CHC NEWS

For Community Health Councils

July 1980 No 56

Treat the child not just the illness

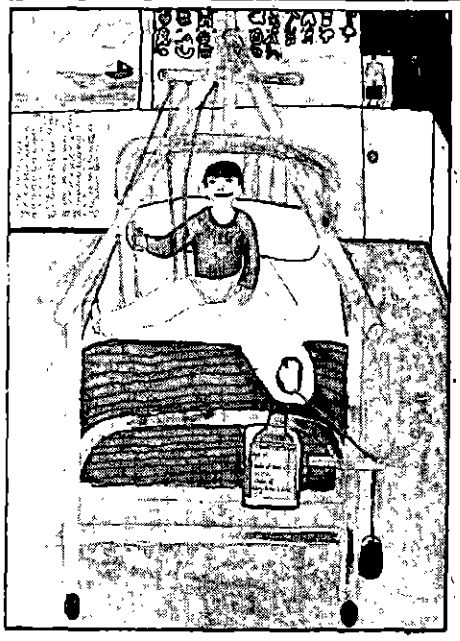
-says consumer report on hospitals

Some hospitals are still defying NHS policy on access for parents to visit their children in hospital. Some even actively discourage parents from staying with their children, although for 20 years it has been DHSS policy to allow parents open visiting. A major survey by the Consumers' Association found that in only about half the 50 hospitals in its sample was 24-hour unrestricted visiting practised. And although almost all hospitals claimed to have overnight facilities for parents, over half the parents questioned said they had not been allowed to stay or had not even been told of the facility.

The survey aimed to find out how far the philosophy of the Platt report on welfare of children in hospital (1959), largely adopted as DHSS policy for more than 20 years, has become a reality for child patients. It found that in many cases hospitals and medical staff failed to treat children any differently from adults.

Over 900,000 children under 15 go into hospital each year, two-thirds of them for an operation. Half the admissions are emergencies, usually caused by accidents. The Consumers' Association has published an "action guide" for parents which advises: "Insist politely that you wish to remain with your child . . . offer to sleep on a chair if necessary"

The guide recommends parents to check up in advance that, for example, children may take with them their favourite toys and some personal clothing, and to ensure that they will be nursed in children's wards and not in a ward with adults. It recommends hospitals to provide parents with information leaflets and to encourage pre-admission visits by children and their parents.



Drawing: Consumers' Association

The survey found that play facilities in hospital were far from satisfactory. Two-fifths of the hospitals had no playroom, and many failed to make any provision for children's schooling.

Children in hospital (£15) and the *Action guide for parents* (free with a stamped addressed foolscap envelope), both from the Consumers' Association, 14 Buckingham Street, London WC2N 6DS.

NEW NHS STRUCTURE 'COULD COST MORE'

Instead of *saving* £30 million as the Government hopes, reorganising the structure and management of the health service could actually cost an *extra* £30 millions. A new way of looking at management costs in the NHS has produced figures which have startling implications for NHS reorganisation and the size of the new district health authorities.

Three Surrey area health authority administrators have looked at the costs of management in relation to the numbers of *staffed available beds per year*. They have found huge disparities between costs from one area to another, even after the pricey teaching authorities are excluded. Usually, when complaints are made about the proportion of NHS money which goes towards management, administration, "bureaucrats" or whatever, the comparison is made between management costs and *total revenue spending*. The study is critical of this way of looking at costs.

The survey, which covered about half the area health authorities, suggests that those (both multi- and single-district) with less than 3-4000 beds have significantly higher management costs than those with 4-7000 beds. Authorities with less than 1000 beds are condemned as "unacceptably extravagant". The maximum economic size seems to be around 7000 beds.

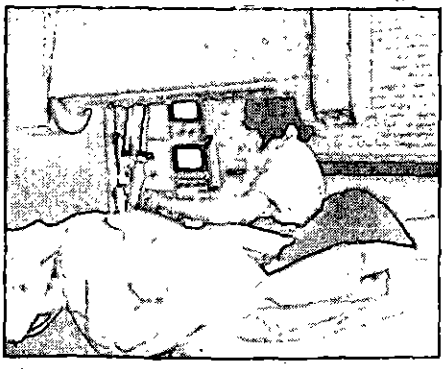
The authors estimate that if the Government creates around 180 district health authorities, with an average of only 2051 beds each, management staff costs will soar. If the average number of beds per district health authority was around 4200 there would have to be no more than around 90 authorities. About 150-180 authorities are envisaged by the Government in its consultative paper *Patients first.*

Management costs – an alternative approach is published by Surrey AHA, 13-21 High Street, Guildford, Surrey.

CORRECTION

Because of a printer's error on this page last month, some words were omitted from the piece headed *Consumer views improve planning*. The sentence in question should have said that *only 65%* of district planning teams without a CHC representative were satisfied with their effectiveness in planning.

INSIDE....



Your letters

Drug approval

Brian Maunder, Secretary, Swansea/Lliw Valley CHC

I am appalled at the recent statement by the Committee on Safety of Medicines (CSM) that it intends to take no action in respect of the drug Debendox.

I find the CSM's torpor and lack of appreciation of the suffering caused to patients by the side effects of drugs cleared for marketing by the CSM to be thoroughly inconsistent with normally expected standards of an independent monitoring authority. One is forced to consider what part the influence of the drug companies plays in the decisions made by the CSM.

It is my hope that it will not require independent researchers, as in the case of the drug Eraldin, to bring any side effects of Debendox to the CSM's attention before it can galvanise itself into action on this occasion.

The public has a right to expect that the CSM will put its protection first, but the CSM does not give the impression that this is its first priority.

In view of the failure in the last few years to protect the public from Thalidomide, Eraldin, Depo-provera and now Debendox, there is an urgent need to review the activities of the CSM and introduce an authority which is more sensitive to the needs of the public.

Furthermore, the latest Government proposals to, in effect, allow an even greater avalanche of inadequately tested drugs onto the drug market must, in view of recent events, be totally misguided. There can only be one winner from the premature release of a drug, the drug company marketing it, and one loser, the patient with "unforeseen" side effects.

I hope ACHCEW will make the strongest representations against the proposals.

"The Extown scandal"

W T Evans, Secretary, Cardiff and the Vale of Glamorgan CHCs

Members of my CHCs took the view that the seminar organised by the Manchester CHCs, and described in the above article (see *CHC NEWS 54*) was a very worthwhile exercise. However they took exception to the reference to Ely Hospital in the opening paragraph and wish to remind readers that the events to which it clearly referred took place more than a decade ago. In the interim period a great deal of hard work has been carried out by staff at the hospital and much has been achieved. A recent visit to the premises by the Health Advisory Service culminated in a report which reflected the efforts which had been made and the improvements which had been brought about.

References to Ely which do not refer to these very considerable improvements do nothing to bolster staff morale and enthusiasm, and could impede the introduction of further innovative practices which are designed to improve the quality of life of the hospital residents. Indeed, we believe that references of the kind which were made are positively harmful and should not be encouraged.

None of us have forgotten the history of Ely, neither are we complacent about its future. This is evidenced by regular CHC visits and reports and a stream of suggestions, comments and criticisms by visiting members of the two CHCs in South Glamorgan.

Chaplaincy services

Graham Hoult, Secretary, Leeds Eastern CHC

This CHC has been trying to bring about an improvement in the level of chaplaincy services in Leeds. We are particularly concerned about the service available to the elderly, who constitute such a large proportion of the hospital population.

I would be interested to learn whether other CHCs have done any work in this field.

Pre-menstrual tension

Diana Knight, Hon. Secretary of the Patients Association and Editor of Patient voice, *11 Dartmouth Street, London SW1H 9BN.*

I must take up the point made by the reviewer of the book *PMT – the unrecognised illness (CHC NEWS 51 page six)* when she (he?) comments about premenstrual tension: ("Finally, all women menstruate. Yet this book does much to reinforce the prejudice that all women are sick/mentally disturbed once a month and are therefore biologically inferior".

Our latest issue of *Patient voice* (February 1980 no 12) is a special edition on the topic *Hormones in a woman's life* (30p each, including post, or £9 for 40). This points out that only about 50% of women fall into the two hormone deficiency categories (oestrogen-deficient and progesterone-deficient), the other 50% having a good balance of hormones leading to few problems. Pre-menstrual tension is suffered by the progesterone-deficient group, which amounts to about 20% of women.

Although I take your reviewer's point about not labelling PMT an "illness", I should like to point out that other hormone deficiency conditions such as diabetes are regarded as "illnesses". Once we have defined the group of women who could suffer from PMT it is unlikely that we shall regard womenkind as a whole as biologically inferior. (Although being progesterone deficient myself, I should prefer to be regarded as unfortunate rather than inferior!)

Prescription charge exemptions

Mary Merricks, Secretary, Cambridge CHC

The national chairman of the Psoriasis Association*, Ray Jobling, has written to our CHC about the problems of sufferers from some chronic conditions now that prescription charges are rising so rapidly. He writes:

"The point has been made that exemptions are available for sufferers from chronic disorders who are long-term consumers of prescription items for the management of their conditions. The present exemptions by no means cover all such disorders. In the case of psoriasis for example daily use of preparations only available on prescription is common. The consequent financial burden is obvious, despite the availability of the block payment system.

The whole question of exemptions requires more consideration, with a view to the extension of them. My own personal view is that we could most satisfactorily dispense with charges entirely. But since this is unlikely, certainly the exemption of all of the chronically sick should be a matter of course. This is perhaps an area that CHCs could enquire into."

This seems to be an area where it is reasonable and legitimate for CHCs to act in concert, even though most of us accept the premise that our activities should be primarily local. May I, through your columns, urge all the CHCs who are concerned about the needs of this particular client group to urge the Government to consider extending exemption from prescription charges to ALL who suffer from chronic illness or disability and in consequence need constant medication.

*see article about the Psoriasis Association, page 14.

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

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Comment

The consultative document on a new pattern of hospital services (see page 11 of this issue of CHC NEWS) is attractively straightforward— at first glance. Many CHCs are familiar with the strains of establishing a spanking new general hospital in the district. In the Wirral a 1000-bed giant is due to open in 1981 — it has been planned for 20 years to replace four obsolete units — yet its 'birth' demands the closure of no less than ten other hospitals around the district (see The challenge of a new hospital, CHC NEWS 43). The Royal Liverpool Hospital has become almost a byword for the poor industrial relations and planning blight which so often accompanies the establishment of such big hospitals.

No more such monsters will be built says the Government. Unless there are exceptional reasons, major new units will have no more than 600 beds and more of the other hospitals will remain open. It sounds very good indeed — rural areas have been hit hard by the concentration of hospital services and the loss of local "infirmaries".

Health minister Dr Gerard Vaughan has been at pains to present the policy switch as "getting the balance right", between the needs of the community and the "sound medical reasons" for integrating services within a big district general hospital (DGH). The effect this will have on patient care is far from clear.

For example, what will the policy mean for the rapidly growing population of old people and for the "quiet epidemic" of mental infirmity among the elderly? The long-term care of the elderly severely mentally infirm will continue to be provided in out-dated mental illness hospitals. Age Concern sees worrying implications in this and in the plans to reduce the proportion of acute geriatric beds to be provided in the main DGHs.

Centralisation of maternity services has been a widespread source of grievance, as has the closure of small casualty units. Because of the problems of ensuring skilled staff cover around the clock, access to these services will still mean long journeys (unless GPs can be induced to staff minor casualty units). Obtaining staff for a decentralised service is a really daunting problem, except in the case of ancillary and clerical workers. There is a danger that this could harm patient care.

Much of the nation's hospital building stock has already outlived its economic life — kitchens, heating systems, operating theatres are out-of-date and dilapidated. If these hospitals are to be kept in use money must be found to bring them up to scratch. A recent estimate quoted £400 million for urgent repairs alone, and it is unlikely that such a sum could be scraped up from the money lopped off the new buildings programme. Perhaps the document's reference to local pride in local hospitals, "which encourages support in many practical forms", gives us a clue as to where the Government hopes to find the cash to patch up hospitals.

The consultation paper gives no blueprint for a national hospital pattern. There is great stress on health authorities' local decision-making "within their financial allocations". It will be very much up to CHCs to ensure that this does not mean a return to the old days before the planning systems, when those who shouted loudest in the district got the biggest share of the money for staff, equipment and buildings. For the vulnerable groups of NHS users, CHCs will be needed more than ever before.

Health News

Hospital complaints procedures

Doctors' cherished "freedom of clinical judgement" remains the major obstacle to achieving a widely acceptable standard procedure for complaints about treatment in hospital. The previous government decided in principle that the Ombudsman's powers should be extended to permit investigation of complaints which involved a doctor's clinical decision. A draft circular of guidance was issued to health authorities in April 1978.

The hospital doctors declared open warfare and the British Medical Association's Joint Consultants Committee (JCC) prepared counter-proposals "to combat the suggested incursion of the Health Services Commissioner". These were fired at the DHSS in January this year. Even though social services secretary Patrick Jenkin and health minister Gerard Vaughan have both been much more sympathetic to the doctors than their predecessors, their response to the JCC has been very cool indeed.

In a letter to the JCC Mr Jenkin says he finds it difficult to accept the JCC's proposals that the consultant concerned in a clinical judgement complaint should have sole responsibility for the initial handling of the complaint, and could effectively block the next stage in the procedure — other consultants giving "second opinions".

Now the committees will sit and think again. The DHSS is preparing a memorandum for the next round. The slow, complicated and fragmented hospital complaints procedure remains.

NHS pay claims

In April it looked as if nurses were prepared to negotiate pay settlements within the 14% cash limits for the NHS laid down by the Government—despite their original claims for rises of 30-35%.

Photo: Nursing Times

Then came the news that the Government was acccepting the recommendations of the tenth report of the Review Body on Doctors' and Dentists' Remuneration* that doctors' and dentists should get total average increases in pay of nearly 30%. It was explained that 10.7% of this related to the 1979 pay settlement and brought doctors' incomes into line with comparable earnings in April 1979. Even so, the doctors were being awarded an increase of 18.7% — nearly 5% above the cash limit. The review body explained that it was told by the DHSS "that individual limits will not be applied to each profession or individual group within (the NHS)" and pointed out that part of the extra money will come out of the family practitioner services budget which is exempted from cash limits.

Nurses were incensed that another group of health service workers should be excluded from the 14% limits. A fresh impetus was brought to their campaign for the nursing profession to be better paid. The possibility of industrial action is being discussed by all the unions to which nurses belong. Even the Royal College of Nursing is balloting its members about whether they wish to continue the college's long-held policy of forbidding all forms of industrial action.

Nurses' leaders met with Mrs Thatcher who was adamant that the cash limits would be strictly applied to the nurses' pay claims. The Government's case is that over a two year period nurses and doctors have had equivalent average increases in pay (65%), and that the decrease in nurses' official working week from 40 to 37½ hours will be implemented where possible in April 1980 rather than April 1981. Thus even when nurses still have to work 40 hours they will be paid for an extra 2½ hours - though not at overtime rate. And NHS administrative and clerical staff are also angry about the 14%

Continued on next page

Health News

Continued from previous page

limits set on their pay settlements. Traditionally their pay rises have been in line with those received by civil servants in comparable grades - who this year were awarded 18.75%.

*Cmnd 7903, HMSO £2.75

NHS cuts

Press reports of a hearing of the Parliamentary Select Committee on Social Services at which Patrick Jenkin appeared reveal that despite his publicised promises of a 0.5% growth in the NHS, he has now admitted that there will have to be cuts in the provision of NHS services if inflation rises above 14% this year — as even the most optimistic forecasters are predicting will happen.

Apparently Mr Jenkin would not be drawn on where cuts would fall. Nor would he elaborate on the impact that reductions in local authority social service provision will have on the NHS — removing the "props" that have enabled elderly and disabled people to remain in their homes.

Speaking a few days later Mr Jenkin reiterated the Government's belief that a "streamlined management and simplified structure" will produce savings of £30m a year — although the report of Surrey AHA (see page 1) suggests that smaller health authorities, as proposed in *Patients first*, will have the effect of *increasing* expenditure.

At the same time as the Government is admitting that the future holds cuts rather than growth for the NHS, the *Sunday Times* has reported that the estimated cost of doing vital short-term repairs to hospitals and other NHS buildings would be £400m. And an estimated £4000m is needed to bring hospitals up to modern standards.

In real terms NHS overall capital expenditure in 1979/80 was less than four fifths of the 1974/5 levels, and when local priorities have to be decided maintenance work is usually bottom of the list. Over half the NHS hospitals were built before 1914, and many NHS works officials are very worried about the state of the buildings in their care. They believe that enormous repair bills are being stored up for the future.

Health centres

Following a review of its policy on health centres (see *CHC NEWS 54*, page four), the Government has issued guidelines to health authorities on their development*. It is felt that too much emphasis has been placed on the building of new centres, with a consequent drain on capital resources and an unnecessary increase in publicly-owned premises.

Area health authorities are now asked to reconsider all their plans for new health centres. With the help of family practitioner committees (FPCs) they should find out if there is clear support from local doctors for proposed centres — unless a new scheme is considered essential to attract new GPs into an under-doctored area.

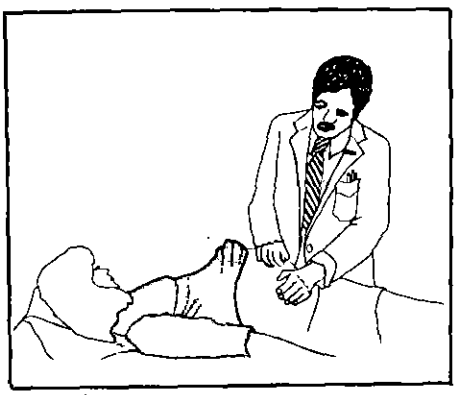
Doctors are to be encouraged to improve their premises by their own efforts, with the help of improvement grants from FPCs, and loans from the General Practice Finance Corporation.

A *reasonable*, rather than *ideal* level of provision should be aimed for. Unless more specialised facilities are lacking elsewhere, only basic general medical and nursing services should be provided.

*HC(80)6, *Health centre policy.*

Mothers' rights and babies' welfare

When the Employment Bill becomes law women's statutory rights to paid maternity leave and job protection will be seriously eroded. This is the National Council for Civil Liberties' view of the provisions in the Bill to tighten up the requirements for a woman to notify her employer of her intention to take maternity leave. The Bill, now passing through the House of Lords, will also exempt firms with five or fewer employees from the obligation to grant paid leave for women to have babies. Yet evidence that small firms have found this a problem is very shaky. All employers will have a right to refuse to give a woman back her old job, if this is not "reasonably practicable". On the other hand, paid leave for women to attend ante-natal clinics has been written into the Bill. All firms will have to provide this, regardless of the employee's length of service.



Drawing: Jan Farrell

Strengthening of rights to maternity leave and improved care during pregnancy are some aims of the newly-formed Maternity Alliance. The Alliance includes organisations such as Child Poverty Action Group, National Council for One Parent Families and The Spastics Society. It will campaign to:

"1 Improve the medical care given to mothers and their babies during pregnancy, childbirth and the first year of life.

2 Improve the social support given to pregnant women at home or at work and investigate and publicise ways of improving conditions for pregnant women and mothers at the work place or in the factory.

3 Improve the financial support given to pregnant women, especially the young and/or poor.

4 Improve the legal rights of women during and after pregnancy."

Maternity Alliance, c/o Spastics Society, 12 Park Crescent, London NW1.

Dental charge concessions

All young people will now be exempted from charges for dental treatment until they reach the age of 18, instead of 16 as put forward in the Budget. According to Dr Vaughan, this limited modification of the Government's programme is being introduced as a result of pressure from the British Dental Association. At present all young people under 21 are exempt from charges for dental treatment.

Those in full-time education will be exempt from all dental charges until they are 19. This includes an exemption from payment for dentures. Non-students over 16 will remain liable for denture charges.

Full-time students under 19 will also be exempt from charges for optical appliances such as spectacles, and hospital appliances. Previously only young people at school came into this category—now full-time study at any recognised educational establishment qualifies a student for exemption, if he or she is under 19.

The waiting game

Within days we shall know what the Government's plans are for the future shape of the health service. Straws in the wind over recent weeks seem to point to survival for CHCs, possibly with some clarification of their powers. At a conference last month for the Institute of Health Service Administrators, social services secretary Patrick Jenkin promised that in the autumn the Government would publish a paper on health policy and priorities, dealing with issues such as community care, links with social services and preventive medicine. So that is something else to wait for.

In his speech to the administrators, Mr Jenkin defended *Patients first* against critics who have said that the document shows the Government as only concerned with a hospital-based, curing service. He affirmed that he wanted the NHS to be a "series of local services, serving local communities, run by local people".

Meanwhile a North West Herts CHC member, David Fruin, has responded to Professor Rudolf Klein's "respectable case for abolishing CHCs" (see *CHC NEWS 52* page 3, and *53* page 3). In the *British medical journal* (7 June 1980 pp 1385-7) David Fruin argues that CHCs have a crucial role to play in maintaining a balance between central control in the NHS and local responsiveness.

A recent paper of more historical interest to CHCs looks at the way in which regional health authorities set about establishing CHCs in 1974-75. Some regions set up CHCs within weeks, but with very little consultation involved. At the other extreme some CHCs were not set up for more than a year and a half. The paper takes a close look at the Northern region's establishment process as a case study.

Procedures for establishing district health authorities by David Phillips (Centre Eight paper, *Health and social service journal*, 16 May 1980).

No ambulance for Mister X

by Brian Maunder, Secretary, Swansea/Lliw Valley CHC

During my five years as a CHC secretary, I have often been involved in advising patients who wish to pursue a complaint against a general practitioner. Frequently I have thought how helpful it would be to know if other secretaries have handled similar complaints, and what the outcomes of those complaints were.

I feel that brief but detailed accounts of family practitioner committee (FPC) service committee hearings would be of assistance in advising complainants, and in anticipating difficulties which might be encountered. Such accounts would of course have to be carefully prepared, so as not to include any details which might identify particular complainants or GPs.

Clearly, it will be rare for complaints to be identical, but nevertheless there may well be sufficient similarity between cases to be of assistance. I have therefore outlined below a recent case which may be of interest to others, and I hope that perhaps this will be the first of many such articles.

Mrs X approached this CHC with a complaint in October 1977. Her husband had recently died of a severe heart attack, having in her view been inadequately treated by their GP over a considerable period. It appeared that Mr X had attended the GP's surgery on three separate occasions, complaining of severe chest pains which occurred after any physical effort. Mrs X stated that her husband had described the pain to the GP as being "like a band tightening around his chest".

Indigestion

Mr X was given no examination by the GP, who diagnosed the problem as acid indigestion and prescribed a white, milky fluid. He suggested that Mr X should take this fluid regularly for a period, and should return if no improvement took place.

As the condition did not improve, Mr X returned to the GP twice. On one occasion he was accompanied by his son, who was in his early teens, and who distinctly recalled having heard the doctor say to his father that there was no likelihood of a heart condition, and reiterate his view that the problem was indigestion. No tests of any kind were made to verify the diagnosis.

In view of the doctor's insistence that the complaint was indigestion, and of the total lack of relief which was being obtained from the prescribed medicine, Mr X decided not to attend the doctor's surgery again. As no other course of treatment could be obtained from the doctor, Mr X simply decided to "grin and bear it".

About fifteen months after his first attendance at the doctor's surgery, Mr X was sitting at home, following his return from work, when he suffered considerable chest pain. His daughter, who was in her early twenties, contacted the GP and asked him for an emergency call.

The GP attended Mr X, confirmed that in his view he had suffered a very severe heart attack, and suggested that Mr X be taken to the local district general hospital. At this stage the GP neither made arrangements for the transfer of Mr X by ambulance, nor gave instructions to Mrs X and her daughter as to how they were intended to transfer Mr X to the hospital.

Mrs X stated that the doctor was clearly "in a panic" — which she attributed to his belated realisation that he should have provided more adequate treatment at an earlier stage — and he departed in such a rush that he left behind his bag of instruments and also a number of prescription pads. He returned the following day to collect his belongings.

Nightmare drive

Mrs X and her daughter struggled to get Mr X down the drive of the house and into their car. The daughter then proceeded to the DGH, on what she described as the most horrendous drive of her life, with her father in the passenger seat. During the four-mile drive to the hospital, Mr X continued to have what appeared to the daughter to be minor attacks, and frequently resorted to clutching his daughter's arm, making driving extremely difficult.

Such was the difficulty that the daughter had to drive most of the way in one gear, while steering the car with her right arm. As an additional complication, the passenger door of the car flew open during the journey and the daughter had to struggle to control the car, stop her father from falling out and close the door before any further accident could happen.

On arrival at the hospital, Mr X was transferred to the accident and emergency department, where he suffered another very severe heart attack and died almost immediately. While she was waiting outside the A and E department, the daughter heard a call being made over an ambulance radio, reporting that an ambulance had called at her home to find that the patient had already been taken to hospital. It would appear that, after leaving Mr X's home, the doctor had realised that arrangements should have been made for an ambulance to be sent to the house, and had done this without informing the family of his actions.

On submission of a complaint to the FPC, Mrs X was offered an informal hearing. In view of the attitude of the doctor when he returned for his equipment on the morning after the emergency, Mrs X felt that little would be achieved in accepting an informal hearing, and this was declined. A letter was then sent by the FPC to Mrs X, informing her that the chairman of the FPC's medical service committee had dismissed the complaint.

Appeal

Mrs X was adamant that she wished to pursue her complaint further, and an appeal was therefore made to the Secretary of State for Wales, who in due course notified Mrs X of his decision to hold an appeals tribunal. At this stage, the complainant was entitled to employ legal representation, and with the assistance of the CHC a full "brief" was prepared.

Mrs X has recently received the result of her appeal, which was upheld on the grounds that the patient should have been transferred to hospital in a prone position and not in an upright position. She feels that this is an interesting decision, but is obviously pleased that her appeal was upheld on whatever grounds could be found by the tribunal.

We agree with Brian Maunder's suggestion. In some cases, details of situations which have led to particular complaints would be instructive for CHC members, and information about difficulties encountered while assisting with complaints would be useful for CHC staff. *CHC NEWS* would be pleased to receive details of other cases — in the hospital, community and family practitioner services — for possible publication in edited form. Any details which might identify particular patients, relatives or health service workers would of course be removed before publication.

A day in the life of an...
Ultrasonographer

*by Hilary Noakes**

I'm a radiographer with six years experience in ultrasound diagnosis. Ultrasound diagnosis depends on the operator's ability to recognise the patterns produced by the machine. Sound waves bounce like radar, from the boundaries of structures in the patient, forming an image of the outline of the structure. Unlike X-rays this is not thought to be dangerous, and therefore is used routinely in assessment of pregnancies.

The patient lies on a table in a dark room, while the operator moves a small probe along her abdomen. An image is built up on a TV monitor which the operator assesses, and the patient can also see. At my hospital where there are 2000 deliveries a year, we look at each pregnancy at least once. My work is concerned almost exclusively with women, usually pregnant.

Because I was 'in' at the early days of scanning, I enjoy rather a privileged position amongst radiographers — I choose my hours and start somewhere between 9.30 and 10am and finish anytime between 2.30 and 6pm, depending on workload, a total of 28 hours a week. Work varies from day to day according to which clinics are on. Tuesday is usually the most interesting as we start with an amniocentesis session, followed by patients with appointments from their GPs, other hospitals and clinics.

By the time I have arrived G, the other radiographer, has already switched on the machines and warmed the oil which we use to paint patients' abdomens. Typically an amniocentesis session will have four patients. They have all requested, and been accepted for, a test on the water surrounding the foetus. This test should be done after 16 weeks of pregnancy and before 20 weeks, to ensure that the baby is large enough for its skin cells to have been shed into the water but not so advanced that if the baby is found to be abnormal a termination is impossible.

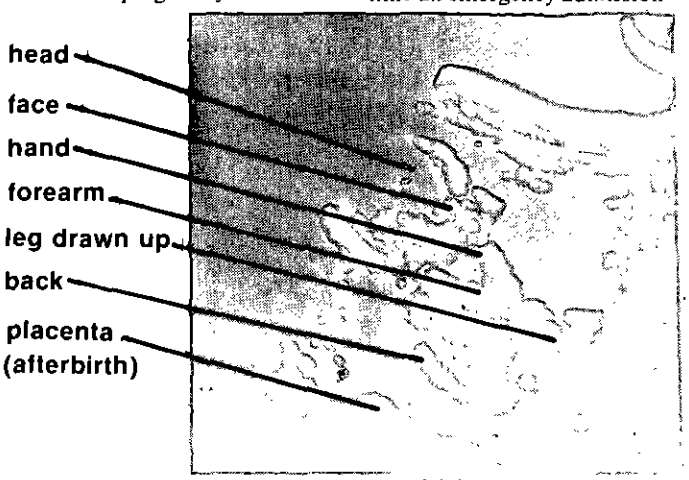
First I scan each patient to determine the number of babies present — if there are twins both babies should be tested separately — and to find the placenta, the afterbirth. Then the baby's head is measured, to determine the exact age of the pregnancy. If the mother is at risk of having a baby with a structural deformity, such as spina bifida, I try to look very carefully at the details of the baby's body and head.

Today, the first patient is 39 and 17 weeks pregnant; the baby is the right size and the placenta is out of the way on the posterior uterine wall, so there should be little problem in taking the fluid. After I have looked at her with her bladder full I ask her to spend a penny and take a seat until I have scanned the other patients. I call the obstetric registrar who will take off the fluid.

The second woman had a baby two years ago with a very rare biochemical disorder, which was not apparent at birth but caused the infant's deterioration and early death. She hopes not to go through that harrowing experience again. By taking fluid and culturing the cells found in it and analysing the chemicals which they produce, it can be determined whether this baby will inherit the disease. The most important analysis has to be done in America and arrangements have been made for half the sample to be taken by taxi to Heathrow, and then by Concorde to the States. But when I look at baby it is only 12 weeks by size and the mother says that she had a short period the month after her last normal period. So I ring the paediatric research unit (PRU), to say that the pregnancy is too small and can the amniocentesis test be rescheduled for four weeks time. A new date is given to the patient and she goes home.

The third lady has had two spina bifida babies, and one normal child. I spend much longer on this scan than on the last two. I am unhappy about the shape of the head and the fact that it is only 3cms in diameter — the patient is certain of the date of her last period so the foetus should be 17 weeks old with a head measurement of nearer 4cms. There is enough fluid, and the placenta is not in the way, so she waits for the registrar to take off her water. I ring the PRU again to check on her previous history. I am not happy about this foetus.

The last patient is a young girl in her second pregnancy. Her first child is with her in a pram and cries when she gets on the table. She has already had a routine scan in this pregnancy at 15 weeks, and subsequently two blood tests which showed an abnormal level of alpha-fetoprotein, indicating risk of an abnormal baby. She had counselling earlier today and is very upset at the thought of her baby not being alright. After a few minutes of looking at the baby I notice a membrane present in the uterus. Moving across the abdomen I find evidence of a second baby; then I find two heads both the right size for her dates. At the first scan we missed the second foetus. I am able to tell her that the raised serum level was probably due to the twin pregnancy but have to ring the PRU to confirm that the level is normal for twins at 18 weeks — it is. The girl is overjoyed and cries with relief.



Ultrasound image of a 15 week old foetus

That leaves us with two patients to take water from. The first goes easily, the water is a good colour. The second is a bit more tricky — it takes time for the water to flow freely, probably because the woman is nervous, and when it comes it is rather an odd colour — another indication that all is not well with the baby. Sometimes patients ask if I think their baby is OK — this lady doesn't, and I am relieved not to have to answer this.

It is 11 o'clock, and time for me to have a coffee. Just as I sit down the phone goes. It is the senior house officer (SHO) in gynaecology — could I see a lady who has just arrived in casualty with pelvic pain and bleeding. I say send her up.

The first of today's appointments is here. She is a lady from the family planning clinic with a lost 'coil'. I can see the uterus and the coil very clearly but there is evidence of an early pregnancy as well. "When was your last period?" I ask. She had had some bleeding fairly recently, but her last normal period was seven weeks ago, and she has been feeling off-colour. I ring the SHO and ask him to see her.

The patient from casualty arrives. The scan reveals a viable intrauterine pregnancy but the gestation sac seems to be separating from the uterine wall which is probably the cause of her bleeding and she will have to rest.

The phone goes again, this time an emergency admission to the labour ward of a lady in premature labour with ruptured membranes — could we check the foetus is alive. She is down within five minutes. There is very little amniotic fluid but the baby appears normal. It has grown the right amount since we first saw the lady, early in the pregnancy, though the heart is perhaps beating rather rapidly.

As it is now after 12 noon I decide to go for lunch. Just as I leave the room, the telephone rings — casualty are sending a probable ectopic pregnancy. I'll just get my lunch by the time she arrives. Down the back stairs, straight to the salad counter where I spot a friend of mine from a laboratory upstairs. He tells me what is happening in the union —thank goodness I am no

longer on the committee. Salad finished, I take the lift up to my floor, make a coffee and take it back to my room. Two more patients are now outside, waiting for a scan before going to the antenatal clinic (ANC) this afternoon.

Things seem reasonably under control so G goes to lunch. I do the two clinic patients, having got out their previous reports, and plotted foetal growth charts. One is fine, the other seems to have a rather retarded growth rate, so I ask her to come back at her next clinic attendence.

It is half past one and the trolley from casualty has arrived. The patient looks pretty ill, and from time to time has some sudden very sharp pain. When I have finished I ring the SHO with the news that it could well be an ectopic pregnancy from the ultrasound appearances.

Then I ask the next patient to come in. This is a third lady from this afternoon's ANC. She is 36 weeks pregnant and was seen once before, at 15 weeks, when her placenta looked in the way of the baby, so we asked her to return. When she is oiled and lying on the table she tells me she has just passed water. As I won't be able to see the lower edge of the placenta if the bladder is empty I am a bit cross — "didn't you read the notice on the toilet door?" I measure the baby's head, plot the graph, check the heart beat, and ask her to wait outside until her bladder has filled up.

The telephone is ringing again. The ANC again, this time a young girl has come into the clinic very worried as she cannot feel her baby move — would we have a look and reassure her. She arrives with her mother looking very anxious, a request form in her hand. G comes back from lunch and we look at the patient together. Although she is 20 weeks pregnant it is her first time as she was late booking. We measure the baby's head and find the heart beat, and show her and her mother. They are both very pleased to see the movement, and go back to the ANC more cheerfully.

Telephone again — two ward patients to book for tomorrow morning. I'll do two more ANC patients, and then go home with any luck.

** Hilary Noakes is a superintendent radiographer at a teaching hospital, and also a CHC member.*

Book reviews

Migraine: the facts

by F Clifford Rose and M Gawel, Oxford University Press, £3.95

This book gives a scientific account of this problem, with chapters ranging from *What is migraine?* to *The future.* It includes brief descriptions of other types of headaches, the treatments for migraine, and also useful relaxation exercises described in the appendix.

It is "down to earth" but not without compassion and, while possibly most useful to professionals, the scientific terms are adequately defined so that the book can be read successfully by those without a scientific background. Illustrated with pictures, diagrams and case histories, it can be recommended as a reliable and helpful writing for sufferers of this debilitating disorder and their immediate associates, as well as to professionals.

Ursula J Avery
East Dorset CHC

Childbirth today

from the Council for Science and Society, 3/4 St Andrew's Hill, London EC4V 5BY, £1.80 inc post.

This is the eighth in a series of brief reports prepared by the CSS, whose object is the study of the social effects of science and technology. It is a readable and well-documented history of the maternity services in Britain today.

In the 1920s some 15% of all births took place in hospital, compared with 96% in 1976. Death rates for babies and mothers have fallen dramatically, for many reasons, but despite improvements there has been public criticism, focusing on the general transformation of the natural event of childbirth into a medical event controlled by doctors. The booklet comments that "the non-professional definition of needs — by patients themselves — is something which has yet to come to prominence".

CHCs are not seen as being the ideal vehicle for the transmission of lay views —yet. The report states that CHC views have often been formulated without knowledge of medical facts and managerial constraints, and recommends a broader role which would enable CHCs to provide a forum for debate between professional staff, managers and users.

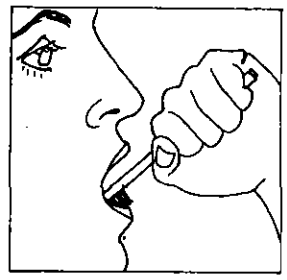
I can recommend this report to all those who wish to see a humane and rational maternity service in this country.

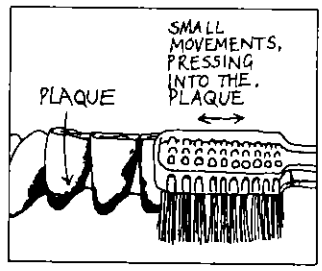
Rita Craft
Lewisham CHC

Good mouthkeeping

by John Besford, Debeli Press, 15 Willenhall Road, London SE18 6TY, £2.50 inc p&p from publishers

After reading this book my first reaction was to go out and buy a new toothbrush and a reel of dental floss. *Good mouthkeeping* is a do-it-yourself guide to dental care. Using lots of diagrams and charts it explains why teeth decay and how to prevent them decaying. For readers like myself who grew up before "plaque" was discovered it reveals what this frequently-cited but mysterious agent of decay really





is. Preconceptions of a lifetime are convincingly destroyed — eg that it is best to clean one's teeth after a meal. Some of the suggestions for cleaning teeth are perhaps a little difficult for the layperson to accept — I haven't yet used a mouth dye to reveal the plaque in my mouth though Mr Besford is very persuasive as to why I should.

The importance of instilling good dental care habits in children is very much stressed and a section of the book is about cleaning small children's teeth in ways which do not put them off looking after their teeth in the future.

The role of medicine

by Thomas McKeown, Blackwell, £3.95 (paperback).

McKeown contends that the activities of doctors are not a major determinant of health. His conclusions have been criticised because they are based upon an analysis of mortality figures which are not a good substitute for morbidity in all illnesses.

In this book he presents a new classification in which disease causation is related to interactions between the environment and genes. From the moment of conception some diseases are predetermined. Others are produced later and the precise timing of significant events determines the possibilities for therapeutic intervention or prevention. McKeown concludes that most medical measures come too late to have useful effects at the "population" rather than the individual level. He therefore suggests that the resources involved are misplaced investment from society's viewpoint.

The political forces behind medical investment are not analysed, nor are the difficulties involved in changing direction. No attempt is made to show that any different strategy would have produced faster improvement in the past.

The book is interesting as one historian's view, but there is a huge gap between these pages and even the relative detachment of a ten-year plan.

Books received

Directory of projects 1980/81, £4 post free from Barry Rose (Publishers), Little London, Chichester, Sussex PO19 1PG. Lists community-based projects for adult offenders, alcoholics, drug-takers, homeless single people and people with histories of mental illness, in England and Wales.

The district administrator in the NHS, by R Stewart, P Smith, J Blake and P Wingate (King's Fund Books/Pitman Medical, £7.50). Report of a study carried out at the Oxford Centre for Management Studies.

The meaning of social policy. by Beernice Q Madison (Croom Helm £14.95).

Medicines: 50 years of progress 1930-1980, by Nicholas Wells. Free from the Office of Health Economics, REgent Street, London, W1R 5FE.

On the state of the public health for the year 1978 (HMSO £4.50). Annual report of the DHSS Chief Medical Officer.

ACT NOW!

to save the Chronically Sick and Disabled Persons Act

*by Raewyn Stone and Mary Holland**

The Chronically Sick and Disabled Persons Act 1970 was an ambitious piece of legislation with a single, simple intention. As its parliamentary sponsor Alf Morris MP said: "The intention is to increase the welfare, improve the status and enhance the dignity of the chronically sick and disabled person". The Act was based on the principle that "what disabled people want more than anything else is to lessen their dependence on other people, to get on with living their own lives as normally as they can in their own homes . . . and have the opportunity of contributing to industry and society as fully as their abilities allow".

The Act sought to achieve this aim by converting what had previously been only a *power* of local authorities under Section 29 of the National Assistance Act 1948 into a *duty* to identify, inform and assist disabled people.

Section 1 of the Chronically Sick and Disabled Person's Act (CSDPA)requires local authorities to ensure they are adequately informed of the numbers and needs of handicapped persons in their area in order that they can develop satisfactory services for them.

Section 2 requires the local authority to assess the individual requirements and where they are satisfied there is a need, to provide some or all of the following services:

* practical assistance in the home
* radio, television, library or similar recreational facilities in the home
* recreational facilities outside the home and assistance in taking advantage of educational facilities
* travelling facilities to enable the person to make use of these facilities
* assistance in carrying out adaptations to the home
* facilitating the taking of holidays
* meals at home or elsewhere
* a telephone and any special equipment necessary for its use.

Section 3 requires housing authorities to have regard to the special needs of disabled people and, in proposals for new housing submitted to the Secretary of State for the Environment, to show what special provision has been made. The duty regarding proposals will be repealed by the present Housing Bill.

Section 4 requires provision for access for disabled people to be included in plans for public buildings and premises.

Achievements

The best way of evaluating the Act's achievements is by comparing the situation of disabled people in 1970 with that of today. In 1970 local authorities were merely empowered but not legally obliged to assist disabled people. There was great inequality in identification and provision of services. To a large degree, a disabled person's quality of life depended on "geographical luck". For example, the number of registered disabled people varied from 1.3 per 1000 population to 7.9 per 1000 and spending from £70.83 in Oldham to £3.08 in Salford. Many thousands of disabled people remained unknown and isolated: 18% of those with severe handicaps were not on local authority registers; 1 in 5 lived alone; of those under 20, 33% had no social contact; 7 in 8 housebound people did not have a telephone and many families were struggling under severe physical, economic and psychological burdens with no support.

Disabled people were effectively barred from participating in the community through the inaccessibility of public buildings, educational, and cultural institutions. Many were condemned to life in geriatric wards or residential institutions because of the lack of purpose-built housing and domiciliary support services and, generally, there was little information, publicity and awareness of the problems and potential of disabled people.

The contrast with 1970 can be best summed up by saying that today we have a society which is more "open" for disabled people — open both in terms of physical accessibility and in changed attitudes. In 1970, 404,000 were on local authority registers, today there are almost 1 million — we have "discovered" many handicapped people. By 1977 2000 wheelchair housing units and 4000 mobility units (for people not totally confined to wheelchairs) had been built. From 1973-77 adaptations such as ramps, downstairs bathrooms, increased from 28,499 to 52,600 and personal aids such as bath hoists, raised toilet seats from 110,200 to 195,300. An extra 59,200 telephones helped reduce social isolation and there was an increase in radios and televisions from 3700 to 40,800; domiciliary support services brought relief to families and holidays increased from 80,900 to 92,000.

There is now greater awareness of the needs of disabled people amongst planners, the media, politicians and the public generally and, most important, the Act has helped disabled people themselves achieve greater independence and confidence not just through material improvements but from the psychological boost that comes when the provision of decent housing and services is seen as a right and not as an act of charity.

Problems

The current cuts in public spending present the greatest threat to the Act. However, right from the start there have been problems in implementing it. The biggest problem is the variation between local authorities in the provision of services and often beneath the veneer of overall progress the situation at local level is not so encouraging. Many local authorities interpret the Act as permissive not mandatory legislation and it has proved very difficult to enforce. Section 1 has been interpreted in widely different ways and identification surveys have ranged from merely pushing circulars through letterboxes to very small sample surveys to one hundred per cent identification surveys with questionnaires and interviews. Most registers are now hopelessly out of date. On the basis of surveys carried out by the Government and by independent researchers, the incidence of appreciable handicap in the population is estimated to be between 6-10%, but most local authority registers are in the range 1.5%-2.5% and some are as low as 0.5% (Cambridgeshire).

Most local authorities with low registration figures are also at the bottom of the list in the provision of services under Section 2 which also varies greatly between areas. For example, for the year 1976/77 the amount spent on adaptations for 1000 population varied from £347 in Hillingdon to £5 in Cambridgeshire; on aids from £453 in Wakefield to £5 in Knowsley and on telephones from £349 in the London Borough of Merton to £5 in Buckinghamshire.

The housing situation is even worse. Of 366 housing authorities in England, 164 have not completed any wheelchair dwellings and 111 no mobility dwellings; 91 housing authorities have not provided *any* wheelchair dwellings and 26 no mobility dwellings.

The reality of all these statistics is that thousands of people are being denied the services which would allow them to live independently in the community and which the CSDPA granted them *as of right*. The discrepancies between local authorities indicate that the significant improvements brought about by the Act only resulted from obligations being placed on local authorities and any weakening of these obligations would mean that at best the discrepancies would remain and at worst would increase and create greater hardship and inequality.

Present situation

Today the Act is in grave danger. The Government has called for a reduction of 3% in public spending overall but has asked local authorities to reduce spending on personal social services by 6.7% (£91 million) in 1980/81 — the largest percentage cut of all areas of local authority spending.

Services for disabled people are particularly vulnerable because the decision as to whether someone is in need of a service is left entirely to the discretion of local authorities. When resources are scarce, local authorities are likely to be increasingly reluctant to establish need and their "discretionary" power allows them to act with impunity. In many areas of the country services already fall woefully short of the Act's intentions, yet of 20 local authorities who had made decisions on expenditure by December 1979, 17 had decided to defer planned projects in the area of personal social services.

Some services are easier to cut than others, e.g. high staff turnover in the home help service means quick and easy short-term savings can be achieved. Some authorities, in an attempt to maintain the *level* of services, have imposed or increased charges for services. But a distinctive feature of disability is poverty. As Peter Townsend, author of *Poverty in the UK* has commented, "It can be estimated that the number of disabled people who are below the poverty line is as high as 65% compared with the Government's own figure of 27% for the total population". Many people will not be able to afford the services which they should be receiving under the Act.

The cost of any reduction in services will not only be counted in terms of human suffering, but also in a shift from care within the community. For people struggling to maintain their independence, the loss of domicilary and community services may precipitate their admission to residential homes or geriatric wards. For those already living in institutions the promise of life in the community will recede further. Mentally handicapped and mentally ill people are likely to be among the hardest hit.

Cutting services is not only inhumane it is also financially foolhardy because the

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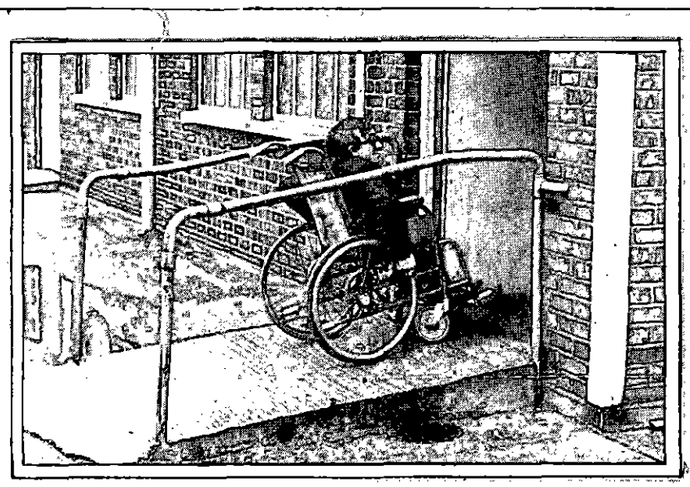
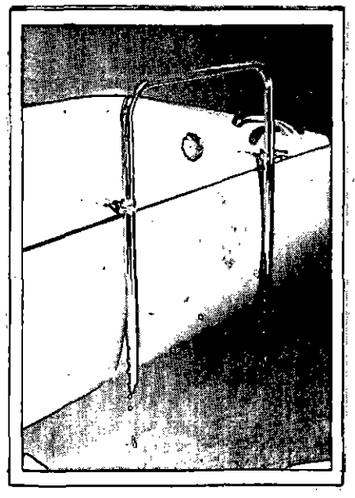
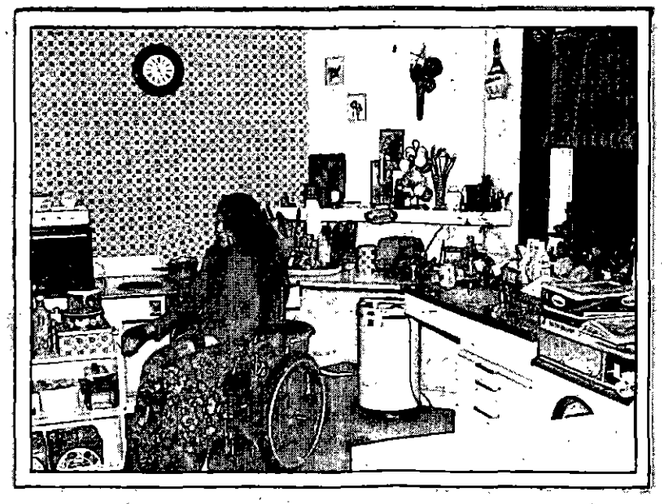






Photos: Courtesy of RADAR and Trowbridges Ltd

** Raewyn Stone is Parliamentary Liaison Officer at RADAR (Royal Association for Disability and Rehabilitation)*
Mary Holland is Intelligence Officer at The Spastics Society.
Both are members of the ACT NOW steering group.

Healthline

No consultation on Welsh hospitals

The DHSS has just issued a consultation paper on the future pattern of hospital provision in England. Will there be a Welsh equivalent?
No. The Welsh Office says it has a sub-committee looking into the pattern of hospital provision in Wales, so no equivalent of the English consultation process is needed.

Exemption from prescription charges for sufferers from particular diseases

I understand that sufferers from some diseases are exempt from prescription charges. Which diseases are exempt, and how do sufferers apply for exemption?
According to DHSS leaflet FP91, "people suffering from certain specified conditions" are exempt. The conditions are listed as follows: Permanent fistula (including caecostomy, colostomy or ileostomy) requiring continuous surgical dressing or an appliance; endocrine disorders for which specific substitution therapy is essential (ie diabetes mellitus, myxoedema, hypoparathyroidism, hypopituitarism, Addison's disease and other forms of hypo-adrenalism, myasthenia gravis); epilepsy requiring continuous anti-convulsive therapy; and any continuing physical disability which prevents patients leaving home except with help from another person (this does not include temporary disability, even if this is likely to last a few months).

The Association of CHCs has suggested that this list could usefully be extended to include heart conditions, high blood pressure, rheumatism, arthritis, asthma and cystic fibrosis.

Applicants must complete Part B of FP91 and send it to their GP. He or she will forward it to the family practitioner committee, which will send the applicant an exemption certificate.

Charges for private referrals

Is a GP allowed to charge a patient for sending him or her to a private consultant if the patient was seen by the GP under the NHS.
No, if an NHS patient is referred to a private consultant the GP is not allowed to charge. Under the NHS terms of service the GP must refer a patient when necessary to an NHS specialist. If the patient wishes to see a private consultant the GP may refer him or her to one but is not obliged to do so.

Receptionists' training

Which organisations have run training courses for GPs' receptionists?
The Association of Health Centre and Practice Administrators (Francis House, King's Head Yard, Borough High Street, London SE1. Tel: 01-407 4146) and The Association of Medical Secretaries (Tavistock House South, Tavistock Square, London WC1. Tel: 01-387 6005).

Marriage guidance counselling

Where can I find out about marriage guidance counselling from GP practice premises?
Try reading *Counselling in the general practice setting*. £1.20 inc post from Barnet, Haringey and Hertsmere Marriage Guidance Council, 5 Woodhouse Road, London N12 9EN.

Local services for the handicapped

Which CHCs have published guides to local services for the handicapped?
Southampton and **Rotherham CHCs** have published guides to local services for parents of mentally handicapped children. **Basildon and Thurrock CHC** has a guide to local services for the mentally handicapped, and **West Berkshire CHC** has produced a directory of local help for the handicapped.

After a stillbirth

Is there a self-help group for parents who have lost a baby through stillbirth?
Yes, it's called The Stillbirth and Perinatal Death Association, and it aims to provide "a supportive network of parents willing to befriend newly bereaved parents". For details contact Hazelanne Lewis, 15a Christchurch Hill, London NW3.

The Healthline column publishes selections from our information service. This service is for CHC members and staff, and for others interested in the NHS and the work of CHCs. To contact the information service, write to or ring CHC NEWS.

ACT NOW!

Continued from previous page

cost of providing help to live independently in the community is far less than providing long-term residential care.

The ACT NOW Campaign

ACT NOW was set up by a group of people working with and for disabled people. Organisations represented on the steering group are OUTSET, RADAR, MIND, Disability Alliance, The Spastics Society, Age Concern, Association for Spina Bifida and Hydrocephalus, Low Pay Unit, Centre for Mentally Handicapped and Child Poverty Action Group. It has launched a campaign to defend the CSDPA because in the 1980's we must all take steps forward to ensure that all disabled people have integration, equality and independence within the community. If the Act is not protected and fully implemented we will be taking a giant step backward. The concept of community care — the goal of social policy for many years — will be seriously and irrevocably damaged.

Disabled people cannot and must not be the "silent minority" — our voice must be strong and vigorous. We must strongly support the ACT NOW declaration. This declaration states:

"We believe that the Chronically Sick and Disabled Persons Act 1970, though in need of strengthening, has played an essential part in the improvement of services and conditions for all disabled people in the last decade.

"We are gravely concerned that the Act is being undermined both directly and indirectly as national and local Government plan and implement financial cutbacks.

"We call upon our elected representatives at every level of Government to maintain the present provisions of the Act; press for its full implementation; and remedy its defects, so that all disabled people receive as of right the service they require."

Last month ACT NOW held a mass demonstration and lobby of Parliament. Letters of support from organisations working with and for disabled people were handed in to Reg Prentice the minister with responsibility for the disabled. Hundreds of people lobbied their MPs to preserve, protect and strengthen the Act. But our efforts must not stop. The time has come for confidence, for now is the time to fight for the rights of all disabled people, and against the Government's deliberate erosion of their rights.

CHCs can play a vital role in upholding the rights of disabled people. They can publicise the need for information about the effects of the cuts on their local authority's provision of services under the CSDPA, they can inform the public about the Act and the present threats to it; and they can mobilise people to put pressure on both local and national government in defence of the Act and for its full implementation.

Information packs are available from ACT NOW, 30 Craven Street, London, WC2.

The future for hospitals

The NHS hospital planning system is a bit like those giant super-tankers, which can only change their direction or their speed with creeping slowness. For almost twenty years hospital policy has been to concentrate services in large, district general hospitals (DGHs). The hospital building programme has acquired its own momentum, but the Government plans to alter course. A consultative paper, *The future pattern of hospital provision in England** has been published, covering all hospital services except those for the mentally handicapped. The Government proposes to "place less emphasis on the centralisation of services in very large hospitals and to allow for the retention of a wider range of local facilities".

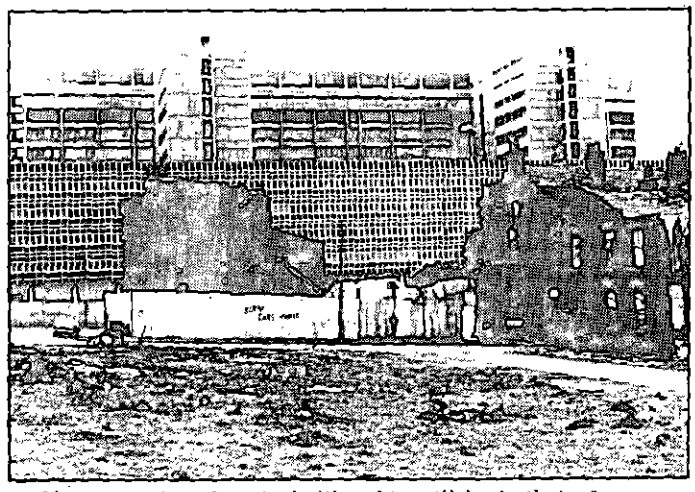
The 1962 Hospital Plan launched the building schemes for the big DGHs of 1000 beds and more. The idea was that in every district, all specialised staff and facilities would be under one roof, leading to economies in staffing and better training facilities for doctors and nurses.

Ministers have lent their support to criticisms that the large hospitals are "impersonal, complex and remote", that they are difficult to manage and eat up a lot of increasingly expensive energy. The rise in fuel costs also makes them costly and inaccessible for staff, patients and visitors to reach. The consultative paper echoes many of the arguments voiced in the campaigns to keep open small and medium sized hospitals. A local hospital has a place in the community it serves. This helps with some staff recruitment and even more with voluntary help. The document argues that the "NHS cannot afford to lose physical assets which are suitable for those patients not needing the full panoply of investigation and treatment".

The paper does not propose a uniform basic pattern for future services. The Government wishes to retain small hospitals "wherever sensible and practicable". Though many of these will have a change of use, the document stresses that, "whatever the pattern of services there will be a need for a main hospital containing the major accident services and the range of specialised facilities needed to deal with the more complex and difficult cases".

The new policy does not mean an end to hospital closures. Some hospitals are so old, inefficient or badly sited that they cannot be adapted. For others closure plans are already beyond the point of no return.

The Government reaffirms its commitment to the "basic concept of the DGH", a key feature of which has been to bring together "acute" specialties (surgery, general medicine) with services for the elderly, chronically sick, mentally ill, and so on. But if this aim is to be retained, yet DGHs are to be much smaller, what does this mean for "non-acute" hospital users?



No more giant hospitals like this will be built in future

It looks like a set-back in progress towards integration of services for the *mentally ill.* Some assessment will still be provided in the main DGH, but the psychiatric units will have fewer beds. The DHSS believes that about 70 districts possess a well-sited mental illness hospital. Even if this is large and unsuitable, it will have to remain for "many years to come".

The paper states that "only in this way" can the remaining districts be helped and it speculates on the possibility of going below the present psychiatric bed guideline of 0.5 beds per 1000 population.

For the *elderly,* there will be fewer geriatric beds in the new main DGHs. The current target of 50% of the district's provision *within* the DGH will be cut back to 30%. The shortfall will be provided in other hospitals. The paper admits that there will still be serious problems in meeting the need for long-term care and that the large mental illness hospitals will still be relied on to care for elderly severely mentally infirm patients.

There will be no decentralisation of *maternity services.* There seems to be resigned acceptance that where geographical factors prevent total maternity provision in a DGH unit, "there will inevitably be difficulties in duplicating facilities and 24 hour specialised staff cover in obstetrics, anaesthesia and paediatrics".

The paper is non-committal on what the policy shift will mean for hospital services in urban areas. Multi-site "mini-DGHs" for conurbations are probably ruled out on staffing and economic grounds. In rural areas and country towns, small and medium sized hospitals might even be expanded, to provide a range of services which are complimentary to the main (now smaller) DGH. Typically, this could mean:

- some casualty services (preferably staffed by GPs)
- out-patients' clinics (including ante-natal)
- some medical and surgical specialist services
- services for mentally ill and for geriatric patients.

The major hospital in a district will provide the same range of services as at present, but on a reduced scale. "Recent calculations in the Department have suggested that a balanced hospital containing the major A and E unit, associated surgical and medical services, the majority of maternity beds, the children's unit, a smaller psychiatric unit and modified target of 30% of geriatric beds would require a minimum of 450 beds." In a main DGH, with a catchment population of over 200,000, a "balanced hospital" would have to have around 600 beds (not counting beds for regional specialties). Hospitals with a teaching function might also exceed the 600-bed guideline.

There is of course a price to pay for retaining more of the small and medium-sized hospitals. The DHSS admits that duplication of some services could result in "a lower overall *quantity* of clinical service for a given level of revenue than would be possible with a more concentrated service". Specialties such as anaesthetics will be even more hard-pressed than they are already. Recruitment of ancillary staff may be much easier when hospitals are "local", but the loss of the very big DGHs has serious implications for medical education and nurse training.

Dr Vaughan has made it clear that the 600-bed figure is only a rough guideline. The Goverment expects that the reduction in pressure on the capital programme will release money to meet the possible increases in revenue costs, and that authorities will have to adjust priorities to meet this. Regional health authorities are already urgently reviewing their hospital building programmes and it is clear that some big DGH schemes will be scrapped.

The consultative paper has been sent to all CHCs in England. This month the DHSS is organising two conferences (in Birmingham for the North, in London for the South) to discuss the proposals. CHCs have been invited to send regional representatives.

Comments should be sent by early October to DHSS Health Services Division 2B, Room 1204, Hannibal House, Elephant and Castle, London SE1 6TE.

*In Wales no comparable document has been issued. The Welsh Office has its own working-party examining capital spending.

Photo: Derek Massey

RAISING CASH FOR THE NHS

by Graham Hills, Secretary, Medway CHC

On 12th October last year I switched on my radio at 7.00 am, to hear a local surgeon urging that if every man, woman and child in the health district was to contribute 20p, it would be enough to prevent threatened ward and hospital closures. He said that donations should be sent to the community health council.

By lunchtime, several hundreds of pounds had been received in the CHC office. There had been little opportunity to consider whether it was legal, whether the public should be asked to bale out the health service in this way and whether this was a job for the CHC anyway.

Certainly the CHC had been running a fund-raising scheme called the *Medway and Swale health development year*, in which it had been encouraging the local community to raise money for a whole variety of equipment and projects, but never anything like this, where local people were being asked to pay doctors' and nurses' salaries, food bills, cleaning bills, etc.

We had to decide whether to oppose the appeal straight away or to give our support to ensure that it reached a successful conclusion. There was really no moral or philosophical dilemma — we had been given the practical means of averting serious closures. All our other political campaigning had failed, so we decided to give it our 100 per cent effort — as it turned out, it needed more than that!

Council members also felt that the CHC was a resource which could, and should in this case, be used by the community for special projects — we could provide the campaign headquarters and promote the campaign. There is no doubt that without this assistance, the campaign could not have been sustained.

In the early stages, the fear uppermost in our minds was that a sterile fund might be created, but fortunately a trust was later formed to manage this side of things. Our own legal position was raised with the regional health authority, as also was the question of whether a health authority could receive money to pay salaries and other revenue costs. Frantic telephone calls to the district administrator, district finance officer, regional administrator's office, and the health minister's personal office cleared the way — health authorities "must not discourage such activities" and as regards the CHC's involvement, the DHSS were aware that such things went on and they would, in effect, "turn a blind eye".

The critical period of, what became known as the *Keep the wards open* campaign and *Save Sittingbourne Memorial Hospital* campaign, came in the first week. We had to persuade the district management team that the CHC had not completely lost its head, and that it seriously believed that it could raise nearly £80,000 to keep all these things open for six months. Reluctantly the team agreed that, if we could come up with £10,000 by the following Friday (similar deadlines were set throughout the campaign), then it would keep the first of the threatened wards open. Incredibly, by the Friday, guarantees for over £10,000 had been obtained and the first of the wards had been given a one month reprieve.

Two fund raising committees were established and both hit their respective targets early in the new year. Now each has achieved a surplus of funds, one committee purchasing £7,500 worth of hospital equipment with its surplus and the other committee placing in trust monies for the development of the one local hospital under threat.

Wherever possible, the CHC attempted to encourage other people to do the "nuts and bolts" of raising money but all CHC members did their share of rattling tins and having their eardrums and various other parts of their anatomy destroyed at fundraising discos and dances and other events. For the six months of the campaign all other CHC activities virtually stopped.

What conclusions can therefore be drawn from our involvement in our *Health development year* and the *Keep the wards open campaign?* First, we have found that there is a huge, largely untapped, source of revenue available to the NHS, even in a relatively "poor" area like Medway. Our first venture into fundraising was out of desperation at our slow progression towards our District's RAWP target and the only way for essential pieces of equipment to be purchased was by asking for it from local people. Nothing new in this, of course, but it worked and over £100,000 was generated.

Our second venture, the *Save the wards etc* campaign must be seen as a "one off" and the CHC has vowed that never again will it call on local people to support the NHS in this way. We fear that if we agree to continue raising money the Government will just say "thank you very much" and reduce our budget accordingly or slow RAWP down even more — if that is possible! Not that I think that CHCs will be faced with dramatic closures again in that way. We are now seeing more insidious cuts — the most recent in our district being the cessation of the family planning scheme in hospitals.

Fundraising is a satisfying experience for CHCs and also great fun and a tremendous publicity vehicle for the CHC itself. I also believe that fundraising is a good vehicle for bringing the NHS and the community closer together. Both campaigns were broadbased in that they involved industry and commerce, very much so in the early stages, local groups and a large number of individuals — on street collections alone there were over 200 people involved.

There is also no doubt that the campaigns have become a powerful political weapon — they have focused attention on Medway's desperate financial position. This year Medway has been generously treated by the AHA over its allocation. This has been some embarrassment to those who expect the patient to lay down after he has received the knock-out drops.

We have been attacked by both of the main political parties. On the one hand for "propping up the Thatcher government" and on the other for embarrassing the Government by drawing attention to the effects of their economic policy on the NHS — which was not meant to have been affected. Judging from these reactions, we seem to have got it just about right!

Photo: South Eastern Newspapers

On the radio

by Heather Higgins, Member, North Birmingham CHC

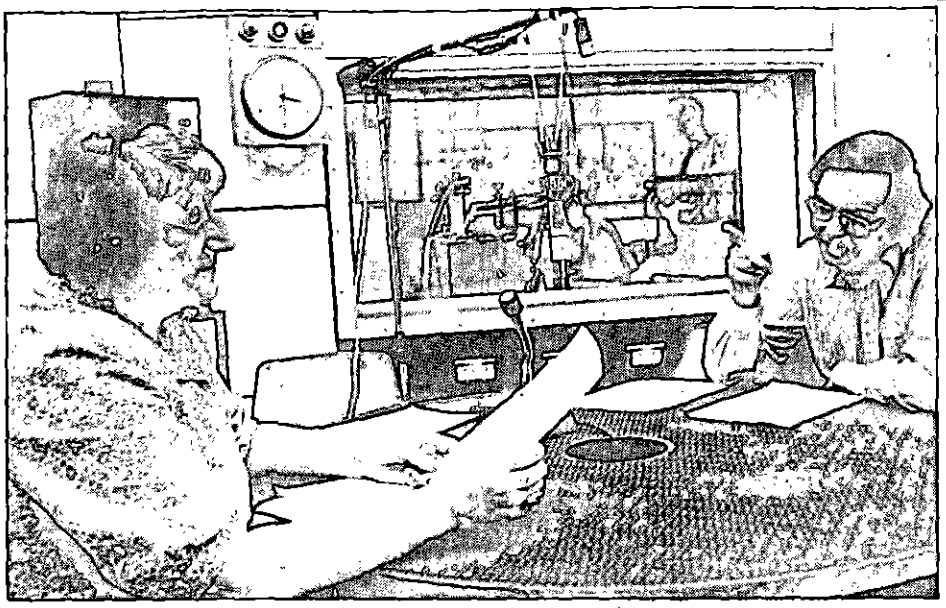


Photo: Stuart Roper

"Why not join us in the Patient's Voice?" In between the pop records, the motoring reports and the weather flashes on BBC Radio Birmingham, this invitation goes out on a "trailer" to midlands listeners early in the morning, twice a month.

It is by now a familiar invitation, for "The Patient's Voice" first took to the air in October 1977, and has been a regular monthly programme ever since.

In the early days of their existence, the five Birmingham CHCs formed a joint publicity committee and one of their ideas was a bid for air-time. Radio Birmingham's station manager readily agreed to the ideas advanced and gave the CHC team 30 minutes a month, later re-scheduled to 20 minutes, to go out on Sunday afternoons, with repeats on Wednesday evenings.

Seven midland CHCs are represented on a planning committee for the programme, and several other CHCs join in to contribute a session from time to time. The "radio committee" sees the allocation of air-time as its main function, and also puts forward ideas for programmes, which it offers to any interested CHC for production.

Continuity of editorial approach is provided by always having the same presenter (myself), to open and close programmes and chair discussions or interview as required. This helped the CHC teams' confidence in the early days, as I had previous journalism and radio experience. We are also lucky in having regular, expert guidance from Derek Dingle, one of Radio Birmingham's senior producers.

Among the subjects covered have been the role of CHCs, waiting lists, community provision for the mentally handicapped, rationalisation of hospital services, abortion provision, the role of the volunteer in the NHS, chiropody services, immunisation and vaccination, mental health services — and of course the report of the Royal Commission on the NHS and *Patients first*. Each CHC producing a programme is free to express its own view — if the subject is controversial this can always lead to a second programme expressing an alternative view.

Most programmes are recorded in the studios at the BBC's Pebble Mill centre, without previous rehearsal, though each participant and the presenter has in advance an outline of the subject and material to be covered. To vary the format, CHC secretaries and members sometimes venture forth, armed with a BBC tape recorder, to try their hand at interviewing in home or hospital. One CHC was bold enough to record the discussion of one of its working parties — while it was actually at work.

Public response in the form of letters is not vast, but we are assured by radio experts that audience reaction takes time to develop, and certainly people who have heard the programme do phone or visit their local CHC from time to time. But, perhaps more importantly, the CHC voice is heard and discussion is generated at local level about the effects of NHS matters on the consumer.

Perhaps the most important thing of all is that our "voice" is allowed to say exactly what it *wants* to say. In our experience of some other media, this is not always possible.

KEEPING AN EYE ON PATIENTS' RIGHTS

by the Rights of Patients Team, West Somerset CHC

Our CHC set up the Rights of Patients Team in 1977 with a special brief to consider the rights of mentally ill patients. Subsequently we extended our terms of reference to include the rights of everyone who uses, or may use, the NHS.

During 1979 we arranged visits to Tone Vale, Mendip and Sandhill Park hospitals, and made short, comparative studies of services provided for physically disabled persons at three different institutions.

To consider personal patient care, including community nursing and midwifery, the team went to two health centres, one in a rural area, and one in an urban part of the county. We approved of the early evening surgeries which prevent time off work and also the fact that any patient requesting an appointment could be seen that day — though probably by the duty doctor, not necessarily their own doctor. We felt that wherever possible patients should be given a printed card with the times of each doctor's surgeries, perhaps including information about telephoning for a prescription. Patients told the team that they sometimes found it difficult to get a home visit, and when they do it is not always from their own doctor.

The other major area of the team's work was to examine the procedures by which patients are compulsorily admitted to hospital, together with their subsequent treatment and discharge. Although the great majority of patients are admitted to psychiatric hospitals informally, we consider it right to emphasise the importance of taking care with procedure and documentation where compulsory patients are concerned so that the risk of injustice is minimised.

Several areas are the subject of continuing discussion and examination by the team. For example, the ability of mentally ill patients to consent to proposed treatment or reject it, is fundamental to their liberty. On the other hand, if patients withhold consent, they may not get the most appropriate treatment.

Various complaints procedures are open to patients aggrieved by a denial or abuse of their rights whilst under treatment. The team has been looking at the difficulties which face patients or relatives when seeking redress, as these procedures are full of complexities. As far as the work of the CHC is concerned, the secretary undertakes the time-consuming and often onerous task of helping and guiding people who have genuine complaints about aspects of the NHS but do not know how to pursue them. The CHC has been approached by several people with particularly disturbing complaints and in these instances the rights of patients team has been given the details of the cases. We have considered each case very carefully. We have been concerned to find that our investigations revealed that if every person involved with the patients had carried out his or her duties with the care and consideration that we have come to expect from those involved with the NHS, the situations which gave rise to the complaints might never have occurred.

Following a recommendation of the team, the CHC has now set up an annually appointed panel of members to which the Secretary can refer complex or difficult complaints for discussion and guidance.

Parliament

CHCs' future role

The Government is considering how the role and constitution of CHCs should be modified if it decides that they should continue (Robert Adley, Christchurch and Lymington, 23 April).

Consumers and "expertise"

The Government will not consider appointing a consumer representative to the Committee on Safety of Medicines. Members of the CSM "are appointed for the expertise they bring to the subject and not as representatives of particular interests" (Lewis Carter-Jones, Eccles, 3 April).

There'll be no limited prescribing list....

The DHSS has investigated the possibility of issuing a "limited prescribing list" to encourage doctors to prescribe the cheapest and most effective drugs, but has decided that this would not be worthwhile. DHSS Permanent Secretary Sir Patrick Nairne told the House of Commons' Public Accounts Committee that such a list would require a costly bureaucracy to maintain it, and similar schemes in other countries were not impressive. Between 1971 and 1979 the cost of pharmaceutical services had only increased from 10 to 11% of the total NHS bill, and on the credit side drugs reduce lengths of inpatient stay and help people to avoid taking time off work. Sir Patrick also agreed to let the Public Accounts Committee have details of the Department's criteria for deciding whether a drug company's profits are excessive, but this information will remain confidential.

but better information is on the way

A completely revised edition of the *British National Formulary*, containing "very readable prescribing information covering a much wider range of drugs than previously", will be published later this year. The new edition, which will probably also contain information about drug costs, will be sent free to every prescriber and pharmacist in the NHS. A copy will be available in every hospital ward, for use by nurses. Whether *patients* are given information on their drugs is a matter for the clinical judgement of the doctors concerned (Lewis Carter-Jones, Eccles, 3 April).

Charges and exemptions

Prescription charges were introduced in 1952, at 5p per prescription form, regardless of the number of items. In December 1956, when the average cost of a prescription item was 25p, the charge became 5p per item. Allowing for inflation, the equivalent charge in February 1980 would have been 27p, and the average cost per item then was about £2.65 (Arthur Lewis, Newham NW, 3 April). A list of "specified medical conditions" exempt from prescription charges exists, but to be included on this list an illness must be "a permanent and clearly identifiable condition requiring continuous medication" (Robert Atkins, Preston North, 3 April). Conditions such as coronary thrombosis, congestive heart disease, hypertension, arthritis and thyroid disease are "unlikely" to meet this requirement. Under present exemption arrangements about two-thirds of all prescription items are supplied free, and the Government is reluctant to consider any extension of exemptions "since that could only lead to an increase in public expenditure" (Laurie Pavitt, Brent South, 26 February).

Advice on incontinence

According to an article in *British Medical Journal* (14 January 1978), over two million people in Britain suffer from incontinence. Nurse managers were sent advice on incontinence in DHSS letter CNO(SNC) (77)1. The Health Education Council has a leaflet on the subject, and the Disabled Living Foundation (Tel: 01-602 2491/5) runs an incontinence advisory service (Lewis Carter-Jones, Eccles, 14 April).

Fund-raising

When the Health Services Bill becomes law, health authorities will have power to employ full-time fund-raisers (Ivan Lawrence, Burton, 23 April).

Hospital closures

280 hospitals were closed between 1 January 1974 and 31 March 1979. During the last three quarters of 1979, health authorities decided on the permanent closure of 21 hospitals and units (John Wheeler, Paddington, 25 April).

Extra kidney machines

An extra £2.1m was allocated for purchasing kidney machines in 1978/79, but only £1.1m was spent. Allocations to the Oxford and South Western regions were untouched. Unspent allocations were carried over for possible spending in 1979/80 (Jeff Rooker, Birmingham Perry Barr, 21 April).

Dental charges

NHS dental charges should raise about £89m during 1980/81, at November 1979 prices (George Foulkes, South Ayrshire, 25 March).

What is psoriasis?

by Linda Henley, Secretary, Psoriasis Association

Psoriasis is a common skin condition which can occur at any age on any part of the body. It appears as raised red patches covered with silvery scales and is very definitely neither infectious nor contagious. One person in fifty has psoriasis, many more carry an inherited predisposition. It usually appears when people are between 11 and 45 years old. About 4% of sufferers have an associated form of arthritis.

In simple terms psoriasis is only a vast acceleration of the usual replacement processes of the skin but the basic causes remain unknown. Hereditary factors are thought to play an important part with a genetic tendency being triggered off by such things as injury, throat infection, certain drugs and stress. There are many clinical forms and considerable variation in intensity may occur. Widespread ignorance and the real or imagined reactions of non-sufferers may also lead to a withdrawal from society and to feelings of isolation and depression. Permanent cures are not yet possible, although many people are helped by treatment, but cures will most certainly be found following increased and more intensive research.

In 1968 a group of patients in Northampton and their consultant dermatologist founded the Psoriasis Association. It has now become an important self-help organisation providing support and mutual aid for sufferers. It is also the main source of information on all aspects of the condition.

Branches and groups have been set up in various parts of Great Britain and Ireland and these provide a social contact point for sufferers, their families and friends. Medical evenings with question and answer sessions are held. Fundraising and publicity are the main activities of most branches and groups.

The association is supporting more research projects each year, with particular emphasis on investigations into the working of the basic skin, as well as treatments and their effects.

Public education and acceptance is one of other main aims of the association, and information is constantly given out to the media, hospitals, health centres, information services and other voluntary bodies. A set of slide/tape programmes on all aspects of psoriasis is being developed in conjunction with the medical illustration department at Oxford. The programmes have dual tapes, so that they can be used for a lay audience or medical personnel.

Through its branches, groups and members the Association can act as a pressure group to obtain better dermatological services and recognition of the special needs of sufferers from chronic skin conditions.

A journal, *Beyond the ointment* is issued three times a year and is sent free to every member. Membership is open to everyone and further details about the association and its work can be obtained from *The Psoriasis Association, 7 Milton Street, Northampton NN2 7JG. (0604) 711129.*

Scanner

Royal Commission on the NHS

A collection of 14 booklets based on working papers of the Royal Commission is being published by the King's Fund. *Conflict and consensus,* is an analysis by the editors of the series, Rosemary Davies and Christine Farrell, of the evidence submitted to the commission. *Essays on nursing* by Jean Mcfarlane and *The expanded role of the nurse* by Jillian MacGuire discuss issues facing the nursing profession — the role of the nurse, career structure, training. In *Ideology, class and the NHS,* Rudolf Klein looks at the 1974-1976 pay beds dispute. From King's Fund Centre, 126 Albert Street, London NW1 7NF (£1.00 each plus 20p post).

Patients' property

The law governing the custody by health authorities of patients' property—including income and allowances and estates of deceased patients—plus relevant DHSS guidance and suggested procedures, are set out in a useful publication from the Association of Health Service Treasurers (£1.50 from I W Dawson, Nottinghamshire AHA(T), Sub-Area Headquarters, Park House, 369 Woodborough Road, Nottingham NG3 4JH).

The wife's tale

Is the subtitle of a booklet written by a woman married to a paranoid schizophrenic. In *A tragedy of schizophrenia* she describes the growing delusions, jealousy and threats which made him a stranger to her. The attitudes of doctors, social workers and lawyers are revealed in the correspondence. From the National Schizophrenia Fellowship, 79 Victoria Road, Surbiton, Surrey KT6 4NS (80p plus 25p post).

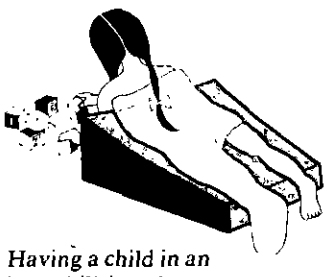
Health choices

The Open University is presenting an eight-week course called *Health choices* in October this year, to be repeated in January 1981. It deals with health in the widest sense, as a product of the individual's life-style and society in general. The course includes a book, a resource pack and programmes on television and radio and will cost about £14. More details from *Health choices,* P921, The Open University, PO Box 188, Milton Keynes.

Footwear advice

The second edition of *Footwear – what to get and where to get it* lists manufacturers and retailers of all sorts of shoes and boots for people who have special footwear needs but do not require specially made surgical shoes. It has been compiled by Margery Thornton, clothing adviser to the Disabled Living Foundation (£1 inc post from DLF, 346 Kensington High Street, London, W14 8NS).

Children in plaster



Having a child in an immobilising plaster presents all kinds of problems for parents — Angela Greenwood had both of her young daughters in plaster at the same time. As a result of her experiences she has written a booklet giving practical suggestions and encouragement for parents with children in plaster. Called *Your child in an immobilising plaster* it is published by the National Association for the Welfare of Children in Hospital, Exton House, 7 Exton Street, London SE1 8UE (50p plus 15p post).

Ombudsman's report

Details of 37 of the 67 cases fully investigated by the Health Service Commissioner between August 1979 and March 1980 are given in the *Fourth Report for session 1979 - 80* (HMSO £6.00). In 52 of the cases the Ombudsman found some justification for the complaint. Causes of complaint included unsympathetic staff attitudes, unreasonable waiting times for patients, long delays by FPCs in dealing with complaints and failure to notify relatives of a dying patient's admission to hospital.

Cancer costs

Cancer patients live under the double strain of uncertainty about the progress of their disease, and the unpleasant effects of treatment. Research has now begun at Manchester University's Department of Psychiatry to investigate the non-medical needs of these patients, using a group of 152 women who have had mastectomies. Half underwent specialist counselling by a trained nurse in the practical and emotional difficulties resulting from the loss of a breast. Eighteen months after surgery the counselled group were markedly more psychologically and socially adjusted than the other half of the group who had received no counselling.

However the particular focus of this study is on a cost-benefit analysis of the counselling treatment. All extra direct and indirect costs are taken into account, and the completed research will include a comparison of the extra cost and extra benefit to the patients. *Cost benefit of cancer treatments* by Dr David Allen is available from Health Services Management Unit, University of Manchester,, Manchester M15 6PB (£2.00).

Directory of CHCs: Changes

An updated version of the Directory of CHCs was last published in October 1978, and each CHC was sent a copy. This version is now out of print. Work on a 1980 version is now in progress, and an announcement will be published in *CHC NEWS* as soon as this is available. Meanwhile changes to the 1978 directory will continue to be published each month on this page. Please notify us of any alterations in address, telephone number, chairman or secretary.

Page 3: Huddersfield CHC Chairman: Mrs K I Hinchcliffe
Page 5: Peterborough CHC Chairman: Mrs H Sneden
Page 5: Barnsley CHC Chairman: George Millar
Page 5: Bury St Edmunds CHC Chairman: A F S Davies
Page 9: Bexley CHC Chairman: R Penny
Page 10: Bromley CHC, 40B Masons Hill, Bromley BR2 9JG Tel: 01-464 0249
Page 10: Greenwich CHC Chairman: Glyn Williams
Page 12: Wandsworth and East Merton CHC Chairman: David Uttley
Page 15: Worcester CHC Chairman: Canon A T Bartlett
Page 18: Stockport CHC Chairman: P Allen
Page 19: Arfon-Dwyfor CHC Secretary: Robert Roberts

The Birth Centre

Is for those who seek "an alternative to the increasing 'mechanisation' of birth". It publishes a quarterly newsletter and has produced leaflets on birth in hospital and how to have a home-birth. For further information contact The Birth Centre London, 16 Simpson Street, London SW11.

Supplementary benefits

The DHSS has at last revised its *Supplementary benefits handbook.* The subtitle, *A guide to claimants' rights,* is perhaps a misnomer, as discretion remains a powerful element in the administration of the SB scheme. Nonetheless this official guide, especially if used in conjunction with the Child Poverty Action Group's *National welfare benefits handbook* (see *CHC NEWS 52* p15) is invaluable for those dealing with DHSS officials about SB problems. Despite a disclaimer that the handbook is not a "complete and authoritative statement of the law" it can sometimes be effective to quote recommended procedure and guidelines for discretion from an official source (HMSO £1.70).

Mental health statistics

Have just been published by MIND. They include basic figures for hospital admissions, staffing, community provision and NHS expenditure on mental disorder. *Mental health statistics* from MIND, 155/157 Woodhouse Lane, Leeds LS2 3EF (65p inc post).

Keeping personal health records:

HC(80)7; WHC(80)9

Increasing use of personal health records in legal action has led to this circular which recommends longer minimum periods for the retention of records.

News from CHCs

☐ **Central Nottinghamshire CHC** has won a considerable victory in its campaign against plans for a regional secure unit for mentally ill offenders at Balderton Hospital, Newark. The RHA issued a consultation document which aroused widespread opposition — it proposed to mix mentally ill and mentally handicapped patients on the same hospital campus. Although the Balderton option has not been finally abandoned, the RHA will now look again at other sites and will also examine SE Thames RHA's unique plans for secure units (see *CHC NEWS 53*, page 8).

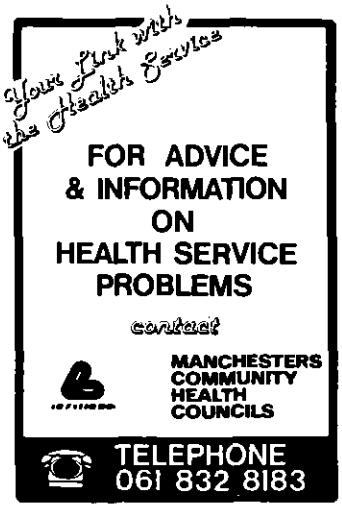
☐ A group of CHCs in London have strongly attacked the reports of the Flowers Committee and the London Health Planning Consortium. A statement supported by **King's, Ealing, Haringey, South Hammersmith, Brent, City and Hackney, Islington, Kensington-Chelsea-Westminster South** and **North-West**, disputes the reports' conclusions that London has too many acute hospital beds. "The real problem is that there are too many medical schools in London", says the group, which also condemns the lack of any consumer representation on the Government's new advisory group on London.

☐ The idea of personal nursing care plans, publicised last year by **North-West Durham CHC** is catching on (see CHC secretary Stan Fitches' article in *CHC NEWS 45*). For almost a year' patients have been nursed this way in two wards in the NW Durham district — soon two more wards will take up the scheme. Four neighbouring districts have also adopted the nursing care plan quite extensively.

☐ A course of six talks and discussions on health issues for women has been arranged by **City and Hackney CHC**. Topics will include cystitis, hormones and contraception, premenstrual tension, compulsive eating, and women and their doctors. **Cardiff CHC** has written a report on the women and health course it ran, describing how the course was organised and what issues women raised in the discussions. The Cardiff course was set up with the help of a community group and the university extra-mural department.

☐ A working party on "word-blindness" or dyslexia has been set up by **Arfon/Dwyfor CHC**. The council hopes to persuade the Gwynedd AHA to make a grant to a unit for dyslexic children at the University of North Wales, Bangor. The CHC is also looking into the problems of alcoholism.

☐ A regular phone-in on local radio is being run by **Basildon and Thurrock CHC**. For the first programme, the CHC secretary, Maureen Narbeth, was in the hot seat to take the calls. If you dial a special **Newham CHC** number you can hear a taped message giving information about how to see a doctor out of surgery hours.



☐ *Out-patients in Manchester hospitals will soon be able to read about the* **Manchester CHCs** *on the prescription bags from the hospitals. The CHCs have supplied 5000 bags (for £190) and are now trying to interest retail chemists in the publicity scheme. The bags also carry messages from RoSPA about keeping medicines safely.*

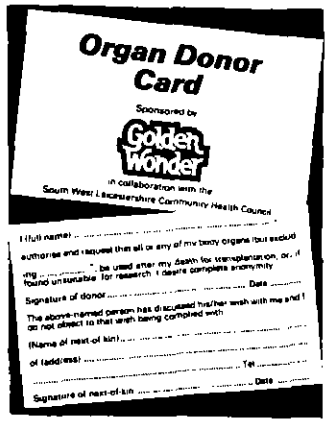
☐ **Plymouth CHC** members toured 41 country villages in a mini-bus to publicise the council's work and to find out what people in rural communities think of the health service. The CHC's report *Rural survey – spring 1980* can be compared with a similar survey conducted by the CHC in 1977. Inadequate transport for reaching health service facilities is high on the list of problems mentioned.

☐ Complaints about GPs and about the complaints procedure itself are in the news again. At the request of **Coventry CHC**, local MPs questioned health minister Gerard Vaughan about delays of more than a year in hearing appeals against decisions by the Coventry family practitioner committee's medical services committee. The CHC is also concerned about delays in notifying complainants and their doctors about the outcome of the appeal.

Barnsley CHC is investigating allegations that a local doctor has a notice in his waiting room warning that anyone who complains against him will be struck off the practice list. Patients have said that appointments vary from 7 — 14 days ahead. Now the FPC has defended the doctor's right to remove any patient from the list and says it cannot deal with a general complaint, an individual must complain. "Not surprisingly", says Linda Denis, personal assistant at the CHC, "people are frightened to make a complaint and give their names, for fear of being struck off".

North Derbyshire CHC's advice to patients who feel ill but are told "wait until next week" for a GP appointment has prompted the local FPC to accuse the council of being "irresponsible". In its annual report, the CHC says that such patients should request a home visit ... "while it is realised that this could lead to a waste of general practitioners' time, it is the only way, faced with an inefficient appointment system, that a sick person can ensure prompt treatment". Now the CHC has published a booklet, *You and your doctor*, for local distribution.

☐ There should be no hospital closures until *after* the new district general hospital has been commissioned — this is **Llanelli and Dinefwr CHC's** case against the closure of a 43-bed pre-convalescent hospital. The CHC organised a public meeting attended by over 100 people, and it argues that closing the hospital would mean that scarce acute hospital beds in the present district general hospital would have to be occupied by the long-stay geriatric patients who are now at the "convalescent home".



☐ **South West Leicestershire CHC** *attracted national publicity when it launched its all parts organ donor card. The CHC cards "ensure anonymity of the donor", according to Brian Marshall, CHC secretary. And if the donor wishes to exclude certain organs, there is room on the card for this to be specified. The cards come in small, plastic wallets and have been paid for by local firms. A £250 donation buys 5000 cards with the firm's name on one side. Other CHC's are taking up the scheme –* **Blackburn CHC** is *aiming to get sponsorship for 100,000 cards. As for the possibility that the Government may issue an all-parts card Brian Marshall is delighted. But the CHC is still anxious that donors' anonymity must be ensured and has asked local MPs to take up this point.*

MEETINGS

☐ A local branch of MIND, the National Association for Mental Health, has been launched in Bolton, sponsored by **Bolton CHC. South-West Herts CHC** has formed "Action Group for the Elderly," a local co-ordinating group or voluntary and statutory organisations involved with the care of old people. The elderly were also the topic of conferences organised by **South Nottingham CHC** and **Merthyr and Cynon Valley CHC. South Nottingham** concentrated on nursing the elderly and in Merthyr the meeting focussed on services in the community. Incontinence was the topic under review at a public meeting staged by **Bexley CHC** — the film *Home and dry* was screened. Last month more than 150 women attended **Sunderland CHC's** meeting on menopausal problems — the council will now press for a specialist clinic.