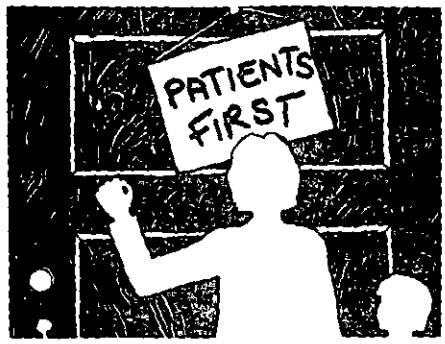
CHC NEWS

For Community Health Councils

August 1980 No 57

CHCs will continue -but under scrutiny



CHCs will be retained — one for each new District Health Authority. But "later on, when it is possible to form a considered judgement of the need for separate consumer-representative bodies to exist alongside the new, more locally-based health authorities, the position will be looked at again".

This is the Government's decision on the future of CHCs, as announced in circular HC(80)8, *Health service development: Structure and management.* It still leaves some clouds on the horizon, but since most DHAs will probably not begin work until 1982 it seems unlikely that the need for CHCs will be reviewed again in the lifetime of the present Parliament.

Announcing his decision to the House of Commons on 23 July, Patrick Jenkin said that over 3500 responses to the *Patients first* consultative paper had been received, and within this there had been "considerable support" for CHCs. A summary of the evidence has also been published by the DHSS, and this reveals that comments from the public were "overwhelmingly in favour" of CHCs (see page three Comment for further details).

The circular and other Government statements have unveiled a range of new DHSS initiatives, including:

- A consultative paper on the membership and role of CHCs, to be issued "in the Autumn".
- A document "outlining the Government's strategy and priorities for health", also to be published in the Autumn.
- A circular about Family Practitioner Committees, intended to improve their collaboration with DHAs in the planning of primary care, to appear "later".
- A consultation paper on simplifying the planning system, to be issued shortly.

A new document inviting further comments on possible structural changes in Wales (more details below).

Apart from the question of CHCs, the other *Patients first* decisions which have now been firmly taken are much as expected. The 90 English AHAs, and their 199 districts, will be replaced by 180 to 200 DHAs, using the existing district boundaries except where there are powerful management reasons against. Boundaries of DHAs or groups of DHAs should normally be co-terminous with local authority social services boundaries. RHAs will issue proposals for the changeover, with three months allowed for consultation, and will make recommendations to the Secretary of State by the end of February. DHAs will normally have 16 members, including four appointed by local authorities and seven other "generalist" lay members.

Below district level services will be arranged into "units of mangement", which will usually be smaller than existing sectors. Examples could be: a large single hospital, a district's community services, a group of smaller hospitals, or a hospital or group of hospitals and associated community services which seem to form a geographical unit. Alternatively, some units could be based on client care groups, eg maternity services.

Each unit will have an administrator and a director of nursing services, both "of appropriate seniority", who will work in conjunction with a senior doctor. These teams' control of their units' budgets is seen as "an essential element in increasing

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SHABBY TREATMENT FOR THE HOMELESS

Homeless people get a raw deal from the health service, and almost every aspect of NHS provision for them needs radical improvement. This is the message of *Homeless and healthless*, a study of health care provision for the single homeless published by City and Hackney CHC (Price £1.14 inc post).

CHC researchers found GPs unwilling to register homeless people as temporary residents, Accident and Emergency departments being used to obtain simple nursing care or even just to keep warm, and hospitals discharging homeless people to recuperate on the streets. As an experiment, the CHC sent a dirty, scruffy "researcher" with no fixed address to six randomly-selected local GPs — four of which refused temporary registration *and* emergency treatment.

The CHC recommends that its AHA should "actively encourage" GPs to register homeless people, and should educate NHS workers about the needs of the homeless. A and E departments should help patients to register with a GP, and hospitals should not send

patients "home" without enquiring into their circumstances. Other recommendations in the report cover the needs of the homeless mentally ill and alcoholics.

- A national report on health and homelessness, based on evidence from CHCs and local groups of the Campaign for the Homeless and Rootless, is nearing completion. Details from CHAR, 27 John Adam Street, London WC2 (Tel: 01-839 6185).

INSIDE ...

Your letters

Humanising our FPC

Shirley McCarthy, Secretary, North West Herts CHC

In *CHC NEWS 40* (page 2) we asked other CHCs for examples of the standard letters which Family Practitioner Committees use to advise patients that they have been removed from their GP's list. We were seeking to compare Hertfordshire FPC's terse and off-putting version with those used by other FPCs.

We had earlier, jointly with East Herts CHC, submitted a more informative and "human" version, but this had been rejected by our FPC on the grounds that "it almost doubles the length of the letter, and verbosity we try to avoid at all costs".

In response to our request, Wakefield Eastern, Macclesfield and Central Birmingham CHCs forwarded copies of their FPCs' standard letters. These too were potentially daunting for patients, particularly bearing in mind that unexplained removal is upsetting *per se*.

Later we hit on the idea of contacting an FPC whose attitude we expected would be more accommodating, because of what we knew of its attitudes on other issues. Sure enough, this FPC's standard letter was an improvement on Hertfordshire's and after further discussion our FPC has now produced an amended version along similar lines.

The new version explains that "For your information the doctor is not required to give the committee a reason for the removal of your name from his list, in the same way that a patient is not required to give a reason if he wishes to change to another doctor".

It emphasises that patients should not wait until they are ill to join another doctor's list, and explains how to do this. It also gives advice on where copies of the FPC's list of local GPs can be consulted, on how the FPC itself can help in cases where it is difficult to find another doctor, and on how to get emergency medical treatment in the meantime.

We feel that this is a small, slow, but very constructive step. Thanks to *CHC NEWS* for your help.

NAHA on the fence

Philip Hunt, Assistant Director, National Association of Health Authorities in England and Wales, Park House, 40 Edgbaston Park Road, Birmingham B15 2RT.

I was somewhat surprised to read in *CHC NEWS 55* that NAHA wants CHCs to be abolished. I think this may give your readers a somewhat inaccurate picture of NAHA's views on the future of CHCs.

In our comments to the Government on *Patients first* we pointed out a number of criticisms that have been made about CHCs, and said that the virtual doubling of the number of health authorities would increase identification of those authorities with the public and would weaken the case for separate representation by CHCs. We went on to say that *one* option would be the abolition of CHCs.

An alternative option was seen as keeping CHCs but curtailing some of their present powers, such as those over the closure of health care facilities. We did not in fact come down specifically in favour of either option.

Ed: Readers could ask NAHA for a copy of its Patients first *comments, consult paragraph 26, and draw their own conclusions.*

Putting ACHCEW on the map

Juliet Mattinson, Secretary, East Berkshire CHC

We are submitting to the Association of CHCs' AGM the motion to open Standing Committee meetings to the press and public. The vote last year showed an overwhelming majority in favour, but it fell just short of the required two-thirds. May we suggest some active canvassing, for those extra few votes needed to get this measure passed and put CHCs on the national map.

It's not our film!

Gordon Tollefson, Secretary, Wakefield Eastern CHC

The film to be made by York University about the work of CHCs (*CHC NEWS 55*, page 16) is being organised by the Association of CHC Secretaries in the Yorkshire Region, not by this CHC. The film is being financed by a grant from Yorkshire RHA, and by contributions from CHCs throughout the region.

I hope this will reassure members of CHCs throughout the Yorkshire region that the film is a regional film, and is in no way centred on the Wakefield Eastern Health District.

Incontinence

Barbara Johnson, District Occupational Therapist, Lewisham Hospital, Lewisham High Street, London SE13 6LH

I read the article on incontinence in *CHC NEWS 51*. For at least 4-5 years now the occupational therapists (OTs) in this district have taken measures to ensure that advice is available on incontinence.

1. OTs joining the district are given the opportunity to attend a seminar on incontinence at the Disabled Living Foundation.
2. A large information file has been compiled. Demonstration models of clothing and equipment are available for assistance to be given to patients, relatives and nursing staff at Lewisham Hospital and Hither Green Hospital.
3. Meetings have been held jointly with the district nurses to discuss the problem.
4. The cases of incontinence are included in training sessions in the geriatric unit, and a lecture by a consultant is included in our joint in-service training sessions with physiotherapists.

The OT department in this district has also been responsible for the design of two commodes to help immobile patients who may have difficulty getting to the toilet quickly enough to avoid "accidents".

Graham Girvan, Secretary, Bexley CHC

We would be very interested to hear from CHCs who have done any work on the problems of those suffering from incontinence.

Early day motion

William Ashworth, Chairman, Advisory Group, NW Regional Association of CHCs

The early day motion in support of CHCs (see Parliament, *CHC NEWS 54*) was tabled as a direct result of a Parliamentary lobby which we carried out. On the same day in the House of Commons we were able to meet the North West groups of Labour and Conservative MPs, and also Cyril Smith.

We were struck by the searching interest, diversity of comment and varying levels of knowledge about the NHS and us, shown by the MPs. Frank White, Labour MP for Bury, promised at the end to arrange for the Early day motion.

So many of us assume that important people like MPs know all about us, our aims and our aspirations. They don't, and we need to keep on educating them.

Problems with statistics

Jean Robinson, Member, Oxfordshire CHC

I am giving a paper at this year's Statistics Users' Conference, on the present state and future needs of health statistics in this

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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

CHCs have come through the *Patients first* consultation with flying colours. The summary of comments published by the DHSS (1) says it all:

"A considerable number of individual members of the public wrote to record their support of CHCs, in some cases relating the circumstances in which they personally had been assisted by them. This was in contra-distinction to the paucity of comments from members of the public on other issues covered in *Patients first.* Of the nearly 5000 comments relating to CHCs ... *over half the responses were* from members of the public, who were overwhelmingly in favour of their retention ..."

CHCs were seen, "particularly by voluntary organisations, as the champions of the 'Cinderella' services, the apparently unattractive community services for the 'silent' groups such as the elderly, the mentally ill and the mentally handicapped. These services were sometimes said to be neglected by authority members and chief officers in deference to more glamorous services. CHCs provided a timely reminder of the needs of the community in those services, and one that might be all the more necessary in more locally-based DHAs where consultants from the acute services would form a major power group.

"Members of the public felt that the views of an individual would carry more weight when expressed through the CHC than if transmitted directly to the health services. They saw CHCs as a source of impartial advice and assistance and many found the CHC more approachable and accessible than health authorities. They also saw CHCs as an essential channel by *which consumer opinion could reach* the NHS".

So the big question now is — will it all work. One danger is that the drive to "get decision-making down to the hospital and the community level" will actually push some important decisions *below* the level at which CHCs can exert much influence. In this context the Welsh Office's proposal to "harness the knowlege and advice of CHC members" by linking special CHC sub-committees direct to unit management looks interesting.

The other central issue is whether the new DHAs, being "closer to the communities they serve", will indeed turn out to be "more responsive to local needs". The average DHA will apparently have 11 lay members out of 16, but only four will be appointed by local authorities. Whether the other seven will have real roots in their communities remains to be seen. Whether those lay members will be capable of spotting, and where necessary resisting, the professional pressures transmitted through their own full-time officers is even more doubtful. This is the root of the problem — it is not necessarily *resolveable by devolving power into* smaller and smaller units, and it is the basic reason for the separation of consumer representation from management.

In the meantime, there will be further consultation on the role of CHCs — with ACHCEW's proposals for national publicity, improved consultation and better working information already on the table and presumably setting the tone of the whole debate.

1. *Patients first: Summary of comments received on the consultative paper,* DHSS July 1980.

Health News

152 ways of improving maternity care

If modern knowledge and care were fully put into practice at least 5000 babies would not die every year and 5000 would not suffer significant handicaps. This is the estimate of a major new Parliamentary report on perinatal and neonatal mortality in England and Wales*.

The House of Commons Social Services Committee, chaired by Renee Short, has investigated all aspects of maternity provision. It considered large amounts of written and oral evidence and made visits to two of the regions with the highest baby death rates, the West Midlands and the North West. It makes 152 recommendations for improving services and lowering the infant mortality rates, many of which could be carried out at no extra cost.

The *committee points out that although* there has been a reduction in baby deaths over the last three years the overall figures for England and Wales are still 50% above the best rates (in Sweden) and the figures vary markedly between different parts of the country and different classes.

The committee emphasises the importance of identifying and supporting "high risk" mothers — schoolgirls, women on low incomes or with large families, new immigrants. Medical priority in antenatal clinics should be given to the "high risk" women.

Considerable concern is voiced about the shortage of intensive care units. Witnesses repeatedly told of seriously ill babies being turned away from these units because they were full. The report recommends that the number of intensive care cots be immediately increased from 176 to 400. Most of these should be in specialised *regional perinatal centres.* At the same time the report says that sophisticated modern facilities should not be used to save severely damaged babies unless there are overwhelming reasons to do so.

The importance is stressed of having 24 hour cover in all units caring for pregnant women. Immediate access to a suitable operating theatre is also vital. In the interests of lowering the infant mortality rates the committee recommends that more mothers be delivered in large units and home deliveries be further phased out.

The shortage of consultant paediatricians *worried the committee. And as the first four* weeks of life are so crucial — two thirds of all infant deaths occur then — a minimum of 50 consultant posts in neonatal paediatrics should be established.

Midwives should have greater responsibility for the care of women with uncomplicated pregnancies. The training of GPs who give obstetric care should be tightened up and a distinction made between GPs who deliver their patients and those who only give antenatal and postnatal care.

Despite evidence from Patrick Jenkin that he was unconvinced of the need for minimum standards, the committee recommends that the DHSS establish these for staffing, practice and equipment in all maternity units. It also calls for *regional perinatal working parties* to be set up to monitor obstetric and neonatal work within every region.

**Perinatal and neonatal mortality.* House of Commons Paper 663-1, HMSO £5.00

Fluoride gets a big Yes

Two-thirds of the adult British public support water fluoridation, a major public opinion survey commissioned by the West Midlands Regional Health Authority has shown.

In a survey carried out by NOP Market Research Ltd, 1946 adults throughout Britain were asked the question: "Do you think fluoride should be added to water if it can reduce tooth decay?" Only 16% said No, *18% said they didn't know and an* overwhelming 66% said Yes. The Yes vote was 76% in the north of England, 69% in Wales and the west, 67% in the south-east, 60% in the midlands and 46% in Scotland.

Other questions in the survey asked people what they knew about fluoridation. Fifty-five per cent were sure that fluoridation does reduce tooth decay, as against 8% who were sure that it does not. But only 18% correctly identified their area health authority as the body responsible for deciding on fluoridation locally.

Roger Bell, dental adviser to the West

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Health News

Continued from previous page

Midlands RHA, commented that this hard evidence of public support would give a "much-needed boost" to fluoridation nationally. Most health authorities support fluoridation, but many "have felt constrained in the past because of a vociferous anti-lobby", he added.

According to the RHA, tooth decay in five-year-olds decreased by 62% over the first 5½ years of fluoridation in Birmingham. Dental decay is thought to cause the loss of about two million working days annually in Britain. Over 7000 NHS dentures are supplied annually to schoolchildren.

● Patrick Jenkin has set up a working party to be called the Dental Strategy Review Group "to review the development of dental health policy, and in particular a preventive strategy and the future functions of the community dental service", as recommended by the report of the Royal Commission on the NHS (paragraph 9.74). Mr Jenkin commented that public opinion may be "nearly ready" for an extension of fluoridation, and that the DSRG might make recommendations on this.

How to get a patient into hospital

The DHSS has written a letter to the General Medical Services Committee (GMSC) of the BMA setting out the procedure for GPs to follow when they have difficulty in getting their patients admitted to hospital. The GMSC has been increasingly concerned about this problem, which it believes is a result of cuts in the NHS. On several occasions it has questioned the DHSS on the legal position of GPs who cannot get their patients admitted.

The letter includes the following points:

● If a junior hospital doctor refuses admission the GP should refer the matter to the responsible consultant. If the consultant decides immediate admission is essential a bed must be found somewhere — in another hospital if necessary — and the consultant "could be expected to initiate that".

● If the consultant does not contest the need for admission but says that facilities are not available the GP "could be expected to draw the attention of the AHA medical staff to the inability of services in the district to meet the needs of his patient".

● It is up to the consultant and the junior doctors responsible to him to assess clinical priorities.

● The formal power to admit or refuse to admit a patient lies with the health authority.

Doctors disagree over CHCs

The British Medical Association's Annual Representative Meeting last month voted 168-107 against the retention of CHCs, and a motion that CHCs should be abolished was subsequently carried. But the Conference of Representatives of Local Medical Committees voted 114-79 in favour of retention. The LMCs saw CHCs as valuable allies in the fight to defend and improve primary care.

Out-of-hours health care for children

The Children's Committee, which advises the Secretary of State about ways of improving the health of children, has reported* on the services available for children when doctors' surgeries and social services departments are closed. The committee's report looks at GP services, deputising services and casualty departments, as well as access to health visitors, dentists and other staff.

Sometimes children are not registered with a GP, particularly in inner cities where families move frequently. Such children have difficulty in seeing a doctor at home.

The largest commercial deputising service estimates that 15-20% of its calls are to children under 16. The committee is concerned that the doctors who work for such services almost never have access to patients' records and rarely have any special training in the care of children. Liaison with the child's GP tends to be rather haphazard.

If a GP cannot be reached, the child must be taken to hospital, to the accident and emergency department. For some children, this is the main source of primary care. The committee states that in A and E "there is frequently a lack of expertise in treating children and understanding their special needs".

"When parents know that good care from professionals is available in-hours, the level of out-of-hours demand is probably less", the committee suggests. The report concludes with an excellent checklist for use in evaluating local services. CHCs are invited to ask themselves:

● Are you aware of the extent of provision of out-of-hours care for children in your district?

● Have you visited or talked to any deputising services in your district?

● Have you visited A and E departments which take large numbers of children, especially at night and weekends?

**Out-of-hours social and health care: Report of a working group,* published on behalf of the Children's Committee, by Health and Social Service Journal. Reprints 50p from Centre Eight Papers, HSSJ, 4 Little Essex Street, London WC2R 3LF.

Jay is quietly buried

The Government has accepted in principle the Jay Report's proposals *(CHC NEWS 41,* page four) to shift the care of mentally handicapped people into the community — but it has *rejected* Jay's recommendation that nurses and social workers caring for the mentally handicapped should have a common training.

Instead it has invited the General Nursing Council and the Central Council for Education and Training in Social Work to set up a joint working party to consider introducing common elements into nurse and social work training — or even setting up a jointly organised course. Patrick Jenkin said the shift into the community will be gradual and take longer than Jay had hoped, because of restraints on public spending.

Continued from page one

local responsibility and accountability". Apart from these posts and the appointment of a District Management Team, DHAs will be free within cash limits to establish whatever posts will provide "the most effective and economical delivery of services" in their own particular circumstances. The Government has affirmed its intention to reduce management costs by £30m (10%) from their March 1980 level, and expects this to be achieved by March 1985.

Services which at present cover more than one district should be divided into district components, unless there are strong arguments against. Existing arrangements for joint planning between health and personal social services authorities will continue, with new Joint Consultative Committees being established to cover all the DHAs in each local authority area.

An appendix to the circular contains guidance from the London Advisory Group, on what to do where the boundaries of existing inner London health districts are considered unsatisfactory. In difficult cases two boroughs, or parts of neighbouring boroughs, could be matched to one DHA, and wherever possible all the main hospitals associated with a particular medical school should be managed by one DHA.

In Wales a further consultation on *Patients first* is to take place, based on the new document *The structure and management of the NHS in Wales* (HMSO £4.50). The Welsh Office says this has been issued because of "considerable misunderstanding" about the implications of *Patients first* for Wales. There has not been general support for the proposal to retain the existing area boundaries, because of a feeling that the Welsh public was entitled to the same locally-based service as that proposed for England. The Welsh Office is arguing that new health authorities based on the present area boundaries would be "broadly similar" to the English DHAs, in terms of resources available and population served.

CHCs are to be retained in Wales, but are invited "to undertake a critical review of their operation over the next year or so to see whether some rationalisation would be desirable". It is also suggested that Welsh CHCs could appoint small sub-committees to liaise with each team of unit managers, "to discuss general operational policies, desired developments, patient and visitor amenities and related issues". Comments on the new Welsh document are needed by the end of December.

Going to the law

by Liz Haggard, Secretary, South Nottingham CHC

Few complaints go as far as legal action because of the cost, the continuing distress and complainants' belief that they have little chance of success. Even so, such complaints are important, because they focus current social, medical and legal thinking.

I've just read a short report (1) on medical negligence, which balances the legal, medical and patient viewpoints fairly. CHCs are sometimes involved in legal action as the "patient's friend", and this report — though written for lawyers — would give CHCs a grasp of the basic issues in brief and readable form.

It begins by explaining the legal obligations of doctors and health authorities, and their duty of "reasonable care". Medical negligence is hard to define, but this report contains sentences worth pinning to our mental notice board:

- "It is so easy to be wise after the event and to condemn as negligence that which was only misadventure".
- "The fair question is... what would most doctors do in this situation given this amount of information? If a person acts in accordance with the professional norm and something goes wrong, it is very difficult if not impossible to assert that he was negligent".
- "Most of the ill-effects arising from so-called negligence prove after investigation to be the result of complications of the disease process itself or of its treatment, and not the result of any lack of care on the part of the hospital staff".

Of course if doctors clung rigidly to professional norms to avoid negligence suits there would be no progress, so a departure from the norm which is supported by "a respectable minority of informed medical opinion" is not negligent.

The legal medical complaints road is rough for patients. A *modest* case with no legal aid can apparently cost £2000 if it reaches trial stage, and does well to get to trial in eighteen months. It's hard for patients to know if something has gone wrong with their treatment and why. Often they don't know who may have been at fault, and it is useful to know that a patient can sue the health authority if he is not sure who to blame. This is important when patients do not know the names of the many doctors who have treated them.

It is sometimes possible to be misled by an apparent lack of negligence. For example, causing damage may not in itself be negligent but not being aware that the damage has been done *is*, for instance in a case where bleeding has been caused when taking a kidney biopsy. Similarly, no claim for negligence alleging failure to cure an incurable disease will succeed, because some diseases can only get worse whatever the doctors do. But that doesn't mean that there cannot be negligence in delaying treatment or failing to relieve symptoms.

Should hospitals be legally responsible if patients suffer because of scarce resources — for instance understaffed wards? In law the hospital cannot normally blame inadequate funding. It is held that if you start a service knowing that there is a risk through inadequate facilities, you could be liable for any resulting injury. The legal advice is "If in doubt, close down" — even though this seems harsh when it means denying patients treatment. Yet if it is better to disappoint a bus-load of pensioners by cancelling their outing than to allow them to pile in when you know the brakes are faulty, perhaps the same is also true for hospitals with inadequate facilities.

How can society compensate for the loss of health? Recently in Britain there has been a small number of judgements awarding six-figure sums, and this has invited worrying comparisons with the situation which exists in the USA. However, in America juries assess damages and the client's lawyer takes a percentage of the amount awarded as his fee. The combination of sympathetic juries free from legal precedent considerations with the financial inducement to lawyers is very different from the British pattern. In Britain a judge assesses damages, and the lawyer's fee does not depend upon the outcome of the case. In 1978 settlements to patients, in and out of court, totalled about £5m, and this was nearly all paid in relatively small sums. It still costs a doctor less for his annual medical insurance protection than the safe driver pays to insure his car.

The law knows that it cannot give *real* compensation, and that money is a poor substitute for good health. The law takes into account pain and suffering, loss of enjoyment of life, shortening of life expectancy and loss of earnings. It can compensate for the loss of others, as when a mother has to give up work to care for a brain-damaged child.

Yet the logic of the law can seem harsh. I was particularly struck by the judgement that only a small award for pain and suffering is appropriate if the complainant has injuries resulting in coma — injuries so severe that it is judged on medical evidence that the patient was unaware of pain.

The way that the law focuses on *fault* means that where fault is not an issue there can be no compensation for any injury and suffering caused, which is why "no fault" compensation seems needed for social equity.

The report explains doctors' resentment of complaints, many of which they see as irresponsible or frivolous. Medicine is a profession where cooperation and acknowledgement of differing yet acceptable views is built into the job, and opposing a medical colleague in a legal case is at odds with medical attitudes. Doctors consider that they have the right to judge the best treatment for each patient and not to be blamed for inevitable risks and complications, which is one reason why they fight tenaciously even when the damage alleged is small. But where negligence has clearly occurred, doctors and their defence unions are quick to settle.

In 1978 the *Which?* report on NHS complaints procedures (2) concluded that if articulate members of the Consumers' Association found these procedures unsatisfactory, the general public must find them even more so. Most people would settle for an apology and an assurance that other people won't have the same problems in future. It is important to improve the complaints procedures, so that fewer people will feel that only through the law can they get satisfaction of some kind.

1. *Legal proceedings against doctors and health authorities,* £19.95 (special price of £12.50 to CHCs) from Taliscourt Publications, Tavistock House, Tavistock Square, London WC1.
2. *Treating medical complaints,* October 1978. £2.50 from the Consumers' Association, 14 Buckingham Street, London WC2.

Photo: Granada TV

Book reviews

Progress in geriatric day care

by J C Brocklehurst and J S Tucker, King's Fund Books, distributed by Pitman Medical, £7

People are often confused about what day hospitals are supposed to do and how they are different from day centres. This study gives general information — buildings staffing, facilities — about a wide range of geriatric day hospitals in the UK. Secondly, it looks at what went on in an average week in 104 hospitals, giving numbers of patients, sources of referral, treatment given and so on. Finally, 30 hospitals are the focus of an in-depth study of their objectives, management, costing and — most important — the views of patients and staff.

It is discouraging to find that in many hospitals there is no agreed policy among the staff about the basic aim of the place. Some staff told the authors that the aim was to give medical treatment, some said rehabilitation and some put stress on social care.

Transport emerged as the biggest single problem for the hospitals. Half of the staff interviewed complained about unpredictability and many thought patients' journeys were too long.

This study probably gives far more information about day hospitals than the average reader would need, including lots of statistics which merely provoke the reaction — "So what?". But it still provides a very useful background read for CHC members doing pre-visit "homework".

Prescribing practice and drug usage

edited by Roy Mapes, Croom Helm, £12.95

There was a time when the public took little interest in drug prescribing — it meant being issued with large bottles of "The Mixture".

In recent years the pharmaceutical industry has vastly expanded and a proliferation of complex drugs now compete with one another for the attention of the busy GP. Following publicity about the disastrous side-effects resulting from one or two of these drugs — eg thalidomide, practolol — the public in general, and CHCs in particular, have grown concerned about the whole process of testing, approving, prescribing and monitoring new drugs.

This book is a collection of essays which deal with the "prescribing" aspect of this process. Why doctors prescribe certain drugs is the underlying question throughout the book. Several writers make the point that the key factor affecting prescribing patterns is the doctor's feelings rather than the patient's needs. Giving the patient a prescription is often the GP's way of finding a "solution" and satisfactorily rounding off the consultation.

The use of long-term repeat prescriptions causes some concern — untrained receptionists are writing an increasing number of these for GPs to sign without seeing the patients, and a quarter of these are for tranquillisers which are now thought to produce no long-term improvement in patients. One essay specifically looks at the way doctors continued to prescribe practolol/Eraldin despite increasingly strong warnings about it from its manufacturer, ICI, and the Committee on Safety of Medicines.

One or two of these essays make too technical a use of statistics for the general reader, but by and large they are written in an accessible and jargon-free style. They would be of considerable interest to CHC members with a particular concern about this area.

Fund-raising and grant aid

by Ann Darnbrough and Derek Kinrade, Woodhead-Faulkner, £7.75

Bingo, sponsored walks and jogs, flag days, trading shops, cheese and wine parties, and raffles are all ways of getting people to dig into their pockets for a good cause. Whether you aim to raise a few hundred or many thousands of pounds this book is full of useful tips and addresses. It tells you how to keep on the right side of the law in house-to-house collections, and about how to make the most of your hard-won gains with tax relief. There is also a helpful chapter about getting money from charitable trusts and from bodies such as the European Social Fund, government departments, the Manpower Services Commission and the Voluntary Services Unit.

The needs of children

by Mia Kellmer Pringle, Hutchinson Education, £2.95

The director of the National Children's Bureau has brought out a second edition of her book, first published in 1975. It has five basic premises: that the environment is of over-riding importance; that the early years of life are particularly vital to later development; that there are marked individual differences in the extent and rate of children's growth; that huge improvements could be brought about in children's emotional, social, intellectual and educational achievements; and that the strategy so successfully used in the health field may well be appropriate to these aspects of development as well.

Dr Pringle discusses the available findings from the many relevant fields clearly and comprehensively. She argues for changes in attitudes to parenthood and child-rearing, and the provision of better services for families. She suggests that the question should not be whether we can afford to provide such services, but whether we can afford not to do so. Sadly, her voice seems unlikely to be heard in the present political climate.

The proposals for a more effective programme of preparation for parenthood are convincing. Some of Dr Pringle's concluding remarks are more controversial; such as whether two forms of marriage should exist, with a much more binding commitment for those wishing to raise a family; and the claim that the rights of children are being undermined by the women's movement, assisted by the media. In the present imperfect state of contraception, the assumption that parenthood can be entirely by choice seems optimistic.

This book contains much valuable background information for CHCs considering services for children and their parents, although only certain sections have immediate relevance to the health field.

Juliet Metcalfe, Walsall CHC

Books received

The consumer's guide to local government, second edition, edited by Martin Minogue (Macmillan Distribution Ltd, £4.95). Includes vital statistics of all local authorities in England, Wales and Scotland, and essays which discuss developments in local services.

The ignorance of social intervention edited by Digby C Anderson (Croom Helm £10.95). Looks at forms of state intervention such as health education in schools, the Manpower Services Commission and social work, and discusses to what extent, if at all, this intervention is made in an informed way.

The Family Fund by Jonathan Bradshaw (Routledge & Kegan Paul £10.95). Describes the origins and the administration of the fund set up in 1973 to help families with handicapped children. Argues that although the fund has a role to play the provision is not adequate, and such families should receive a general expenses allowance.

Overseas doctors in the National Health Service by David J Smith (Policy Studies Institute £12.50)

Living with a toddler by Brenda Crowe (George Allen & Unwin £5.95).

Social work in conflict edited by B Glastonbury, D M Cooper and P Hawkins (Croom Helm £10.95).

Family care of old people by Tim Dartington (Souvenir Press £3.95 paperback).

Social services year book 1980/81 (Longman Group Ltd £14.95).

Directory of private hospitals and health services 1980 (£12.50 inc post from MMI Medical Market Information Ltd, 38 Hockerill Street, Bishop's Stortford, Hertfordshire CM23 2DW). Expensive, of course, but contains details of 150 private hospitals, 1000 nursing homes, 3200 private and voluntary homes and 200 nursing agencies, arranged by health area and county council. Also includes useful articles summarising legislation on private medicine and briefly describing some of the leading organisations concerned with providing private health care in the UK.

BACK PAIN

A national calamity

by Anthony Reed, Information Officer, Back Pain Association

Back pain causes the nation more lost working days every year than all our industrial disputes. Only now is it becoming accepted as the problem it really is. During the last year we have had a report (1) from a working party on back pain, which was chaired by Professor Cochrane and set up by the DHSS, and debates on the subject have been held in both Houses of Parliament.

Government, industry and the public in general are beginning to understand that the human back cannot be taken for granted, nor can the country afford the considerable losses which are known to be caused by back pain. The total cost resulting from back pain each year in lost production, sickness benefit and medical care, has been estimated at nearly £1000 million (2). It is generally accepted that four out of five people will suffer back pain to some degree during their lives.

Back pain is a general term which covers a multitude of different pains and problems. The Cochrane Report (as the report of the DHSS working party is known) said back pain "is a sympton and not a disease. It may arise from a wide variety of established causes; from injury at one extreme, these extend through a diversity of disease states even to cancer. Clinical experience suggests that much back pain is mechanical in nature ... The causes of other forms of back pain are still uncertain, despite many and conflicting orthodox and heterodox theories to explain its occurrence".

Among the many conclusions of the Cochrane Report was the fact that back pain was widespread, unpleasant, and at times serious, and it imposed a considerable burden on our society. It recommended that "further improvements in services can be planned nationally only when there is better understanding of the nature, occurrence and causes of back pain and of effective ways of modifying it". The report said that sustained and increased support for research relevant to these areas was essential, and should command high priority. Its criticism of the level of research was justified, as it is estimated that only seven pence in every £100 spent on medical research is allocated to the study of back problems.

The Back Pain Association (BPA)(3) was registered as a medical charity in 1968, to encourage research into the causes and treatment of back pain, to educate people to use their bodies properly and so help to prevent damage — and to raise funds for these objectives. From its limited income it has directed over £100,000 into back pain research over the past few years, and hopes to step up its programme as funds become available from industry.

The Government's view of this was clearly stated in a House of Commons debate, when Sir George Young, Under Secretary of State for Health, stressed that research need not be confined to public funds. "The pharmaceutical and other industries have a part to play in financing research ...Industry in general stands to gain a great deal from giving financial support either directly to research projects, or to such bodies as the Back Pain Association."

Although part of the BPA's income does come from companies' trust funds, a recent direct appeal to industry produced most disappointing results. However, despite this lack of funding for research and education, the BPA has been able to make considerable strides over the past year. In addition to the clinical research that it has initiated, £10,000 has been allocated to the first phase of a research project to evaluate beds for back pain sufferers.

A report of a Royal College of Nursing (RCN) working party last year established that the incidence of back pain amongst nurses was as great, if not greater, than amongst manual workers in industry. Around 20,000 nurses report absent every year due to back pain. They are off work for an average of two weeks each which costs the NHS around £¼ million annually, as well as reducing the number of trained nurses available. The BPA, in conjunction with the RCN, is preparing an educational programme, for which £11,000 has been allocated, to train nurses in the efficient manual handing of patients.

The association's local back pain groups are also helping in the battle against back pain. In Surrey schools a group has shown that giving lessons in sitting, bending, standing and walking can reduce stress in schoolchildren, and this scheme is now being extended to other areas. In Richmond-on-Thames, exercise classes with music, under medical supervision, have proved popular and beneficial.

By continuing its programme of educating and influencing industry with posters on lifting and other literature, its initiation of selective research and its campaigns to make the public aware of the need to consider their backs at all times, the BPA hopes that awareness of the problem of back pain will become widespread. If we can reduce the incidence of back pain by only 10% not only will we save a lot of suffering and misery in the community but also we will reduce the cost of back pain to the nation by up to £100 million a year.

Photo: Back Pain Association

Some points from the Cochrane Report

★ There is a fundamental need for more research into the nature, occurrence and causes of back pain. Research should be concentrated in a limited number of specialist centres, and local GPs should be involved.

★ The ideal way of controlling back pain would be by primary prevention. The "generally unsatisfactory state of present knowledge" in this area handicaps educational efforts — eg there is no scientific evidence that following instructions on manual lifting reduces the severity or frequency of back pain — so the report recommends carrying out controlled trials of preventive measures.

★ Various manipulative techniques seem to give relief to certain back pain sufferers but there is an urgent need for comparative studies into these treatments — including those which the report calls "heterodox', eg osteopathy and chiropractic.

★ Establishing back pain clinics for acute sufferers is not recommended. Most sufferers recover spontaneously within a short time, and there is no satisfactory evidence that treatment is sufficiently effective to justify diverting resources to crisis clinics.

1. *Working Group on Back Pain*, 1979, HMSO £1.50.
2. Estimated costs of over £900 million in lost production and £90 million in social security payments — *Health & Safety Information Bulletin, Number 43.*
3. The Back Pain Association can be contacted at 31-33 Park Road, Teddington, Middlesex TW11 0AB. Tel: 01-977 5474/5.

Partnership of care

*by Susan Nattrass**

So often discussion about care of the elderly is polarised between family care and state care. We hear that the expansion in statutory provision has eroded family responsibilities. In practice it is clear that the only way we will be able to care effectively and sensitively for our elderly people is by a partnership between families and caring services. It would be more constructive to concentrate on examining how far this partnership exists and how it should be strengthened in future.

Despite popular misconception, family devotion is still an important characteristic of the British social scene. There is no truth in the assumption that the relatives of the elderly are looking to institutions in order to "ditch" their responsibilities. The proportion of elderly people in care has remained constant for half a century. More than 1 in 4 of all elderly people live with relatives (other than spouses) or with friends.

The National Council for the Single Woman and her Dependants recently launched a campaign to reach Britain's "stay at home" daughters who were caring for elderly parents. The 1971 Census figures showed that 310,000 single women are living with parents of pensionable age — there are also some men in the same situation. Through its local support groups the council is in touch with around 7000 of the women.

Age Concern has also been interested in these caring relatives, in seeing what they need in the way of practical and emotional help, and whether our own local groups could play a role. When we asked relatives and families with whom we were in contact to tell us their problems, it was clear that the majority of relatives were devoted to their dependants, despite suffering considerable strain over a prolonged period. There were few complaints about feeding, washing and dressing the elderly person — these tasks were accepted as a natural part of caring.

The unanimous opinion was that the greatest strain was having disturbed sleep at night, when during the day they were expending massive amounts of energy and therefore were exceptionally tired. This was particularly difficult for those who were trying to maintain a paid job during the day. The second and almost as frequent potential cause of crisis was the onset of incontinence — toiletting problems were a frequent cause of distress for both parties. The third major aggravation was the social isolation and often depression on the part of the carer, that is inevitable when it becomes impossible to leave the invalid and so the carer is also housebound.

From what relatives told us, the overwhelming need seems to be for a sitting-in service, so that the relative can have a regular break of a few hours. So often all that social workers and others from the caring professions are able to offer is "tea and sympathy". What is wanted is a regular period of respite which can be enjoyed *in the confidence* that all is being looked after at home. The quick dash to the shops, keeping your fingers crossed that nothing happens while you are away, causes its own strains. Also if relatives have had to give up a job to devote themselves to the caring task it is very hard to also give up visiting friends regularly or give up an evening class or other leisure interest. Where there are friends and neighbours prepared to call in and help, it is important that the commitment should be regular, or at least planned ahead at a time which suits the carer. Often the carer, anxious not to offend, will accept any offer of help and is reluctant to suggest that the helper comes at a particular time.

Day centres and day hospitals can provide much needed relief for relatives. However the waiting list for transport to day hospitals and day centres in most places means that many relatives are having to spend a greater proportion of their time caring and are perhaps having to give up their jobs sooner. This is particularly true for the relatives of confused elderly people. They are undergoing the greatest strain and yet are naturally anxious not to leave the elderly person alone all day. However the shortage of day places for confused elderly people is particularly acute.

The majority of "good neighbour" schemes and visiting services have concentrated attention on the isolated housebound. However there is scope to adapt these schemes to a sitting-in service to help relatives caring for the elderly. The relative has a break and the elderly person makes new friends. This has happened in Bromley where Age Concern found that many of the most distressed calls to their good neighbour service were from relatives caring for the mentally frail elderly. Often the situation had reached a point where the relatives were at the end of their tether.

It is the lack of help at night which can so often precipitate a crisis. The only way to get any relief at night is to pay considerable sums to private nursing agencies — often for a full nursing service which is much more than the patient really needs. Hardly any local authorities provide any night relief service.

Sitting-in services, both day and night, are conspicuous by their absence from the DHSS policy documents and from most health and local authorities' plans for services for the elderly. Yet a co-ordinated service of night-sitting and night-nursing, day-sitting and community nursing could be a most desirable and financially effective way of maintaining elderly people in the community. CHCs should be pressing for this and suggesting schemes as a possibility for joint financing.

Holiday relief for elderly people is becoming an accepted part of the short-term service provision made by local authorities. Last year Leeds social services department set up a short-term fostering scheme with joint financing (1). Substitute families were paid £30 per week to look after an elderly person for up to 14 days during the carer's holidays. In the pilot scheme 72 successful placements were arranged. It proved cheaper than providing institutional care, it was a more pleasant break for the elderly people, and many of the new relationships continued beyond the placement. This year the scheme is being expanded.

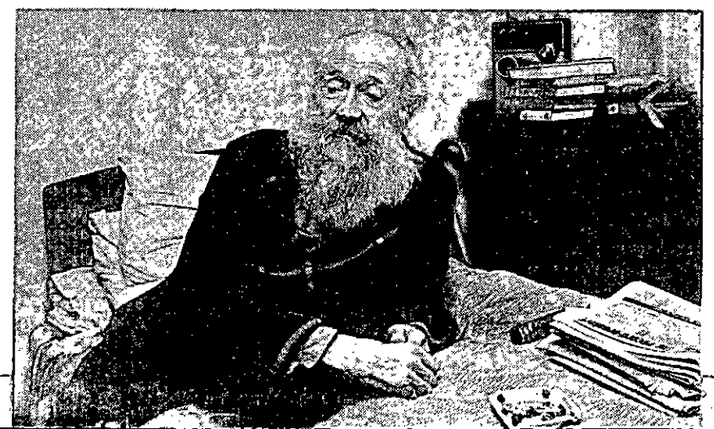
The exhausting work of lifting, turning and toiletting the elderly person can be a great strain, and when relatives need this kind of help they want it right away. Delay in obtaining help, at night or at weekends, and especially in emergencies, can be the greatest destroyer of morale. The district nurse is probably most needed at 7.30 in the morning — to get the patient up, washed and dressed. And yet a visit at 11.30 am is often all that is possible. A GP who is working for a deputising service during the evening and takes two hours to answer an emergency call, is not going to be reassurance to an anxious relative.

Photos: Raissa Page

To deal with this problem a home care scheme has been devised in Tower Hamlets (2). Two full-time workers have been recruited to work flexi-times — mainly in the evenings and at weekends. These hours are an integral part of the project — the workers are available when they are most needed to provide practical help and support for the elderly living alone and also to relieve relatives who are caring for the mentally and physically frail. They are coping with bathing, dressing and getting the invalid up and to bed.

Age Concern in Lewisham has a group worker who runs a support group for stroke patients which provides rather more than the average stroke club. She has found that certain problems are constantly raised — the most common complaint being that relatives are over-indulgent and do not allow the stroke victims to help themselves. Such issues need to be discussed sensitively with the relatives. The support group gives them a chance to meet together and express what they soon learn are common and natural feelings of frustration, self-pity, and aggression in a way that can be channelled constructively and not inter-mingled with too much guilt.

Glib generalisations about the breakdown of family care are unhelpful as well as unjustified. Care must be a partnership between the family and a whole range of outside resources. The care of *relatives is one of our most valuable* assets and is in danger of being squandered. "Our aim should not simply be to prevent breakdown, defined as the removal of the old person from the family, but to prevent excessive stress — which has a spin-off effect on all family members including the elderly person" (3).



References

1 **A new approach to caring for the elderly: a short-term family placement scheme,** Leeds City Council department of social services, Merrion Centre, Merrion Way, Leeds 2 (1979).

2 Details from Spitalfields Project, 192 Hanbury Street, London E1.

3 **Ageing — a professional perspective** by Olive Stevenson, Age Concern England 1979.

Useful addresses and further reading

National Council for the Single Woman and her Dependants, 29 Chilworth Mews, London W2. Tel: 01-262 1451/2. The council's local groups would welcome contact with nearby CHCs.

Take care of your elderly relative by J A Muir Gray and Heather McKenzie, Allen and Unwin with Beaconsfield, 1980.

**Susan Nattrass is a research assistant at Age Concern Greater London and the author of* Sharing the caring *a booklet to be published by Age Concern England in December.*

Healthline

CHCs in print

Which CHCs publish regular newsletters and which have produced guides to local services?
We get asked questions like this quite often, so here is a list which is as complete as we can make it from the files in the *CHC NEWS* office. If CHCs are not on the list please send a copy of your leaflet, newsletter and we'll be glad to publish an additional list.

Guides to local NHS services *(general information)*
City and Hackney
St Helens and Knowsley
Trafford
Newcastle
Ealing
Northampton (jointly with) Kettering
North Tees
Basildon and Thurrock
East Surrey
East Leicestershire
High Wycombe
S E Staffs
Cheshire CHCs (5 pamphlets)
South-West Durham (newspaper pull-out)
Cleveland CHCs (jointly)
Huddersfield (in preparation)
North Camden (jointly with) South Camden (in preparation)

Guides to local NHS services *for special groups of NHS users*
Children:
North Devon
Aylesbury and Milton Keynes
Mentally handicapped:
Basildon and Thurrock
Mentally handicapped children:
Southampton
Rotherham
Physically handicapped:
Bromsgrove and Redditch
Harrogate
West Berkshire
Elderly and handicapped:
Sheffield CHCs
Weston (in preparation)
Elderly
Wandsworth and East Merton

CHC Newsletters*
Leeds Western
North Surrey
Manchester CHCs
Waltham Forest
Hillingdon
Bristol
South Tees
Crewe
North Camden
Kensington-Chelsea-Westminster (South)
Hull
Weston
King's Lynn
Haringey
Havering
Tower Hamlets
**All these CHCs have published newsletters at some time — not all are doing so at present.*

Leaflets about aspects of the NHS and patients' rights
GP Services
Central Birmingham
Wandsworth and East Merton
Sutton and West Merton
N Derbyshire
Kensington-Chelsea-Westminster (South)
Haringey
Manchester CHCs (jointly)
Sefton Northern
South Hammersmith
Dental Services
Kensington-Chelsea-Westminster (South)
Haringey
Sefton Northern
Ealing
South Hammersmith
Opticians
Haringey
Sefton Northern
S Hammersmith
Kensington-Chelsea-Westminster (South)

Out of time

Can legal action be taken for a personal injury arising from alleged negligence — when the event in question took place $13^1/_2$ years ago?
Without knowing the facts of the case in detail it is only possible to point out that the law on personal injury states clearly that there is a time limit of three years on actions for negligence. The best known exceptions to this are certain industrial diseases such as pneumoconiosis — coal miner's lung — which may develop only years after the disease is contracted. However, if the patient in this instance was at first advised that the injury could be remedied and was only later told that it was irremediable and might have been caused through negligence, it could possibly be argued that the time limit of three years began to run from this point. Solicitor's informal advice is that the chances of success in court are pretty slim.

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.

Your letters

Continued from page two

country from the patient's point of view. I am particularly concerned with how far the statistics which are at present available meet the needs of those who are looking at health care from the patient's point of view. I should be most grateful to hear from any CHCs which have had problems in finding and using statistics. All contributions will be acknowledged in the paper, which has to be written by mid-October.

Euthanasia — thin end of the wedge?

Michael Domoney, Secretary, Wolverhampton CHC
I was amazed at the audacity of Mrs Lark, who calls (*CHC NEWS 55*) for the legalisation of voluntary euthanasia on the grounds that it would relieve pressure on the NHS. Her true colours are of course revealed in her last paragraph, where she pleads that Christian ethics should be ignored and only down-to-earth thinking allowed.

Does Mrs Lark not realise that she is in fact making the NHS her God? As for the kind of thinking she prefers, one has only to meditate on Hitler's treatment of the Jews to see where that treacherous path leads. I am the first to admit that there are immense problems to be overcome, but I would prefer not to run away from them.

Valerie Riches, Wicken Manor, Wicken, Northants.
Mrs Lark's letter is chilling. Is she really suggesting that CHCs should lay the foundation for official "voluntary" extermination of the sick, and/or assisted suicide, because it would be politically expedient and beneficial to the economy?

It takes very little imagination to see how such a measure would soon be abused, leading to the sinister situation we have already witnessed in this century. I refer to Nazi Germany in the 1930s, where undesirable elements were disposed of in the name of "rational" thinking.

Monica Pearce, 5 Glebe Close, Ipsley, Redditch, Worcestershire B98 0AW
Mrs Lark should recall that our western civilisation was built on "out-dated Christian ethics", and that it is the disregard of these ethics that is creating so much deprivation and unhappiness today.

The care of the elderly is firstly the responsibility of the family, then of the community, and only when these are inadequate or frail of the state. Once a society accepts that any human life is disposable, for no matter what reason, then that society is on the road to its own destruction. We have seen this happen in Europe in our own time — God forbid that it should be repeated in Britain.

Richard Lamerton, Medical Director, St Joseph's Hospice, Mare St London E8

Since it opened in 1905, only two of the patients of St Joseph's Hospice have committed suicide. In other words, among these terminally-ill hospice patients the suicide rate is lower than for almost any other population group. When proper care is given, no-one wants to kill himself. So Mrs Lark's recommendation that CHCs fight for euthanasia is way off the mark.

The reason for having CHCs is so that we can fight for better health care. Killing inconvenient patients would be one solution, but not the right one. We should so improve our care that no-one is driven to ask for euthanasia.

For example, our local CHC gave us splendid help when an official of the health authority tried to withdraw the salary for one of our home-care nurses. The CHC resisted strenuously, and our service has been able to continue its work in that district. Every CHC should be demanding hospice in-patient and home care in its area. That would be more like progress!

Old people in hospital

Some elderly people have to spend the last days of their lives in hospital because they are too ill or too confused to be cared for at home. This article highlights a survey* conducted by the late Winifred Raphael and her co-author Jean Mandeville, which compares the views of long-stay geriatric patients with those of the staff who care for them. The findings give important pointers to everyone concerned with making the lives of elderly hospital patients as dignified and pleasant as possible.

Photo: Mike Abrahams

Six hospitals took part in the survey. Interviews were conducted with a range of staff, both those working on wards and others such as therapists, administrators and doctors. Interviews took place with 40% of the patients who had been in hospital for more than three months (ie long-stay). The rest were too ill, deaf or confused to join in. Some regular visitors were also asked for their views and to some extent they represented the views of patients who could not participate.

People were all asked to say what they liked best and least about the hospital and to give their views on different topics such as the environment, patients' daily lives and the care they received.

Both patients and their visitors were full of grateful praise for the hospital. The survey report points out that old people often contrast modern hospitals with old workhouses. Also patients may be unaware of shortcomings such as the lack of bath hoists or beds which can be adjusted for height. They appreciate warm and clean conditions and do not miss the aids which would ease the tasks of the staff.

The day room came in for heavy criticism from all quarters, usually because it also had to serve as a dining room, TV room, quiet room, a place for hobbies and games, and in one ward even as a store for wheelchairs. The uncontrolled noise of the television, often switched on all day, was a cause of considerable distress to many patients. Only one hospital encouraged patients to have their own sets and to wear earphones while they watched. Another upsetting source of noise came from confused patients who shouted much of the time.

There was great disparity between the views of staff and patients about the standard of bathrooms. Unless a room was freezing cold, few patients complained, though many expressed embarrassment at having to wash completely in public between their weekly baths. Staff spoke bitterly of new facilities which were poorly designed and about a general lack of showers to clean heavily soiled patients. Lavatories were often in short supply or too far away — this aggravated the problem of incontinence.

The report says "It is difficult for most people to imagine what it would be like to be confined indoors for months or years on end, yet this happens to many long-stay patients". More comments were made about pastimes than any other topic. The more fortunate, walking or in wheelchairs, can go out to the hospital garden, or to shops and pubs. Sometimes minibus trips could be arranged. But many people were dependent on others to take them out, and the nurses were usually too busy.

For the housebound there is almost always the TV, and books from the library trolley. But opportunities for occupational therapy, physiotherapy, art or handiwork varied enormously. In some hospitals nothing of this sort was offered to long-stay patients.

It is sometimes hard for staff to find a happy medium between allowing patients to doze and dream in a chair all day, uninvolved with therapy and singsongs, and encouraging them to join in and be sociable. The report says "Staff need to be very sensitive when determining whether such people should be stimulated or not. It may bring a new interest to their lives or it may make them feel bullied".

The amount of choice which patients could exercise, for instance about when to get up and go to bed, was limited by how much they needed help and the gravity of staff shortages.

Comments by both patients and staff about patients' care usually focussed on the constant problem of staff shortages. Doctors were so pressed for time that often minor disablities such as incontinence, poor teeth or eyesight — all of which might have been cured — got ignored and only the unwell patients received attention.

The survey also covers staff views on training opportunities and working conditions. Like Winifred Raphael's other surveys on patients' views**, this one could easily be repeated by other people, and readers are encouraged to use the checklist and questionnaires at the end of the book.

In her reflections on the survey findings, Winifred Raphael poses the issues of patients' choice, boredom, money in hospital, antisocial patients, and so on. She asks the crucial question — if your mother needed to go into a geriatric hospital, how would you feel about it? If you could afford it, would you consider sending her to a private nursing home instead? The survey's list of "probable disadvantages of an NHS hospital" includes: lack of solitude and personal possessions, noise, frequent change of junior doctors, overworked nurses, and possible "workhouse" stigma.

In his preface, Professor Klein pays tribute to Winifred Raphael, whose surveys "drew attention to what might be called the 'pea under the mattress' syndrome: the fact that a disproportionate amount of irritation can be caused through lack of thought about minor and remediable aspects of hospital life such as noise at night. If those who work in hospitals have become more aware of the needs and preferences of patients, no little measure of credit is due to Winifred Raphael".

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* **Old people in hospital,** by Winifred Raphael and Jean Mandeville, £2.50, King's Fund Books, (distributed by Pitman Medical Ltd).

***Other titles in the series:*
Patients and their hospitals — report on general hospitals;
Psychiatric hospitals viewed by their patients;
Just an ordinary patient — survey of psychiatric units in general hospitals.
All King's Fund publications.

MATERNITY CARE

Sharing the cream

by Christina Vaughan-Griffiths, Member, Central Birmingham CHC

In Birmingham's inner city we have a situation which it is hard to believe can exist in the 1980s. In parts of this section of the city as many as 35 babies in every thousand born each year will die within a week of birth. In some electoral wards the perinatal death rate is twice the national average, and at a time when national trends are improving some of our local figures are actually getting worse.

The problem is all the more difficult to comprehend when one realises that in the middle of the city we have one of the finest maternity hospitals in the country — the Birmingham Maternity Hospital (BMH).

One of the reasons for the high perinatal mortality rate in our district is the fact that many middle-class expectant mothers are booked for ante-natal care and delivery within eight or nine weeks of conception. Women in the "at risk" groups book later. Their doctors may not think it worth bothering to try for BMH, and difficulty of access may discourage women from choosing BMH anyway. Instead, they will go to nearby hospitals which are grossly overworked, and under-equipped.

To overcome this problem we have suggested a catchment area and quota system for all bookings. The suggestion is that there should be a fixed quota for mothers-to-be from electoral wards outside Birmingham, the size of the quota to be related to admissions from these wards over the past three years. There should be an "open quota" (ie no limit) for certain electoral wards in Central Birmingham which have been identified as having high perinatal mortality rates.

We would also anticipate that, if this idea is taken up, hospital funding arrangements would have to reflect the quota system by taking account of the perinatal mortality rates in the wards to be served by the BMH.

Our proposal would enable GPs to refer mothers-to-be directly to the BMH, which would have agreed to take responsibility for accepting mothers from particular city wards. Birmingham AHA is already developing a catchment area system for bookings made after 26 weeks of pregnancy, but this will have a minimal impact on the problem and may even

Photo: Jonathan Zeitlyn

result in some women being advised to *delay* booking in order to get into BMH. This would be disastrous, in that it would mean that more women at risk might not get ante-natal care early enough.

Although in the centre of the city, the BMH forms part of a hospital complex which is difficult to get to by public transport. We support the suggestion made last year by the AHA, that it might experiment with consultant ante-natal clinics in inner city areas where the late bookings problem is most acute. We have also asked the various authorities involved to improve sign-posting to the hospital, and to improve bus and train services. With the opening of a suburban train service calling at a new station near the hospital, and with a newly-extended bus route passing close to the BMH's door, we hope that the problem of accessibility will soon be largely solved.

Early access to ante-natal clinics and a reasonable chance of obtaining admission to the BMH are only two aspects of the problems which concern us. Pressure on the staff working at the BMH is another major matter of concern. As well as our quota system proposals, we are also suggesting a review of the ways in which work is allocated to nursing staff, to make sure that nurses and midwives do not undertake unnecessary work for which they are over-trained, and an increase in the number of auxiliaries, to free midwives to carry out their professional responsibilities.

Central to our work has been the recognition of the importance of *informed patient choice*. We want full information to be available to all mothers-to-be in our district, so that they may understand the full range of options open to them, and what these options imply for the process of childbirth and its outcome. The women themselves will then be able to make the choice between, say, an awkward bus journey on the one hand, and the availability of epidural anaesthesia on the other, or between technologically sophisticated ante-natal and birth facilities and more home-like and informal environments.

The life and times of a CHC assistant

by Wenonah Hornby, Assistant, Hull CHC

May I write about myself — and perhaps in doing so publicise the existence of the CHC Assistant, hitherto seemingly unrecognised? Much is written about CHC secretaries — deservedly so, I hasten to add — but little is heard of their assistants.

This probably stems from the fact that in the beginning assistants were only somebody to do the typing and make the tea (still a sideline!). However six years later the same job has changed out of all recognition. We literally "mind the shop", besides sweeping the floor.

If a realistic attempt is to be made to deal with the vast range of a CHC's activities, covering every aspect of the NHS, it is physically impossible for a CHC secretary to cope alone. She (my boss is a "she") cannot be out visiting, lecturing, giving talks, attending conferences, and at the same time be in the office, organising administration and coping with phone calls and visits from occasionally aggrieved members of the public. And as for the relentless amount of literature that comes in, she cannot pass it out to the appropriate departments as there aren't any, so she needs someone to help her digest it by picking out the tastier morsels in advance.

CHC assistants are in the "front line" when it comes to complaints from the public and deal with subjects as diverse as "how can I donate my eyes" and a lady suffering from a phantom pregnancy. The CHC is in contact with social services, social security officials, the family practitioner committee, police, voluntary

'IN DEPTH' visiting at the Ida Darwin

by Sheila J Gatiss, Vice-Chairman, Cambridge CHC

Photo: Cambridge Evening News

Visiting is one of the most important functions of a CHC. It is one area of work to which our council has given much time and thought. Over the years we have developed different methods but it is our lengthy "in depth" visits which have been of most value to us.

Before we visited the Ida Darwin, a hospital for the mentally handicapped, we studied various national and local documents and met twice to discuss issues and identify the criteria which we would be using to assess the provision of services. A simple check list was devised and used as a guide by each member.

The Ida Darwin is a purpose-built hospital, commissioned 14 years ago. Its ten wards are separate units of two different designs, scattered around a grassy area about three miles from the city of Cambridge.

Twelve members were involved in the visiting which was undertaken during a three-week period last summer and covered all the wards and various departments of the Ida Darwin. The visits lasted between two and twelve hours. One member spent a 12-hour day-time period on a ward and later a 12-hour night-time period on the same ward. Another member spent 15 hours overnight on a different ward. The two members who stayed during the night found it very useful and felt that they had got a more complete picture. It was encouraging to find that the more able adult residents were generally free to go to bed and get up in the morning as and when they wished.

Members made their own individual arrangements for the visits after an initial approach by the Secretary to the hospital management team. The visits were informal, and contact was between the individual visitor, the residents and the staff on duty on the ward.

Immediately after the visits individual reports were written, and later a composite report was compiled which was discussed with the hospital management team, debated in public at a council meeting and then discussed with the district management team and the area health authority.

All the members felt that an increase in the staffing levels, in particular in the level of trained staff, would improve the quality of life of the residents. It was clear that staff recognised many of the problems themselves and felt frustrated at the restrictions under which they worked. The shift system of providing care, especially with an inadequate number of staff, meant that wards were orientated primarily towards completing "tasks". It became clear that in wards with highly dependent patients certain times of the day — such as the period between 7am and 8.30am — create particular strains. Staff had to do things for patients rather than help and encourage them to undertake tasks for themselves, such as putting on shoes and cleaning teeth.

On the whole members found that although the environment of the wards tended to be clean, spacious and institutionalised, the atmosphere generally was positive and encouraging. It was noticed that there was a striking difference between single rooms, which had been redecorated for a particular individual, and the bare dormitories.

We were impressed by the work being done at the Ida Darwin hospital. When we talked about our visits with the full council it was felt that certain aspects needed to be discussed further with the authorities. We are now actively exploring ways in which one unit could be made more domestic in scale and run as a household rather than a ward. We are also interested in the possibility of increasing and varying volunteer input, and of developing "fostering" for hospital residents who have no family ties.

There seems to us to be a danger that mentally handicapped people now in hospital may be "shelved" whilst new community services are being fashioned, and that these people may live out their lives in a relatively impoverished atmosphere. We do not want the impulse towards change to be stifled in hospitals, especially when local authorities feel impotent to provide resources for alternative kinds of care.

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organisations, local authorities, hospitals, clinics, hostels and day centres — the list could go on endlessly. Much of this work falls upon the shoulders of the CHC assistant, who has no training whatsoever.

I myself came from a job in industry, and didn't know a DHSS office from an FPC. A fair description of what it was first like for me would be to say that I almost drowned on more than one occasion only to be hauled up and resuscitated. I think that what I had not bargained for was the serious responsibility of giving advice and comfort to people when they are very vulnerable and sometimes frightened. You cannot say to a distressed caller, "please don't be distressed today, be distressed tomorrow when the secretary's in". As private individuals we are often called upon to give advice and comfort but this is usually accepted by the recipient as sheer goodwill. When the advice is from someone they regard as an authority it is taken as being right, and you are sometimes left agonising, not about whether you have given the correct advice (never give it if you're not sure it's correct), but about whether in fact it was that advice that they really required, and if you have left anything unsaid which would make a great difference to their situation.

However the job is not all agony — except when making tea for a meeting of 15 people and having to wash up in the wash-hand basin! It involves taking an intelligent interest in strategy plans, guidelines, discussion documents, DMT minutes etc, in order that one is not caught on the hop when faced with enquiries from members of the CHC. It involves a computer brain to find, select and extract the right information at the right time, and a determination that a member of the public shall not go away disillusioned with the CHC because, in the absence of the secretary, the assistant did not know, or could not find out. The work of a CHC assistant is mundane, stimulating, sad, laughable — and sometimes rather lonely.

However, it's a good job and I hope we don't vanish in any forthcoming reorganisation. And if my fellow assistants don't recognise themselves in this, I did say at the beginning that it was about me.

Parliament

Mental Health Act

The Government has no intention of introducing legislation to reform the 1959 Mental Health Act — at least not during this session of Parliament. Instead it is considering comments which have been made in response to the previous government's White Paper on the Mental Health Act (Martin Stevens MP, Hammersmith, Fulham, 30 April).

The toll of smoking

In 1977, *apart from lung cancer,* the discharges and deaths from hospitals in England and Wales classified under diseases related to smoking were 111,600 for men and 52,000 for women. (Greville Janner MP, Leicester West, 24 April).

No direct elections for CHCs

Appointments to CHCs will continue to be made in much the same way as at present. The Government believes that direct elections would be complicated, costly and would make it harder to achieve a "mix of professional experience and lay membership". It also fears that there would be a lack of public interest (Barry Sheerman MP, Huddersfield East, 3 June).

GP complaints

In 1979 750 complaints about GPs were formally investigated by family practitioner medical service committees. No records are kept by the Government of the complaints which were withdrawn or were informally dealt with (John Wheeler MP, City of Westminster, Paddington, 30 April).

Medical records

The fact that medical records are technically the property of the Secretary of State and are kept by health authorities should not be used to "circumscribe the ethical responsibility of doctors for confidentiality in relation to their patients". Safeguarding the confidentiality of medical records is an ethical matter for doctors and the use of identifiable information from a patient's record requires the consent of the doctor, though not necessarily the patient as well. For this is also an ethical matter on which the doctor must decide (William Shelton MP, Lambeth Streatham, 6 June).

Hospitals' lifespan

Hospitals now being built should last for 100 years. Thirty years is the expected lifespan for engineering plant and equipment. Almost a third of hospital stock was built pre-1900 and less than a quarter dates from later than 1949. These figures come from a 1972 survey of stock:

Pre-1850	6%
1850-1899	27%
1900-1918	16%
1919-1948	22%
1949 to date	23%
Age not known	6%

The DHSS does not keep a record of how much building stock and equipment has outlived its planned lifespan (Renee Short MP, Wolverhampton NE 13 June).

Rights to NHS treatment

British women whose husbands are foreign and work abroad cannot be denied NHS treatment on that basis alone. The criteria for eligibility to treatment is not nationality but whether a person is ordinarily resident in this country. If a person is settled or working here this is accepted as qualifying, although the fact that a spouse is living abroad may be taken as an indication of whether the would-be patient has genuinely settled here (Renee Short MP, Wolverhampton NE, 19 June).

Patients' money in NHS accounts

About £2.9 million of patients' money was being held in NHS accounts on 31 March 1979. Some of this is unspent mobility allowance payments, though the DHSS does not know exactly how much (Edward Lyons MP, Bradford West, 17 June).

Spending patients' money

The Government has been looking into ways in which money belonging to long-stay patients can be used more flexibly "while at the same time avoiding abuse". It will consult widely before any changes are made (Baroness Masham of Ilton,House of Lords, 2 June).

THE PATIENTS ASSOCIATION

by Dame Elizabeth Ackroyd, Chairman, the Patients Association

The Patients Association was born in 1963, out of a burst of indignation. The trigger was experiences of unethical experiments on patients in hospital. A public meeting was called by Helen Hodgson, the association's founder and first chairman and the response was considerable. A constitution was adopted and the association was under way.

The then Ministry of Health gave moral support, which some years later took tangible form in the shape of an annual grant. Our other income comes from members' subscriptions, donations and sale of publications. We achieved charitable status at the beginning of last year but we still live on a shoestring. We have only one paid, part-time member of staff.

Our objectives are defined as:

- To represent and further the interests of patients;
- To give help and advice to individuals;
- To acquire and spread information about patients' interests;
- To promote understanding and goodwill between patients and everyone in medical practice and related activities.

We put on punch cards the complaints from patients which we receive by telephone or letter. The same problems turn up in our files with depressing frequency: difficulty in changing your GP; doctors' attitudes — not listening, writing off the patient as a "nut case"; the brick wall of silence and evasion when you try to pursue a complaint involving clinical judgement. This store of information contributes to the submissions we make to DHSS and other bodies on national health issues, and to answering queries from the media.

When people contact us with a complaint, we explain the best way to pursue it, and what they have a "right" to and what they don't. We don't encourage people to see everything in terms of "rights" as we don't believe that that necessarily solves their difficulties. Perhaps the most helpful function we perform for many people is to lend a sympathetic ear to their troubles.

Often, so far as NHS patients are concerned (we do what we can to help private patients too), we refer them to the appropriate CHC — this is especially the case when it is a local hospital or GP service which is the trouble. CHCs contact us for advice and information on general issues. We believe that we have a mutually helpful relationship with CHCs. Long may it continue — we told the DHSS as much in our response to *Patients first.*

We produce a number of informative leaflets, free to members and available to others at modest prices. We publish a directory of self help organisations at £1.20 post free. Any individual can join the association. The subscription is £3 per year at present. Our advice and information are available to non-members — indeed it is the former who primarily seek our assistance; the latter provide the solid basis for our work. Our members come from all over the country. We don't at present have branches although the formation of a branch in Scotland is under discussion.

A leaflet about the association and an application form are available from 11 Dartmouth Street, London SW1H 9BN, Tel. 01-222 4992.

Scanner

Final report from RAWP group

The Advisory Group on Resource Allocation (AGRA), set up in November 1978, has issued its first and final report*. It recommends a number of minor changes to the existing RAWP formula, including a special allowance for higher staff costs in the Thames health regions and alterations to the procedures for calculating Service Increment for Teaching. The Government's decision to wind up AGRA has prevented it considering a number of other important matters, including teaching hospital costs, cross-boundary out-patient flows and the use of Standardised Mortality Ratios as a measure of the need for health care.

* *Report of the AGRA,* DHSS 1980.

Wanted — warmer welcomes

Welcome home?, a news-sheet from the Continuing Care Project, warns that discharge can be a disaster if it is not well planned. It explains how relatives, professionals and voluntary organisations can help, and makes a strong case for a "short period of well-planned assistance in the right place and at the right time", as the best way of avoiding admission to residential care or re-admission to hospital. Copies from Jane Gibbins, CCP, 20 Westfield Road, Birmingham B15 3QG (Tel: 021-454 7894). Copies of the CCP's publications *Going home?* (70p inc post) and *Organising aftercare* (£1.25 inc post) are also available.

A rose is a rose ....

The National Corporation for the Care of Old People has changed its name to the *Centre for Policy on Ageing.* A leaflet describing the CPA's current work is available from Nuffield Lodge, Regent's Park, London NW1 4RS (Tel: 01-722 8871).

The Voluntary Euthanasia Society is now called *Exit: The Society for the Right to Die with Dignity,* and is still at 13 Prince of Wales Terrace, London W8 5PG (Tel: 01-937 7770).

Fire precautions: HN(80)17

Contains recommendations on fire precautions in nursing homes, from the Home Office's Joint Fire Prevention Committee. The DHSS will shortly be issuing guidance on fire precautions in hospitals, dealing with aspects such as means of escape, staffing, staff training and furnishings.

The Health Education Council has published two leaflets on childminding, in conjunction with the National Childminding Association. One leaflet is intended for people who want to become childminders, and the other is for parents. Copies are available from AHA health education units, or from the HEC at 78 New Oxford Street, London WC1A 1AH (01-637 1881).

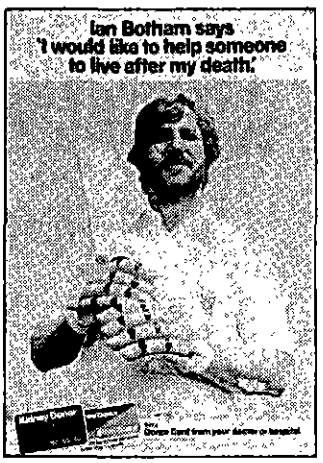
Thinking about waiting

Waiting for hospital treatment is a collection of 11 papers given during a seminar held at the NHS Training and Studies Centre in Harrogate, in one of a series of meetings designed to help clinicians make better use of resources. The papers discuss problems associated with waiting lists from the clinical, management and economic points of view, and give examples of good practice. Copies from DHSS, Room 1221, Hannibal House, London SE1.

Register of special buildings

For three years the Centre on Environment for the Handicapped has been compiling a register of information on buildings which have been designed or adapted for use by people who are handicapped, mentally ill, elderly, blind or deaf. Details of 500 such schemes are now available for consultation at CEH's office, by appointment, and a report* on the project has been published. This can be used as a guide to the material on file, but also highlights current concerns and problems in this field.

* *Report on the CEH register of buildings for handicapped people,* £2 inc post from CEH, 126 Albert Street, London NW1.



Sportsmen Ian Botham and Kevin Keegan, newscaster Anna Ford and actor Richard O'Sullivan star in a series of posters to publicise the new kidney donor card – now plastic, credit-card-sized and no longer needing to be signed by the donor's next of kin. Circular HN(FP) (80)17 announces the card and posters, which are being distributed to GPs.

Surplus hospital land: HC(80)4

Announces amendments to the NHS *Handbook on Land Transactions.* Says it is "essential that the benefit of sale proceeds from surplus land should so far as possible be directed to the point of origin, so that the staff at individual hospitals should see the importance and opportunities attaching to a rigorous review of NHS land holdings". Also suggests that authorities with land to sell should approach private medical organisations before putting it on the open market.

Attendance allowance

Severely physically or mentally disabled people who need a lot of looking after should claim *attendance allowance.* There are two rates of allowance, the higher one for people who need looking after both day and night, and there is a six-month qualifying period before payments can begin. DHSS leaflet NI205 gives up-to-date details on how to claim.

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 4: South West Leicestershire CHC Chairman: Coun. Kenneth Chell
Page 7: Mid-Essex CHC Chairman: Mr H Kersey
Page 11: West Surrey and North East Hampshire CHC Secretary: Alan Baldwin
Page 12; Basingstoke and North Hampshire CHC Chairman: Maurice J Dyer
Page 15: North Warwickshire CHC Chairman: Coun. Mrs E E Blower
Page 17: Burnley, Pendle and Rossendale CHC 18 Carr Road, Nelson, Lancs. Tel: No change. Secretary: Jeffrey Haydock
Page 18: South Manchester CHC Secretary: Mrs Rosemary Hutchinson
Page 19: Aberconwy CHC Chairman: Mrs Gladys Monk
Page 20: North Gwent CHC Chairman: Coun. H S McKelvie
Page 20: Neath-Afan CHC Chairman: Lt. Col. Maurice Sheehan
Page 20: Rhymney Valley CHC Chairman: Coun. F S Nind
Page 24: Mersey Regional Association of CHC Secretaries c/o Wirral Northern CHC, 21 Hamilton Square, Birkenhead, Merseyside L41 6AY. Tel: 051-647 4251. Chairman: W G Favager. Secretary: Nuala Kent.

News from CHCs

☐ Several CHCs have been getting their teeth into dental problems. After receiving a number of complaints from old people unable to find dentists willing to provide them with dentures on the NHS, **Worthing CHC** contacted all the local dentists to find out what their attitudes to this were. Nearly ⅔ of them replied and more than half of these confirmed that they would not fit NHS dentures to *new* patients—they claimed it was not financially viable.

Leeds Western CHC has been pressing its AHA for two years to start a mobile dental clinic and at last this has been agreed. The clinic will visit schools and training centres for handicapped children, who often miss out on dental check-ups.

Local head-teachers revealed to **South East Staffordshire CHC** that only one in sixteen schools had received a visit from a school dentist in recent years. And all the AHA can offer to schoolchildren in future is instruction by the health education unit in how to look after their teeth.

A survey organised by **North Surrey CHC** has shown that only a very small proportion of local dentists have surgeries which are accessible to the disabled without help. Sixth form students carrying out the survey found that there was a widespread assumption that disabled people will always be accompanied. The CHC would like to do a similar survey on GPs' premises but the local medical committee will not agree.

☐ Members of **Doncaster CHC** have been taking a particular interest in the effects of contact with asbestos—some local workers at the British Rail depot are suffering after removing asbestos panels from railway carriages. The CHC wants to enlarge general awareness about the dangers of asbestos and is now organising a day seminar to discuss this.

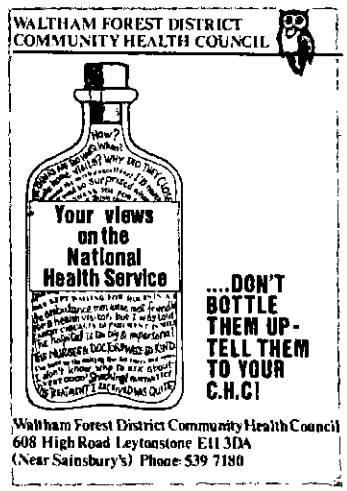
☐ **West Cumbria CHC** is hoping that International Year of the Disabled will be marked locally by the upgrading and expansion of a rehabilitation unit. The CHC discovered that the running costs for this project could be considered for funding by the EEC social fund. With the help of the Euro-MP it has been pressing the RHA to apply for this money but has found the authority unforthcoming about the progress of the application.

☐ Because the waiting time for "routine" X-rays at Wycombe general hospital is eight weeks some anxious patients are reluctantly choosing to pay for X-rays — in which case they are then X-rayed at the same hospital within 24 hours. Several patients have complained to **Wycombe CHC** about this. Although the CHC has been told that clinically urgent cases are X-rayed immediately on the NHS and very little time is spent on private X-rays it is still very concerned about the situation. It is now trying to find out if Wycombe hospital is under particular pressure as its X-ray waiting list is much longer than in surrounding hospitals.

☐ **South Camden CHC** believes that NE Thames RHA has wasted £2½ million of public money, despite warnings from the CHC, the DMT, Camden Borough Council and the local community. In 1976 the RHA was looking for accommodation for single hospital staff and Camden council offered to sell it the leasehold of Maple Flats, a purpose-built block of single flats. However the RHA refused this, claiming it could only purchase freehold property, and bought up former police family flats in Huntley Street. It has had to convert these large flats into single apartments — and Camden council has had to convert Maple Flats into family flats! Meanwhile staff have continued to live in an old nurses' home — where not only has the rent risen eleven-fold but the owners have now served a £1 million writ against University College Hospital for dilapidations to the building. The CHC is considering what action it should now take — it sees no reason why South Camden health district should have to foot the bill.

☐ A police inspector with responsibility for "community contact" gave a talk to **Salford CHC** about the role of the police after unexplained infant deaths, often called cot deaths. The police have a duty to investigate all sudden deaths to ensure that there are no suspicious circumstances. The Salford police are supplied with leaflets for parents from the Foundation for the Study of Infant Deaths, but feel it is "inappropriate" for them to distribute these. Instead the coroner gives them to the undertaker to hand out.

☐ **Basingstoke and North Hampshire CHC** is "waiting to be convinced" that if the Lord Mayor Treloar orthopaedic hospital is closed the alternative orthopaedic provision will be as good. The proposal is to close the Lord Mayor Treloar and transfer its functions to the new district general hospitals in the region. The CHC has met with a blank wall in its efforts to find out the medical and financial implications of the transfer.



☐ **Waltham Forest CHC** *will be having a stall at most of the major local community festivals this summer, and has designed a new publicity leaflet and poster.*

☐ The DHSS is being asked to lay down minimum standards of fitness for GP surgeries, following an approach by **Barnsley CHC** to the **Association of CHCs** about this. Barnsley asked its FPC to visit GP premises which the CHC knew to be in need of repair, with no toilet facilities, poor access for the elderly and disabled, and "a certain lack of privacy". The FPC inspected, but in the end was "satisfied that the premises conformed to laid down criteria". Last month's ACHCEW Standing Committee meeting agreed to suggest to DHSS that these criteria need strengthening.

The Standing Committee also called for the imposition of a nurse training levy on the private health care sector, and put on record its opposition to the Medicover private visiting scheme.

☐ **Southend CHC** is organising a one day conference and exhibition on "Hazards of the handicapped" on 17 September. Professionals and voluntary workers with the handicapped have been invited.

Reports

☐ Following a very detailed survey of women's attitudes to maternity care in **Barnsley**, the CHC has published a report on local maternity services. Recommendations range from introducing routine screening tests for spina bifida to including fathers during some of the relaxation classes. **Eastbourne CHC** has been investigating the difficult subject of child abuse. Members interviewed professional workers who deal with cases of abuse. In their report *Children at risk* they conclude that a high proportion of these workers feel that the present methods of dealing with abuse are unsatisfactory. **Stockport CHC** and a residents' association have produced a joint report on the need for health care facilities on a local estate, Offerton Green. In view of the high proportion of young couples and small children the writers are concerned about the lack of clinics, GP services and chemists' shops on the estate and urge the AHA to consider the local demand for such facilities. Outpatients and visitors are the subjects of two separate surveys at Sandwell district general hospital by **Sandwell CHC**. Outpatients seemed reasonably satisfied with the service provided and had little difficulty in getting to the hospital. People visiting patients found public transport difficult and directions to the hospital unhelpful. The majority were content with the comparatively short visiting times. **Wakefield Western CHC** distributed eight thousand questionnaires asking for the public's views on local health services. Analysis of the seven hundred completed forms indicates that respondents had few criticisms.