers resent the charges made for these notes, which vary from 20p to £1 and average 50p....

Hospital staff should be made aware that if men have an accident at work and are sent to the casualty department, they receive only four hours off work and after that they lose their pay.... Diagnostic staff should be made aware of the financial hardship for those required to make regular visits....

In every factory, concern was expressed over the role of **GPs' receptionists** by a large number of patients.... It was generally felt that the receptionist, who had no training, barred patients' access to their doctor in cases of serious illness....

Receptionists had too much power and demanded private details of illness before giving appointments.... Prescriptions were apparently offered in place of an appointment to see the doctor.... Receptionists refused home visits without reference to the doctor.... It was universally felt that they needed compulsory basic training to improve their poor relationship with patients....

Some workers said they could get any number of **prescriptions** freely, and they felt this was wrong.... They would prefer examination and diagnosis first, and would feel more reassured by this.... They said doctors overprescribed to keep patients away....

Working people found it a great problem that they could not get a prescription from a GP on a Saturday ... They disliked the requirement to give 24 hours notice for a repeat prescription, which meant two journeys plus possible loss of wages....

Another major cause for concern was the refusal by many GPs to make **home visits** to seriously ill patients.... some doctors sent patients straight to hospital without bothering to examine them first....

GPs need more **time for patients**.... There were repeated cases where the GP told the patient that nothing was wrong. The relatives had to "raise the roof" before anything was done....

Patients in a **joint practice** liked to keep their own doctor.... When seen by a different GP he or she did not know their illness record and often prescribed different drugs.... **Health centres** were intensely disliked. It was difficult to get an appointment with your own doctor. If you saw another doctor, you found later that when you saw your own he had a quite different idea of what was wrong....

Enough people to cause concern mentioned that their doctor berated them for using the **deputising service**, as the GP had to pay for it....

In every factory there was real concern at the difficulty and long delays in obtaining a doctor in an emergency.... Repeatedly workers spoke of the terrifying experience of night emergencies. No doctor in the Jarrow/Hebburn area apparently worked at night. Deputising doctors take at least an hour to arrive ... and then do not always make a proper examination.... It was not always possible to get an emergency doctor....

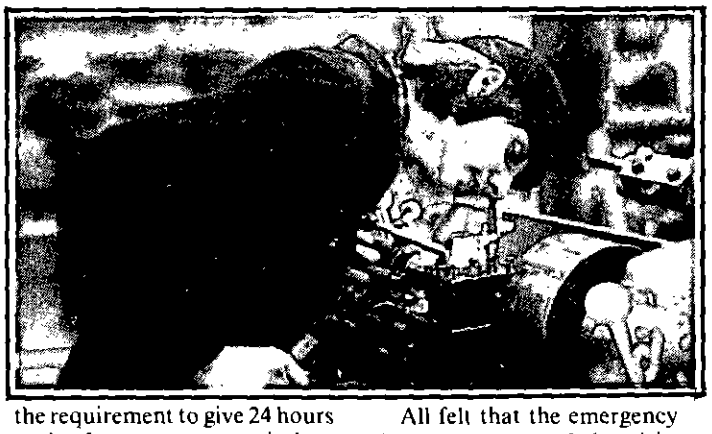


Photo: Manpower Services Commission

All felt that the emergency doctor system needed revision, and in its current form was very dangerous. The words "appalling" and "diabolical" were regularly used.... Possibly it would be better to get an emergency phone number from the police or 999 than from each GP.... Why could not group practices always have one doctor on emergency call?.... All hospitals should give emergency treatment....

After-care services on **discharge from hospital** appeared to be nil.... In hospital social workers and nurses promised aids but these did not materialise.... The AHA "just wants to get you out of hospital and forget about you"....

There should be a voucher system for **NHS glasses**, because NHS frames are unpopular and break easily. Then patients could choose NHS glasses at that price or put it towards better frames....

Dentists worked from 8.30am to 5pm, and now many did not work on Saturdays... Workers would find it helpful to have 6-7pm and Saturday appointments... they deplored waits of three weeks or more when they had toothache....

Frequent reference was made to the high cost of dental fillings.... Dentists should be required to display charges in their waiting rooms ...

Workers felt there should be better coverage for prescriptions by **chemists**. Patients or their relatives had to go from South Tyneside to Newcastle (about eleven miles) after 10pm at night....

The DHSS was asked to consider seriously the provision of "**well units**" to go round factories and check the health of workers.... X-ray and cancer smearing should be brought to the works.... In large factories could not a doctor hold regular surgeries on the premises?

Ambulances often arrived late, eg came to collect at 3pm for a 2pm appointment at the hospital.... Patients who see a doctor and finish at 12 noon have to wait until 2pm for an ambulance.... Ambulances often don't turn up at all for day patients....

The role of **CHCs** was not previously known in the factories, and it was suggested that national publicity be given to their existence.... CHC leaflets were requested for distribution to all in factory work ... CHCs should produce posters for display in factories.

South Tyneside CHC says its report underlines the need for "serious study and consideration of the issues raised", by AHAs, RHAs, FPCs and local medical committees. It adds that many possible solutions to the problems identified by the report "appear to be in the field of administration and do not involve vast expenditure".

* *A study of the NHS as experienced by shop floor and management in industry on South Tyneside during 1978/79.* Single copies free from South Tyneside CHC, 131 Westoe Road, South Shields, NE33 3PA.

Book reviews

Community health, preventive medicine and social services

J B Meredith Davies, Bailliere Tindall, £4.75

Did you know that the infant mortality rate per 1000 live births in 1975 was 9 in Havering and 25 in Rugby; that the incubation period for chicken pox is usually 17-21 days; that by the end of 1978 22% of GPs practised from health centres; that all midwives must attend refresher courses every five years; that only 5% of people survive for five years after treatment for cancer of the lung, compared with 44% for cancer of the cervix? What *is* meant by neonatal mortality rate or standardised mortality ratio? Why aren't venereal diseases notifiable when whooping cough and measles are? What are the legal definitions of a child and a young person?

This useful handbook is full of information on all aspects of its subject, including the structure and management of the health and social services and the legislation governing them. Chapters cover the measurement of health and of social problems, maternity and child health, health education, immunisation, food and nutrition, environmental health control, care and rehabilitation of the disabled, and much more. This fourth edition is fairly up-to-date, with information on joint financing, Inner City Partnerships, and the Court and Warnock reports. One criticism is that the index is not detailed enough to guide you back to specific bits of fascinating information you *know* you have read.

Mental handicap: the social dimensions

by Gillies Owens and Peter Birchenall, Pitman Medical £7.95

If you wish to get up-to-date or extend your knowledge of *Gemeinschaft* or *Gesellschaft* then this is the book for you. *Gemeinschaft* is about community and relationships; *Gesellschaft* is about association. Owens and Birchenall seem to have thrown all their sociological knowledge into this book to satisfy those interested in the social living aspects of mental handicap. The book discusses the family and mental handicap and goes on to look at the community needs and finally at how those with a responsibility to the handicapped can function. The writers make it clear that they have taken sides in the matter of mental handicap problems. For instance, when discussing "good genetic counselling" they use as a model the Regional Genetics Advisory Service in northern England.

The writing is sometimes slipshod. For example, there is a reference to the "shock waves of the recent allegations of the work of Sir Cyril Burt" on page 19, but you have to read on to pages 64/65 before it becomes clear what these allegations were. I started to read this book with interest because of the background of the two authors, one in sociology and one in nursing, and I think the authors should be complimented on trying to put together ideas about social need. But drastic pruning or re-editing in a second edition will have to be undertaken by the publishers. It is certainly a book for the library, to be taken in small doses.

Alfred Boom
West Berkshire CHC

Autistic Children

edited by B Furneaux and B Roberts, Routledge, £2.75

Aloofness and aloneness were the outstanding features of the condition which led American psychiatrist Leo Kanner to apply the term *autism* to a group of children in the 1940s. Autistic children often show outstanding creative talents, in drawing or music, and the condition is quite different from mental subnormality. But it is a most intransigent and bewildering form of behaviour and this book will certainly help parents and teachers of autistic children as well as others involved in caring for them.

The source book for the disabled

Edited by Glorya Hale, Paddington Press, £4.95

Today, people of all ages with varying degrees of physical limitation recognise the importance of taking responsibility for their own lives. This book offers sound and frank advice, on the practical problems of daily living, giving information about education, employment and the psychological, emotional and sexual aspects of disablement.

The contributions on leisure and recreation suggest that the outlook has at last left behind the old weaving and basket-work days. For instance, the book informs us that in the USA there are more than 260 members of the International Wheelchair Pilots Association, and that there are four manufacturers of hand controls for light aircraft. Hand controls for cars are also discussed and well illustrated.

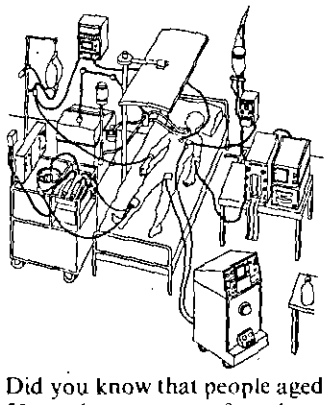
In this large book I was surprised to find only 25 lines on incontinence, and yet eight full pages about overcoming sexual problems. Without finding some means of overcoming incontinence a disabled person cannot always enjoy any of the joys of life.

All organisations involved with the problems of handicapped people should read this book. Disabled people will find it full of practical advice concerning every aspect of their lives.

B Pallett
Croydon CHC

Modern hospital: international planning practices

by Ervin Putsep, Lloyd-Luke Medical Books, £20



Did you know that people aged 50 require on average four times as much light as people aged 20, if they are to see equally well? Or that 15 to 20 air changes per hour may be needed in an operating theatre?

Or, to go from the specific to the very general, that "during the hospital generation process, errors up to 100% can be found in the initial political or administrative statements and early declarative building programmes"?

Perhaps you could have guessed the last one, but the first two would probably have needed looking up, and this book looks like one of the best ways of doing that. Erwin Putsep, a hospital architect and planner, has poured a wealth of international experience into its 690 pages, with sections on infection, environment, access, hospital technology, nursing units, diagnostic services, surgical departments, obstetrics departments, ambulatory and day care, A and E departments and mortuaries. There are many useful drawings (the one shown illustrates the battery of equipment that may be used in a burns unit), and the author shows a keen awareness of areas of medical controversy as well as technical detail.

The book has several drawbacks — it is stiffly translated, poorly proof-read, quotes guidelines that may not always be appropriate for Britain, and costs the earth — but CHC members involved in monitoring new hospital developments should definitely read it.

Fertility and conception: an essential guide for childless couples

by John Stangel, Paddington Press, £3.95

Dr Stangel has written a comprehensive review of the factors causing infertility. He is clearly fascinated by the technicalities and techniques of overcoming infertility — he claims a 60% success rate — and his layman's guide explains in detail the problems and the medical options. An enthusiast for his cause, he remains objective in his attitude and realistic about the reasons for parenthood.

He fails, however, to deal adequately with the 64,000-dollar question — how do couples resolve their problem when medical help fails and there is still no baby to hold? His view of adoption possibilities is over-sanguine — certainly for Britain — as is his American high-technology dream of a future of surrogate mothers, transplanted uteri and micro-surgery. However, this guide could be most helpful for couples with a newly discovered infertility problem.

Dilys Cossey
St Thomas' CHC

A day in the life of...

...a therapy radiographer

by Mary Smith, formerly senior radiographer in a district general hospital and now a clinical tutor in radiography

Very simply, radiotherapy is the use of ionising radiations to treat tumours of all types. All ionising radiation is capable of destroying tissue, if enough is given, so the aim of radiotherapy is to give a dose of radiation large enough to destroy the tumour without permanently damaging the surrounding normal tissue. This is done by aiming more than one beam of radiation at the tumour so that each beam on its own does not have to be of a very high dose, but where they meet, they add together to form a high dose region round the tumour. This requires very careful planning by the radiotherapist (ie, a consultant), physicist and radiographer.

One of the satisfactions of radiotherapy is that it is rare to have a patient for whom one can do nothing at all. Many tumours are now curable if detected early and when cure is not possible, radiotherapy can still usefully relieve pain and reduce the size of tumours. Also the patient is always genuinely ill so there is never any feeling of dealing with triviality.

I arrive at work at about 8.15 in the morning, not so much out of eagerness to start as to find a place to park the car. The first patients are due at nine o'clock but before that, together with the other radiographers assigned to my unit, I go round to the treatment room to check the machine before the day's work. We do a simple test to check that the output of the machine is correct. We also check the accuracy of the devices used for setting up and positioning.

The first patients to arrive are a group of five from the radiotherapy hostel. This is a hospital hostel where people can stay if they are fairly fit but live too far away to travel daily for treatment. (Our unit takes patients from the whole area and a bit beyond the area boundaries.) The hostel is very comfortable and is in the charge of a nursing sister.

The patients are all part way through a course of treatment so they know us and each other quite well. There is much good-natured arguing about who is going to get first turn, but we call them in as is most convenient for us, meaning that we have to change the position of the machine as little as possible between patients.

The first man to come in is having treatment for his larynx. He has been advised to rest his voice as the treatment is making his throat sore. We commiserate with him as he tries to chat in whispers. It is very hard not to whisper back and when we do it by mistake he laughs and is not offended.

This man has to wear a specially made perspex mask which we fit on very carefully to ensure that it is not too uncomfortable. Once it is fitted the mask prevents him from speaking so we give him an alarm bell just in case he wants to call us during treatment. The mask keeps him very still and also has marks on it for positioning the X-ray beam. By moving the bed and asking someone else to move the machine by remote control I am able to ensure that the beam is passing through the correct points. All the staff must now leave the room and observe the patient through a periscope mirror system. The required dose is checked on the treatment sheet and I set it on the control panel and switch on.

The exposure takes about two or three minutes and when it is over we can go in to aim at the tumour from a different angle. When the second exposure is finished we rescue the man from his mask. The same procedure is followed for the next three patients. We try to arrange groups having the same treatment together because it makes our work easier and also the patients give each other moral support when they are waiting together. It is nice to know that you are not alone in your worries and troubles.

The last of the five is also having a mask treatment but is having his mouth treated. He is very worried because his lips are sore and cracked although Sister has given him something to put on them. I reassure him that it is normal reaction to the treatment and will clear up after he has finished.

The next little group is women from the hostel who are all having treatment to the pelvis following internal treatment with caesium. Setting up the treatment is relatively easy so I ask my student if she would like to do it. This means that I must supervise her carefully as all our students must have their work checked. She carries out the treatments correctly but I notice that she is shy of talking to the patients so I make a mental note that I must try to encourage her in this direction. As we have spent an average of 15 minutes with this morning's patients, this brings us to coffee time.

When I return from a quick cup of coffee I notice that a new patient has been brought to the waiting room. I go to speak to her and it is obvious that she is very frightened. She is mainly afraid that all her hair will fall out and that she will be badly burned because this is what a neighbour has told her. I have to explain carefully that hair only falls out if it is in the treatment area, and even then it will grow again. She has to have treatment to the chest wall and so will be quite safe from this point of view. As for the burning I am able to reassure her that this particular machine does not cause any skin reaction and this seems to cheer her a little. I know that she will not completely believe me until she has experienced her first treatment, so we take her in next to avoid any further anxiety. She is very relieved after her treatment and not quite so nervous about coming tomorrow.

The next lady is suffering from a tumour of the oesophagus and is very frail. She has refused to come into hospital whilst having treatment and travels daily by ambulance. She is not really able to look after herself properly although we have given her a lot of advice about diet and general care. I am worried about her condition so I ask the doctor to see her. He is unable to persuade her to come into hospital and so we decide the only thing we can do is to ask the social worker to see her and try to arrange some help for her at home. I go to see the social worker and put her in the picture and arrange for the lady to see her after treatment.

In the afternoon I leave the others on the unit to treat in-patients from the ward while I look through and check all the daily treatment records from the morning. Occasionally I have to leave the checking to help with some of the patients. There is a child coming to complete a treatment for leukaemia. Before the children come to us they have had a very long series of chemotherapy treatment and are often mistrustful of hospital staff because they have had so many injections. Much patience is required to win their confidence.

Another patient who requires all hands is a man sent down from the out-patient clinic. He has secondary deposits in his spine and must be turned over to be treated. We all have to lift him very carefully as he is in great pain. He has one long treatment to try to give him some pain relief quickly, that is within a few days. This is the last patient of the day as far as we know so that when we have booked the ambulance and sent him on his way, all that remains to be done is to clean the equipmment and put clean linen in the room ready to start another day.

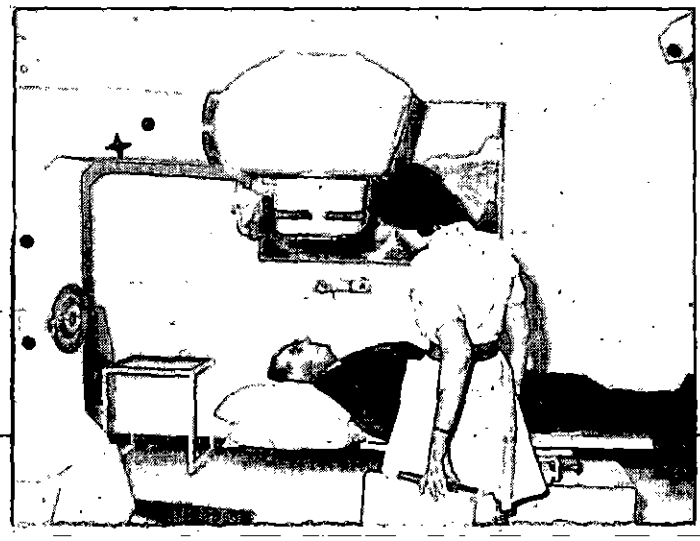


Photo: Photo-Scan Ltd

Quality of Care

This article arises from ideas contributed by ROY SOUTHERN and BRIAN DONALD * to an article published in the *Journal of Medical Ethics* (December 1978) and to a seminar organised for members by West Yoirshire CHCs in November 1978.

Photos Liz Heron

The professional literature on quality of care reveals a kaleidoscope of issues and a piecemeal coverage. Like most professionals, ordinary CHC members when faced with this morass are likely to abandon the topic in favour of something more tangible — thereby neglecting a function for which they and their councils are uniquely fitted.

In the health and social services the word "care" has many uses. It may describe the use of professional skills, as in "medical care and dental care", though nursing care can refer both to professional skills and to doing those things for a patient which he or she if able would do unaided. We wish to stress a general approach, as set out in the figure. The patient's judgement is clearly of the utmost importance: does he or she feel cared for?

The essence of high quality care is for the patient to be treated as though the particular illness or handicap were unique, which of course it really is to each individual. The barriers to such an approach are daunting. Shortage of money, particularly when it causes staff shortages, means that *routines* of care often have to be adopted. The absence of an agreed definition of what constitutes "health" also makes it difficult to know when illness or handicap can be said to have been eliminated. The experience of feeling ill will be different for each person, and depends just as much on the individual's circumstances and capacities as on the severity of the disease and handicap. An important part of caring is the recognition of this subjective element.

Obligation and compassion

There is a definite and vital link between the operational problems of providing high quality care, and those responsibilities which belong to society at large. Improvements in health services can be assessed according to three criteria:

effectiveness, which is often defined in terms of the elimination or mitigation of premature death, disease, disability, discomfort and discontent;

efficiency, which is necessary, in a world of relative scarcity and limitless wants, to ensure that whatever resources are available produce the best value;

social acceptability, which means the acceptance by society as a whole that unnecessary impairment or indignity of one person is a loss of face for all, and that this collective responsibility has financial and social implications. There is the "oh" of concern and the "ouch" of taxation.

To put this another way, we have the "threshold of obligation", which relates the necessity for society to help those in need to the level at which society feels that individuals should help themselves, and the "threshold of compassion", which is the basis of care and caring. The levels at which these different thresholds are set are, and should be, predominantly determined not in the professional world of health care but in society at large.

The lay view of care is determined by the norms of independence, dignity and choice which are set by society in general. How do you react to the lack of a personal toothbrush for a mentally handicapped patient, or to defining a fair day's work and pay for an NHS porter who is nearly crippled by asthma? Through reactions to these sorts of questions the community at large fashions and reinforces the "thresholds of obligation and compassion" within which the professionals, who quite properly seek to influence these reactions, must work.

However, the match between obligation and compassion is difficult to arrive at because of the conflicts and complexities of the issues involved. It is not uncommon for the public to become extremely upset about failures of care while ignoring the possibilities in terms of personal action, or of remedies at increased public cost. CHCs could help to remove public misconceptions by explaining more clearly the constraints within which the health service operates.

Professionals have a golden rule that each patient should receive the best quality care in a technical sense. This may not be the best care in terms of the patient's choice or dignity as judged by relatives or by the public and its agents. Moreover, it may increasingly be impossible to provide the best in a technical sense for every patient.

Individual care — the ideal

Individual care means that all patients will be reassured about their personal worth and the need for them to respond in the interests of recovery or rehabilitation. A paramount factor is the patient's capacity to adjust to changes in circumstances and environment, but cultural and personal differences shape and alter the response to illness, pain and disability. Staff must learn to distinguish between the differences which are mere whims, and those which represent real need.

Economic stringency may necessitate the imposition of routines which while militating against individualised care, yet make possible the delivery of some form of care to a greater number of people. However, routines do involve psychological, social and economic costs for patients and staff. For example, routine admissions in the morning involve an additional day off work for patients, perhaps unpaid, whereas routine evening admissions require more staff to work unsocial hours. We believe that any detrimental effects of routine on individual care should be identified for each patient, preferably in a written plan.

The *nurse's* contribution to care, treatment and service planning is crucial but insufficiently influential. In the intimacies of feeding, excretion, sleeplessness and pain something of the real individual emerges and the true needs and wants surface. The nurse is in a unique position to bring the needs of individuals to the attention of those responsible for managing and planning the service.

Care policies

Good care is comprehensive and indivisible. Care policies should emerge from a flow of consultation between the different levels of the organisation and should be initiated by the listing of barriers to good care at the operational level, and maintained by continuous management review.

CHCs can assist by asking about care policies, if necessary advocating their introduction and providing a lay point of view to professionals and managers.

As a basic principle any erosion of independence, dignity and choice should be minimal, temporary and kept continuously under review. Shortages of resources in terms of money and staff can lead to an undue emphasis on attaining and maintaining only "minimum standards", which can destroy the desire for further progress.

Need for the lay view

It is increasingly necessary to resort to intuitive judgements about the relative priority of different needs. Choices must be made which fall between and beyond the confines of established professional, ethical, social, economic and demographic considerations. A supportive lay view is more likely to be welcomed.

Health professionals develop a view of identity, dignity and choice which is coloured by receiving sick patients who are vulnerable and dependent. Professionals may too readily accept the conventional wisdom about the behaviour of patients within their own specialty. Perhaps the present move towards greater participation by all NHS staff, including ancillary staff, may help. The remark of a new domestic on the intensive care unit may convey a clearer insight into the reactions of patients than can years of attitudinal research.

The professionals do not claim a monopoly of care or caring, although we must remember that few lay people have much detailed experience. Public tolerance is limited by ignorance and fear, and can be misjudged by professionals.

Institutional care has for a long time shielded society from the need to accept and understand the disabilities and capabilities of the handicapped. The insulation of the public from suffering to the point where disclosures of care failures, such as Ely, Whittingham and Normansfield, produce scandalised reactions, is dangerous. The lay public and the professions must engage in a continuous dialogue about problems that

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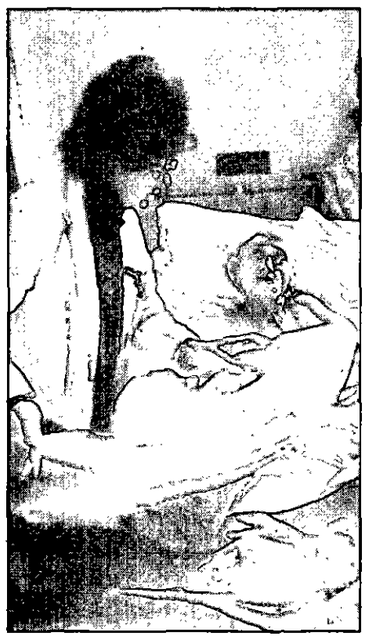
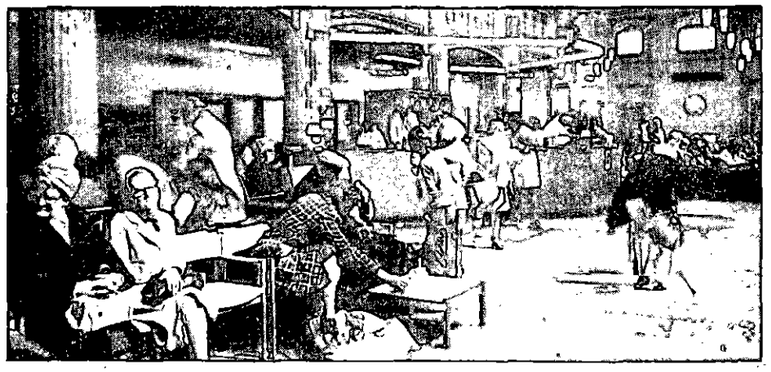


High quality care is:-

1. **Doing all that is necessary to maintain the highest possible quality of life — physically, psychologically and socially — in the present, whilst promoting the greatest potential for the future in the same terms.**
2. **Maintaining and enhancing the identity of individual patients, their dignity and their opportunities for exercising choice.**
3. **Providing emotional compensation for those losses which are caused by sickness and handicap in such a way that the individual can adjust to the handicap, accept it and act in his or her own best interest.**
4. **Involving the patient, the doctor and the care team including the patient's relatives and friends.**

Care requires to be a prominent objective of the organisation of health services and their management.



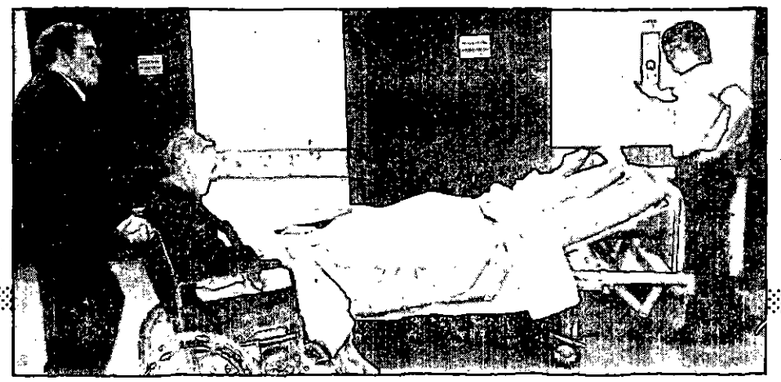


Photo Central Birmingham CHC

* *Roy Southern is a member of Stockport CHC and senior principal information and planning officer with the South Manchester Health District (Teaching). Brian Donald is registrar, Council for Professions Supplementary to Medicine. The points made here represent their personal views.*

Healthline

Complaints about deputising doctors

Is it true that a complaint against a deputising doctor has always to be made against the patient's regular GP?

Not altogether. If the deputy is on the same FPC list as the regular doctor, the deputy is responsible for any alleged breach in terms of service, though both doctors may, at least in the first instance, be called to answer the complaint by the FPC. If the deputy is not on the same FPC list, then the GP is held responsible for all acts and omissions of the deputy. A deputising doctor could however be the subject of a complaint to the General Medical Council if the allegation related to professional misconduct. It is also possible that following one or more complaints about a particular deputy, the FPC might decide to withdraw its approval of that deputising service.

Core health centres

What is a core health centre?

Where GPs are reluctant to move into a health centre the health authority may nonetheless decide to establish a "core" health centre from which other members of the primary health care team — especially health visitors and district nurses — can work. GPs can move into the centre as and when they wish. The West Midlands RHA has taken up the idea of core health centres as a means of ensuring that patients in deprived inner city areas are not denied access to primary care services, such as baby clinics, family planning and vaccination facilities.

Noises in the ear

What is tinnitus and what can be done to help people who suffer from it?

Tinnitus is a ringing, whistling, buzzing or other noise in the ear, inaudible to other people. It afflicts people with normal hearing as well as those with varying degrees of deafness. The sounds can be quite slight but may be so loud and persistent as to be completely disabling. Up till now people seeking advice about tinnitus have been told that nothing can help and that they just have to learn to live with it. But earlier this year the British Tinnitus Association was launched, with help from the Royal National Institute for the Deaf. People interested in the association and the current research being done can contact Northumberland CHC (FREEPOST, Ashington NE63 OSG, Tel: Ashington 813428). They will receive details of the association, news of a tinnitus masker, and information about setting up local groups for sufferers.

Home dental care for handicapped people

What are the arrangements in the NHS for providing domiciliary dental care for handicapped people?

General dental practitioners are obliged by their terms of service to visit and treat a patient whose condition so requires, and for whom they have agreed to provide dental treatment, at an address within five miles of their surgeries. They are paid a fee for such a a visit and although they are not required to travel more than five miles, higher fees are paid to encourage them to do so. During 1978 about 18,000 domiciliary visits for dental treatment were undertaken in England. A handicapped person whose treatment cannot be provided at home may be transported by ambulance to his or her general dental practitioner. The DHSS says that it is not aware of any difficulties in obtaining domiciliary care where it is required.

Music in hospital

Can you tell me about the organisation which arranges concerts in hospitals?

The Council for Music in Hospitals, a registered charity, brings concerts, operas, sing-songs, and children's sessions, to people in hospitals and other institutions in England, mostly in psychiatric, mental handicap and geriatric hospitals. The performers, who are professional musicians, are paid a small fee and hospitals contribute towards the costs. Leagues of hospital friends often pay for a concert or series of concerts. The person to contact is: Sylvia Lindsay, Organising Secretary, Council for Music in Hospitals, 340 Lower Road, Little Bookham, Surrey KT23 4EF.

Quality of care

continued from page 8/9

can only be slowly resolved within the likely available resources.

If a crisis intervention approach is adopted when care has deteriorated to the point that someone *must* do something, this will induce a surrender by staff to dependency on higher management — "they" must tell us what to do (though it is unlikely that "they" actually know).

Training

Education and training, apart from being fashionable, are likely to be the most successful approach to improving the quality of care through reinforcing the dignity of care staff. Criteria for good care should be part of the way in which staff perform their functions. Only staff who are perceptive and concerned will be alerted by the first indications of failures of care and through their training will be able to adopt *prompt* and skilful remedies.

Such training does not require endless courses off the job. Short seminars based in the work place may initially be helpful in re-establishing the priority of care, renewing faded insights and restoring commitment. Thereafter the key is the provision of internal feedback and review, with routine opportunities in shift handover and management meetings for seeing whether current performance is achieving the results which had been planned for each individual patient. DHSS circular HN (79) 35 sets out "A Programme for Improving Geriatric Care in Hospital" and goes a long way towards the kind of approach which we have outlined above.

The role of CHCs

If a CHC is to fulfil its role of indicating to professionals locally where the thresholds of compassion and obligation lie, then the quality of care and policies for its maintenance and improvement must be one of its highest priorities. What can CHCs do? (1) Management can be alerted to the interest of the CHC. A list of questions ** both on specific topics and on care policies in general can help here, even if only to clarify the issues for the CHC members themselves. (2) Concern and support for the care-providers can generate the rapport to sustain *joint* attempts at problem solving. Methods designed to prevent either professional or public representatives feeling threatened have been piloted in the context of mental handicap by Central Manchester CHC (see *CHC NEWS 12* p 3). In such ways community concern can underpin and if necessary uplift professional concern. (3) CHCs should be involved in planning. But the attempt to match the professionals on every aspect of corporate planning and at every stage in the planning cycle is self-defeating. The key time is the beginning of each cycle, when guidelines are issued nationally, regionally and by the area. If at this time the district management team could be presented with the priority concerns of the local CHC, the planners would have something identified and concrete to respond to and subsequently to answer. One main topic must be the quality of care.

Further reading

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2. **Whose life is it anyway?** by B Clark, Amber Lane Press, 1978
3. **To measure NHS progress** by Sir Richard Doll, Occasional Paper 8, Fabian Society, 1974
4. **Quality of care — commonplace or chimera** by B L Donald and R M Southern, Journal of Medical Ethics, December 1978
5. **Basic principles of nursing care** by V Henderson, Karger (for International Council of Nurses), Basel, revised edition 1969
6. **A question of quality** edited by G McLachlan, Nuffield Provincial Hospitals Trust, 1976
7. **Health care the growing dilemma** by R Maxwell, McKinsey and Co, 1974
8. **An assessment of the state of nursing in the NHS 1978** Royal College of Nursing

** *Copies of a list of questions on quality of care, drawn up by the authors of this article, are available from the CHC NEWS office.*

Second childhood

When Mother, aged 83, gets up at 2am for the fourth night in succession, and starts cooking what she insists is Sunday lunch, she is probably suffering from *senile dementia*. If she lives alone, she may be in danger, if she lives with an adult son or daughter and family, her behaviour will almost certainly impose a tremendous strain on the people around her. Either way, Mother is likely to be *regarded* as "a *problem*".

In recent years senile dementia has come into focus as an increasingly important and extremly distressing hazard of old age. This article highlights two recent publications on the subject, from the Office of Health Economics (OHE) and from MIND, the National Association for Mental Health.*

Photo: Liz Heron

Dementia in old age is a progressive brain disease of which the causes are not clear. Sometimes severely depressed old people are mistakenly diagnosed as demented. Loss of *recent memory, inability to* grasp new information, personality changes and disorientation are frequent symptoms.

The term "second childhood' to describe the behaviour of *demented people* is understandable. Eating habits may become socially unacceptable, there may be sudden emotional outbursts such as crying or undirected laughter; incontinence is common. The disintegration may be quite rapid, according to OHE *culminating in* "an inability to survive without considerable assistance... and almost invariably a shortened life expectancy".

The OHE report argues that dementia is "the most *significant single problem* facing the health services". Already, over *700,000* people over 65 years old in England are suffering from the condition. Among people over 80 years old, dementia affects one in five. The MIND report states: "More than half those aged 65 *and over in our mental hospitals* which contain the majority of long-stay in-patient beds suffer from this condition. Equally, half of those who occupy long-stay geriatric wards and a third of those in residential homes also suffer from serious mental deterioration."

That Britain has an increasing population of elderly people is well-known. The number of people over 80, for example, will go up by more than half a million between 1976 and 1995, to a total of 1.76 million. Resource allocation has hardly begun to take account of this.

The majority of elderly mentally infirm people are not to be found in institutions at all. They live "in the community". For every demented elderly patient who lives in an *institution (a mental hospital,* long-stay geriatric ward or local authority residential home) there are five people, *just as severely affected,* living alone or looked after by family or friends.

Senile dementia is irreversible. Drugs are unable *to halt its destructiveness. So* the emphasis is on "management" of the condition, providing a range of services to identify sufferers and support them and their families.

Yet the prospects for family support are not cheerful. OHE states, "An estimated 25 per cent of those aged 65 and over have no children to assist them in times of need". In any case, many "children" are themselves approaching retirement age and *are unable to cope with the* considerable stress of caring for a parent whose mind is wandering.

DHSS policy for old people suffering from dementia who cannot be looked after in the *community is that they should* go into residential homes, run by local authorities.

Residential homes are having to accommodate an increasing proportion of very elderly people with greater and greater degrees of physical and mental impairment. All too often the *criterion for admission is not a* balanced, multi-disciplinary assessment of the person's needs and capability, but a crisis. This pressure on local authority provision can only become more acute as the cuts in spending affect services such as home helps and meals on wheels.

Commenting on the fall in admissions of the elderly mentally infirm to psychiatric hospitals, OHE is critical of the *current bed norm projections. It* suggests that the guidance of 2.5 to 3.0 beds per 1000 population of 65 and over does not take account of the expected increase in the numbers of demented and highly dependent over-80-year-olds. Inadequate provision here will worsen the *pressure on local authority* homes. MIND points out that mental illness hospitals are still the places where demented people are most likely to end up.

Other mentally infirm old people are in long-stay geriatric wards. MIND states that "hospital is not always the best place for the elderly mentally infirm patient and that the medical knowledge and skills of hospital staff and the institutional regime is not conducive to the maintenance of skills and personal mobility".

MIND's report compares *traditional attitudes to senile* dementia with those which used to be universally *held about* mental handicap—that nothing could be done except keeping patients clean and fed. Now these views are being challenged and learning programmes devised to educate the mentally *handicapped are being adapted* to improve the mental functioning of confused elderly people.

The MIND report describes a day unit run *jointly* by a hospital and a social services department which aims to serve "patients" and "clients" on a short term basis. *The unit's* work avoids unnecessary admissions to institutional care and, with co-ordinated backup from domiciliary services, enables the elderly person to remain at home.

Even within the framework of institutions such as residential homes and psychogeriatric wards, changes can be made to help people retain skills and independent personalities. Making such changes often meets staff resistance, especially where *morale is low and there is a* feeling that residents/patients are simply "waiting to die". Changes in working routine just seem superfluous if that is the belief. Yet startling achievements have been made — slowing down the pace of the confusion and making patients *more active, independent and* continent.

OHE estimates that dementia in old age costs roughly £300 million a year, excluding of course the cost of caring for people by their families. MIND points out:-

"Currently *95 per cent of the aged live at home.* A growing proportion of these suffer from severe mental and physical impairment and make huge demands upon their families, often with minimal or no support from the health and social services. In spite of this it is estimated that *95 per cent of the scarce resources allocated* to services for this group *are concentrated upon the hospital and residential services which care for 5 per cent of the aged population.*"

* *Dementia in old age* Office of Health Economics, 162 Regent Street, London W1R 6DD (35p).
* *Positive approaches to mental infirmity in elderly people, MIND, 22 Harley Street, London W1 (£1.50)*

THE WELL WOMEN OF WESTON

by Martha Perriam, Chairman, Weston-super-Mare CHC

Weston-super-Mare is not particularly noted as a bastion of militant feminism. Yet the women of Weston, with the CHC's help, have set up something unique in health care.

It all started with an article in a Sunday newspaper, urging women to ask their CHCs where the nearest well woman clinic was. Nothing of the sort existed around here, but to show willing we invited a doctor from a private clinic in Bristol to talk about menopausal problems to the monthly CHC meeting. A number of women came along, and when they had listened politely they wanted to know why we couldn't have such a clinic in Weston — and why the NHS couldn't run it.

Why not indeed, we asked the district management team. The reply was that local GPs (all except one of whom are male) were quite willing to do cervical smears and that mass screening was uneconomic. The district had no money to spare and would not give the scheme any priority.

However, the CHC did not let the matter rest there. A public meeting was called to discuss the need for provision of a clinic, and we were amazed at the response. In a packed hall, speaker after speaker complained of hurried or unsympathetic doctors who had told them to "buck up" or take tranquillisers. What they wanted was the opportunity of having unhurried consultations with a *woman* doctor, here in Weston, and they told us in no uncertain terms to go back to NHS management and demand action on their behalf.

At about this time events overtook the CHC in a way which proved fortunate for the well woman project. The Weston health district was merged with the Bristol teaching district, and although this shotgun marriage did not find much favour in Weston at least the ladies' demands were looked at afresh. The new district community physician came up with a compromise: an existing fortnightly clinic could be diverted to cytology and breast screening, with blood, urine and weight tests thrown in. This clinic opened last June and has been fully booked ever since.

Meantime the CHC had set up a Well Woman Committee and organised a series of educational meetings, with professionals answering questions on topics such as pre-menstrual tension, depression and self-examination of the breast. Attendances were in the hundreds and the project received widespread publicity. The CHC office was inundated with enquiries and a file of 650 names was eventually compiled.

Gradually the other pieces in the jigsaw began to fall into place. The Family Planning Association showed an interest in running the counselling clinic and the Marriage Guidance Council offered skilled leaders for therapy groups. The Well Woman Committee undertook to raise funds to pay for those who could not afford the FPA fees, and to finance regular educational meetings on women's health topics. A blend of statutory and voluntary effort, public and private initiative, had eventually put together the Weston Well Woman Clinic. The CHC has now handed over the coordinating role to the Well Woman Committee, and the only link that remains is through individual members.

The part the CHC has played is significant. It has acted throughout in response to pressure from the public, but it has been uniquely well placed to give help. It has provided a public platform, has afforded direct access to the media and the management of the health service, and has been the "go-between" for several voluntary organisations. Lastly, the CHC secretary has supplied the professional expertise and office facilities without which the whole thing could not have got off the ground.

The cost of cobwebs

by Marcia Saunders, Secretary, Islington CHC

When CHCs were new many of us were concerned to show that we weren't like the old hospital management committees, running our fingers along window ledges, calling attention to cracks in the floor. We were into *policy* issues of patient care and resources.

Today we call resources *money*, and a cobweb is a cobweb, not a communications failure. Our district has a £6½m backlog maintenance bill. No major ward upgrading has been carried out by the AHA since reorganisation. Proposed upgradings are now costed at £300,000 a time, because of the extent of the deterioration. Staff complain repeatedly about the impossibility of getting minor repairs. Our visit reports now include detailed physical descriptions and we use them to press for action.

In 1978 we campaigned to have patients removed from an acute medical ward whose catalogue of repairs included:

— no bedside lights — doctors visiting at night had to bring lamps or switch on all the ward's lights.

— antiquated two-pin power points — requiring adaptors for heart machines, ripple beds, etc

— one bathroom for 22 men — a women's bathroom doubling as a staff changing room.

Staff had been calling attention to these conditions for years. The CHC had also complained, to no avail. Now the doctors invited the press, including photographers, to see the ward and gave out our detailed report. The resulting publicity led to the patients being moved. An upgrading plan was sent to the King's Fund which has generously granted £150,000, as part of its scheme to improve old London hospitals. One-off campaigns are no substitute for routine maintenance, washing and upgrading programmes. Work eventually undertaken out of dire necessity will be increasingly complicated and expensive. As taxpayers we find this unacceptable, relying as we do on planned and effective use of our money.

Last autumn we surveyed conditions in our general hospital's maternity wards. For years these had been neglected. We described cracked and peeling ceilings, flaking plaster, lifting floor tiles, and cold, damp bathrooms with chipped and stained baths, no showers, bidets or privacy. We gave the report to senior nursing and ward staff, who agreed its content and tone. On publication day we made it clear that this was a joint effort by staff and ourselves to improve conditions — for patients.

STUDENT PLACEMENT

A mutual benefit

*by Roger Farrell**

Educationalists generally agree that a period spent on placement gaining practical experience is an important, if not vital, component of higher education courses. In most social science degree courses undergraduates have to spend a period working with an organisation in some way relevant to their studies. As most students continue to be funded through a grant from their local education authorities while on placement, this provides an opportunity for CHCs to extend their realm of activity without having to tap their own coffers. Both parties can benefit greatly from this symbiotic relationship.

The focal point of the placement will usually be a project, probably a piece of research on some aspect of the local health services. Working under the banner of a CHC, the students will undoubtedly find that they are afforded more time and access, particularly to health and social services personnel, than if they were gathering information from "outside the pale". This semi-official foot in the door bestows many benefits on the student. Because CHCs operate over such a wide spectrum the student will see at first hand many aspects of public administration and service that would otherwise be inaccessible. To attend, say, an FPC or AHA meeting and understand the various issues, interests and personalities at play is to learn a lesson unfathomable except by first-hand observation.

The end product of the research will, one hopes, help the CHC members and the public to understand better some aspect of their local services. As the research will generally be concerned with a problem area, it will act as ammunition for the CHC in presenting its views to the responsible authorities. So often CHCs have to rely on information supplied by administrators, which can be misleading.

For my placement with Haringey CHC I undertook to perform a section of the Good Practices in Mental Health project being sponsored by the International Hospital Federation. The project is concerned with the collection and dissemination of good examples in the organisation and delivery of mental health services, both on a national and an international level. Local projects involve recruiting the assistance of a number of well informed individuals from the local mental health services — statutory and voluntary. Nominations of "good practices" are collected and the recommended services are visited and a standardised report prepared.

The work I did involved investigating a wide range of local services, including counselling and therapy centres, befriending agencies, residential provision, day-care and rehabilitation services, and relatives' groups, as well as assessing planning and administrative systems. In all I visited and met workers, and in many cases clients, from over forty services. I hope that the final report will be a useful contribution to the Good Practices scheme, and that it will also act as a detailed directory to many of the mental health services operating in Haringey.

Student placement projects need not, however, take the form of research, or indeed appeal only to social science students. Many CHCs could benefit, for instance, from an art student designing attractive publicity. The length of placement varies from one college to another, but they often last the whole academic year. In such cases it is not unreasonable to expect the student to play an active part in the running of the office. The experience is useful, and another pair of hands and an extra telephone ear would, I'm sure, be welcomed by most CHC secretaries.

However, it is my experience that the most likely candidates, social science students, do not immediately consider bodies such as CHCs for placement positions. They are attracted to places where they feel they will encounter more radical or academically high-powered views, or where they will have more "client contact". CHCs are often viewed as watch-dogs without any dentures, a powerless concession to local opinion. This is unfortunate, because CHCs offer students a unique opportunity to operate within a public service over a wide spectrum of activities, without the restraints they are likely to encounter once they embark on a career. Given these prejudices, the onus perhaps falls upon CHCs to attract temporary fresh blood from this available pool. Perhaps some enterprising CHC could "collar" a young marketing student to sell the idea of placement positions with CHCs to universities and polytechnics!

** Roger Farrell is a BSc social sciences student on a sandwich course at Middlesex Polytechnic. He spent his year's placement at Haringey CHC.*

At an AHA meeting in December we organised a demonstration which involved many local people. A CHC member, herself booked in to have a baby in the unit, presented our demands for immediate improvements. Soon after, the AHA ordered a survey of backlog maintenance in the entire hospital and allocated £53,000 for works and furnishings in the six worst wards. The worst maternity ward was closed for upgrading.

The CHC's action got wide publicity which upset some of the nursing staff who felt it reflected badly on the standard of care. They told the press we had exaggerated. This disappointing about-face seemed to us to reflect poor morale. In another hospital nurses had declared themselves unwilling to staff wards whose conditions compromised professional standards of care. We do not doubt our nurses' dedication, but we do not agree that this may substitute for decent physical conditions.

Next we tackled the geriatric wards. To avoid the kind of conflict which had arisen from our maternity wards report, we contacted staff working directly with patients and also those whose jobs, such as works supplies, domestic services, were relevant to the geriatric department. We were very pleased to get a great deal of useful information and to have a few misunderstandings ironed out. Comparing conditions with our observations exactly a year earlier, we were pleased to note some improvements. We were still worried by the need everywhere for minor repairs which people would not tolerate in their own homes — a toilet with only a piece of string for flushing and broken toilet roll holders. Throughout the wards paint and plaster was chipped and flaking. Several fire doors were hooked open. One was locked. Storage space was crammed and cluttered.

Cartoon: Lisa Kopper

The most senior managers were reluctant to let their subordinates comment direct to us. This meant delays while they collated views and so some of our report was out of date by the time it was printed. We placed our paragraphs and the staff comments side by side — it is useful for people "outside" to see the dialogue going on. We were delighted when the staff council, criticised by management for publishing similar detailed reports on nurses' living conditions, responded that reports like theirs and the CHC's might be bad news for management but were good news for the hospital and the patients.

A simple mobile surgery

by J A Dunning, Secretary, Norwich CHC

Lack of transport in rural areas is a problem which is likely to continue, and indeed get worse as fuel supplies become less certain. The closure of village branch surgeries for one reason or another — perhaps because the premises are no longer available for this purpose — can make getting to see a GP a major and costly outing. Most villages have places which could easily be used as waiting areas for patients. But a doctor may feel that adaptations or additional facilities would be required if surgeries were to be held there, and then considerations of cost arise.

A possible solution might be a mobile surgery, fixed up with the minimum of fittings to enable patients to have a straightforward consultation with their doctor. Patients would of course have to realise that for consultations on more complicated matters, they would still need to visit the main surgery. For the purposes of this exercise can we assume that the financial matters can be resolved? The physical aspects need a little examination.

A mobile surgery might be housed in an existing two-berth caravan about 12-13 ft in length. Such a van could be towed by a normal family car (1500 cc plus). After removal of the two beds, the wardrobe, and the storage cupboard, a clear space forward of the entrance door would be left in most designs of van. In this space could be built an examination couch across the front of the van, a desk, filing space or cupboards could be put along one wall, and a sitting space for two persons along the other wall. A new floor covering might be required. Modern vans have electric fluorescent lighting and electric water systems, with electric power taken from the car battery. To make the unit mobile, the water and drainage tanks which are usually placed on the ground outside the van would need housing in the cupboard under the sink unit. The toilet compartment could remain and a modern caravan flush toilet be installed for the use of doctor and patients.

Heating could be by a catalytic space heater commonly used in caravans, and the kitchen unit heater could provide one method for heating water, unless one of the "Ascot" type of heaters was built in. Gas could come from the gas bottles stored at the outside front of the caravan on the towing "A" frame. A modern caravan has a screw jack at each corner for use when the caravan is stationary and since it would not be necessary to unhitch the car there would be no need to disturb the electrical plug to the car. To set up, all that needs to be done is to let down the four corner jacks — and the surgery is open for business. On leaving, the reverse procedure is followed, plus the securing of all loose items and the locking of the door. The only requirement at the "waiting area" is a space for the car and caravan, with some nearby place where patients can wait their turn.

No attempt has been made to cost such a mobile surgery, since a lot would depend on whether the starting point was a new or used caravan, but much adaptation might not be necessary. If the demand was large enough, one of the caravan manufacturers might show an interest in making a batch of vans during the winter lull in production.

A mobile surgery would certainly provide more flexibility than exists at present and give those in rural areas easier access to a doctor, especially the elderly and mothers with young children, who are usually isolated in villages because the breadwinner is away at work and uses the family car to get to work.

A simple mobile facility could have many uses to the NHS and to the community in general. Need all the NHS mobile clinics be so comprehensively equipped? The simpler a provision the lower the capital and revenue costs, with less to go wrong and needing repair. Could not such a mobile facility be used in rural areas for child health clinics, services for the elderly — even for a mobile post office?

The idea of the simple mobile surgery has been put to the DHSS, with the suggestion that the financial help available to permanent practice premises could be extended to cover mobile surgeries.

Your letters

Continued from Page 2

later discovered from my Halton colleagues that such was the rapidity with which the motion was brought into the business that it was possible to be present at York and still miss such discussion as there was on this.

Dental charges to pensioners

K M Woods, Secretary, Southampton and SW Hampshire CHC

As a council we are concerned that pensioners are still having to pay dental charges. This we feel to be inappropriate, bearing in mind their financial circumstances and the fact that the treatment many of them need is liable to be costly. We should like to take this matter further and are interested in the reactions of other CHCs to a proposal that charges to pensioners be abolished.

What's the point of screening?

Irene Watson, Secretary, Hull CHC

Hull CHC has for over a year now been attempting to obtain the Local Medical Committee's agreement to a pilot scheme to routinely check the sight, hearing, blood pressure, etc., of the over 70s, but to no avail.

Curiously the Committee's first reaction was to decline the suggestion on the grounds that "they do not feel that such a clinic would attract the ill and infirm for whom it was intended". The doctors felt that it was more likely to attract the aged able-bodied. The CHC replied that that was the intention, so that the healthy aged may be kept in that happy state for as long as possible and in their own homes. We presumed that the ill and infirm would already be under the care of a general practitioner. I would appreciate it if any CHC whose district operates a health check scheme for the over 70s would let me know.

Ante-natal clinic appointments

Neil Pearlman, Secretary, South Manchester CHC

We are interested in collecting information about successful ante-natal clinic appointment systems. Could any CHC with experience or knowledge of good practice help please?

Wales not unanimous

Doris Eryri Jones, Secretary, Arfon-Dwyfor CHC

My council wish me to express their disquiet at a report in *CHC NEWS 47*, that motions submitted to the annual general meeting of ACHCEW had received the unanimous backing of the Welsh Association.

Although this motion was passed at the Welsh Association's AGM, it is a matter of concern that the impression given in *CHC NEWS* is that each council was giving this motion its support. Some of my members would not feel they could subscribe to this.

Ed: Our apologies. Several Welsh delegates at the York AGM had given us this impression.

CHC's view is laughable

D F Jones, District administrator, City and Hackney health district

Your reference in your November issue (CHC NEWS 48, page one) to the *underused* accident and emergency department at St Bartholomew's Hospital might, I think, surprise the London ambulance service. Barts is one of the busiest accident hospitals in Central London and has dealt with three major accidents in succession in recent years — the Old Bailey bombs, the Tower bombs and the Moorgate disaster.

To suggest that the work of St Leonard's Hospital casualty department, which basically provides a walk-in service for the local population, has been restricted to provide sufficient work for St Bartholomew's is laughable and does no credit to the CHC. Would they sooner close Barts?

We welcome letters and other contributions, but we would like letters to be as short as possible. We reserve the right shorten any contribution.

Scanner

Dealing with death

Practical advice about arrangements which may have to be made when somebody dies and a brief guide to benefits which may be payable, is given in a new DHSS leaflet D49, *What to do after a death*. The guide covers the death certificate, registration of the death, and funeral arrangements as well as how to handle any property which may be left. Copies of D49 from the DHSS Leaflets Unit, PO Box 21, Stanmore, Middlesex HA7 1AY.

Failing vision among the elderly

Is the topic of a Disabled Living Foundation report to the DHSS. It emphasises old people's expectations that failing vision is a part of ageing which cannot be helped and suggests ways in which those in need of vision aids can be identified at an early stage. Many old people have the mistaken fear that registration as a partially sighted person (which gives access to a range of benefits) automatically means eventual blindness. *The elderly person with failing vision* £2 from DLF, 346 Kensington High Street, London W14 8NS.

Volunteers in vogue

With voluntary effort and volunteers very much the catchword in government circles, there is a need for training those who work with volunteers, recruiting, training and supporting them. The Volunteer Centre is running training courses in Norwich and Ormskirk and has published three booklets to accompany its courses. For people who cannot attend the courses, the booklets will still be useful and stimulating — *1: Support; 2: Training; 3: Recruitment and selection* are 35p (+ 12p post) each from Volunteer Centre, 29 Lower King's Road, Berkhamsted, Herts HP4 2AB.

Muscular dystrophy handbook

A 100-page handbook to help the families of people with the handicap of muscular dystrophy has been published by the Muscular Dystrophy Group of Great Britain*. The disease is hereditary and progressive, causing weakening of the muscles and increasing disability. Much in the handbook overlaps with other practical guides for the physically handicapped but some information is specific to muscular dystrophy.

*£1 including post, from Muscular Dystrophy Group of Great Britain, Nattrass House, 35 Macaulay Road, London SW4 0QP.

I shall wear purple

Is the title of Age Concern's latest publication about the plight of elderly people in residential homes. The author accuses local authorities and the community of "disregarding their responsibilities for the emotional well-being of the elderly", and highlights the difficulties facing staff in the homes. From Age Concern England, 60 Pitcairn Road, Mitcham, Surrey CR4 3LL (75p plus 15 post).

Family planning information

The Family Planning Association's role is now mainly educational and informative, according to its annual report for 1978/79. Its information service has answered over 150,000 queries about family planning matters and has distributed over 12 million leaflets to doctors and the public. Family Planning Information Service, 27-35, Mortimer Street, London W1N 7RJ. Tel: 01-636 7866.

Mobility allowance

Is a weekly cash benefit to help disabled people to be more mobile. To qualify you must be unable to walk without severe difficulty and be likely to remain in that condition for at least a year. DHSS leaflet N1 211 tells how to claim.

Voluntary sector news

A monthly information service for and about voluntary organisations is published by the *National Council for Social Service*. Each month there is also a briefing on a current topic, a diary of meetings, and a list of recent publications. It costs £6 a year. Sample copy from information department, NCSS, 26 Bedford Square, London WC1B 3HU.

Heart attack

Heart disease was to blame for a third of all UK deaths in 1978 and yet much of it is preventable. The latest "family doctor" booklet, published by the British Medical Association gives straightforward advice on how to reduce the risk of heart attack and if you do have one, how to help yourself get better. *Heart attack*, 45p inc post from *Family doctor publications*, BMA House, Tavistock Square, London WC1H 9JP.

Joint financing

HC(79)18

At present joint finance schemes between AHAs and local authorities receive earmarked central government support which is meant to taper off within five years as the local authority takes over the running costs. Occasionally a seven year period has been permitted. A recent circular provides for an even longer tapering period of central revenue support, in "exceptional circumstances". The circular also states that "proposals to use joint finance for primary or community health care purposes (or for other health purposes which are prerequisites of its agreed use for a social services purpose) need no longer be submitted to the Department for approval". This means that joint finance budgets may be diverted for use on certain health projects, rather than on local authority social services projects.

Dentists' retainer scheme

HC(79)11

To encourage dentists to remain in touch with professional activities when domestic commitments require them to leave full-time practice, the DHSS has introduced the *Dentists' retainer scheme*. In return for an annual £130 retainer, dentists who intend to resume "substantial practice" will maintain registration with the General Dental Council and attend a minimum number of educational and service sessions.

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 1: East Cumbria CHC Chairman: Tom Minton
Page 1: Durham CHC Chairman: Mrs M Halliday
Page 1: Northumberland CHC Chairman: Cllr R A Lee
Page 4: North West Leicestershire CHC 15-17 High Street, Loughborough, Leics. Tel: Loughborough 31031
Page 4: South Nottingham CHC 54 The Ropewalk, Nottingham NG1 5DW Tel: Nottingham 411484
Page 5: Cambridge CHC Chairman: Dr Michael O'Loughlin
Page 5: Peterborough CHC 16a Broadway, Peterborough Tel: Peterborough 53522
Page 8: North Camden CHC Chairman: Jean Davis
Page 8: South Camden CHC Chairman: Alf Roffey
Page 8: Islington CHC Tel: 01-359 5066
Page 8: East Roding CHC is now called **Redbridge CHC**
Page 10 Lewisham CHC Chairman: Alex Patterson
Page 13: West Berkshire CHC Chairman: Mrs Julier Baxter
Page 19: Trafford CHC Secretary: Mrs J L Burn
Page 20: Merthyr and Cynon Valley CHC Chairman: D J Thomas
Page 20: Swansea CHC First Floor, 21 St Helen's Road, Swansea West Glamorgan Tel: Swansea 54967
Page 20: Vale of Glamorgan CHC Chairman: Desmond Perkins.
Page 21: Northern Region Association of CHCs c/o Gateshead CHC, Dryden Road Hospital, Low Fell, Gateshead NE9 5BY Tel: Gateshead 73565. Chairman: Neil Jenkins; Secretary: Raymond Hall
Page 21: Trent Regional Association of CHCs c/o South Lincolnshire CHC, Council Offices, Eastgate, Sleaford, Lincolnshire. Tel: Sleaford 303241 x 117 Chairman: H T Walker; Secretary; Cllr A A Goodson
Page 22: North Western Regional Association of CHCs c/o Oldham CHC, "Tylon", Middleton Road, Chadderton, Oldham OL9 0PA Tel: 061-624 6251. Chairman J W Ballard; Secretary: Mrs Jean Adams.

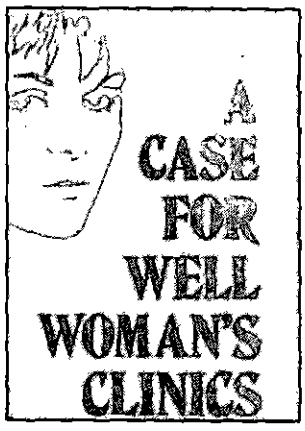
News from CHCs

☐ Some of the liveliest debate at the annual conference in Edinburgh last month of the **Association of Scottish LHCs** was on a composite motion on NHS funding. The motion, which was carried, reaffirmed the association's commitment to a health service free at the point of need, expressed strong opposition to current restrictions on expenditure, and called for more funds and other measures to equalise access to health care, especially for people in working class areas. 31 of the 36 LHCs now in membership of the association (out of a possible total of 48) were represented at the meeting. Russell Fairgrieve, Minister at the Scottish Office with responsibility for health and social services, told LHCs that there would be "scope for possible changes in their functioning" as a result of NHS restructuring, but he spoke mainly about smoking and health education.

Conference elected Rev F Smith (**West Fife LHC** and vice-president of the association) as the new president, and J E McQueen (**Forth Valley LHC**) as vice-president. The association has published its latest annual report, covering activities up to March 1979, and the first issue of its newsletter, *Health Matters*.

☐ The Henderson Hospital, a world-famous psychiatric unit in Surrey, will close in April despite fierce opposition from local CHCs and MIND — unless the DHSS agrees to arrange central funding. The Henderson is a therapeutic community treating young people from all over Britain who have serious personality disorders, without the use of drugs. It was originally to have closed next month as part of an area package of "urgent and temporary" cuts, saving £¼m pa. But last month SW Thames RHA intervened with a "non-recurring" offer of £50,000 from regional under-spending, which will keep the hospital open while the DHSS considers a joint AHA/RHA appeal for funding through the DHSS or the Home Office.

Sutton and West Merton CHC has complained to the NHS Ombudsman about not being consulted, but the complaint was rejected because it was not made by an individual, and because the Ombudsman cannot deal with matters that can be taken to the courts. Dr J Stuart Whiteley, the Henderson's medical director, said that an "imaginative move from the top" was needed to solve the funding problems of units providing supra-regional services.



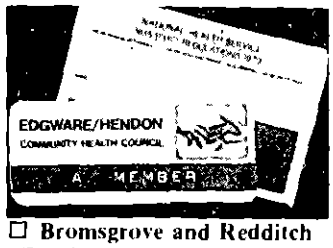
☐ Women's organisations in South Glamorgan have been sent a leaflet from **Cardiff CHC** explaining the case for Well Woman Clinics, with sections on the services provided, the need for an alternative to GPs, and the staffing and cost implications. The Dearne Valley CHC sub-group — set up jointly by **Barnsley, Doncaster** and **Rotherham CHCs** — has also been publicising the idea, and 675 women wrote to the group after reading articles about well women in two local papers. The group's aim is one central clinic funded by the three AHAs. In **High Wycombe** a Family Planning Association clinic is now providing a well woman service, at the suggestion of the CHC.

☐ A letter from the Minister for the Disabled was described as "bureaucratic nonsense" when **Coventry CHC** discussed the provision of spare pairs of glasses for visually handicapped children. Members decided to support **Walsall CHC's** campaign for a DHSS working party to look into this problem, and 20 of the 22 West Midlands CHCs are now backing this campaign. The Minister's letter says that spare pairs of glasses can only be prescribed through the Hospital Eye Service in cases of clinical need, and that a wider scheme would cause "overspending of public funds". The West Midlands CHCs believe that broken glasses can have a serious effect on the education of deprived children, and want to see the criterion of clinical need widened.

☐ CHCs are in disagreement about the £1.3m multi-storey car-park planned for the new University Hospital in Nottingham. **Central Nottinghamshire CHC's** secretary Phil Marsh says local people find such expenditure "hard to swallow" when hospitals and wards are being closed. The CHC feels a smaller scheme would be adequate, but since tenders have already been accepted cancellation could cost £200,000.

The hospital is on **South Nottingham CHC's** patch, and secretary Liz Haggard points first to the inconvenience and distress that parking problems are causing patients and visitors, and secondly to the fact that the £1.3m is regional money not area. She adds that "it would be Canute-like to pretend that we don't have cars".

The area's two other CHCs both side with Central. **Worksop and Retford CHC's** John Kitchen describes the plan as "unrealistic", and adds that there is a "more than adequate" bus service to the hospital. **North Nottingham's** Jean Holden insists that services to patients must come first, and asks: "Why provide for the privileged few who go by car?"



☐ **Bromsgrove and Redditch CHC** *has produced this identity card, to help its members visit NHS premises. The card — not shown life-size — is embossed with the names of the member, and CHC, and a small, passport-style plastic photograph is embedded into the plastic to cover the black area. Bromsgrove could supply other CHCs for about 50p per card.* **Edgware/Hendon CHC** *members are using the badge shown above, which costs about 65p each.*

☐ Recent reports from CHCs include: Problems of caring for elderly infirm relatives at home (**East Cumbria**). Coordination of services for the visually handicapped (**SW Durham**). Report of a conference on health and occupation (Tyne and Wear CHCs — contact **Newcastle**). A report on the experiences of elderly people leaving hospital (**Kensington, Chelsea and Westminster South**). Report on antenatal services and Survey on the use of hearing aids (both from **High Wycombe**). Directory of help for the handicapped in Berkshire (**West Berkshire**), and Outpatient survey at Leeds General Infirmary (**Leeds Western**).

☐ Prompting from **Greenwich CHC** led the SE Thames RHA to survey patients' attitudes to mixed sex wards in the Brook General Hospital. The RHA says its survey showed "most patients are likely to be happy on a mixed ward provided they are in a segregated bay, toilets are not 'shared' and there are facilities to wash in private". Of mixed ward patients, 12.1% said they would opt for a mixed ward again, 34.5% wanted single-sex next time and 52.5% didn't mind. The CHC's working group on the report has serious reservations about its "bland" conclusions. A closer look at the figures shows that sizeable proportions of patients over 64 and people in unpartitioned Nightingale wards would prefer a single-sex ward next time.

Aylesbury and Milton Keynes CHC has asked Women's Institute branches for their views on mixed sex wards. Of the 135 branches that responded, 71 were against and 46 in favour. British Legion branches are also being contacted, and a similar picture is emerging.

☐ Services in **East Hertfordshire's** family planning clinics are to be reduced by 75% in an "emergency" cuts exercise. Patrick Jenkin's letter to Betty Paterson was cited by the AHA as justification for not consulting the CHC. The FPC was not consulted either, though GPs will be expected to take on the extra workload. And, as the CHC points out, it will be much more expensive to have patients seen by GPs rather than in clinics, since GPs get paid a fee for each patient given contraceptive services. But this money comes from central, non-cash-limited funds. So though the actual cost of providing the service will increase the district itself will save money.