CHC NEWS

For Community Health Councils

January 1981 No 62

COMPLAINTS
-*should doctors decide?*

Doctors will be judge and jury in hospital complaints about "clinical judgment", if proposals from a British Medical Association working party are adopted by the DHSS.

A patient may complain orally or in writing to the health authority or directly to the consultant responsible for the patient's care. Patients' relatives may also complain. The consultant is supposed to try to "resolve the complaint within a few days", by talking to the complainant. This would be the *first stage* of the complaints procedure.

If the complainant is still not satisfied, the complaint could be renewed, this time in writing. What the doctors call the *second stage* would probably seem much like the first stage from the complainant's viewpoint. The regional medical officer (RMO) would be informed by the consultant that a complaint had been renewed. "Written communication with the RMO would be confined to the minimum ... so as to minimise material which could be subpoenaed". The RMO and the consultant would discuss the issue and the consultant might also talk to professional colleagues. If it seems to them that there is no point in meeting the complainant again, the RMO must decide whether to set the *third stage* in motion.

At this point the RMO would arrange for two other consultants to give "second opinions". At least one of the third stage doctors must come from another region. The patient may be interviewed and may at this stage bring along a relative or friend. The patient's general practitioner could be present as well.

The RMO would get a confidential report from the "second opinions" and would tell the district administrator what to say in a final letter to the complainant. The whole affair would remain secret "unless previous or subsequent publicity makes it essential for the authority to reply publicly". The working party is silent about what happens if the consultant and the RMO agree not to invoke the third stage and there is no mention of any right of appeal against their decision.

Wales and Scotland would have to have slightly amended procedures — they have no RMOs. The doctors were invited to make the proposals because they so fiercely opposed allowing the Health Service Commissioner to investigate complaints about clinical judgment. Extension of the health Ombudsman's powers was recommended by a Parliamentary Select Committee in December 1977 (see *CHC NEWS 27*).

The doctors' first draft procedure, published last February, was even more defensive and got a chilly reception at the DHSS. The current proposals have been published in full in the *British Medical Journal* (22 November 1980). They accord with the doctors' insistence on "keeping the matter within the profession". Doctors believe this will avoid "the dangers of inexpert assessment on the one hand and elitist judgments on the other, inherent in the Ombudsman's arrangements". CHC representatives would not be allowed to accompany the complainant at any stage, a BMA spokesman said.

● Family practitioner service complaints — see page three.

INSIDE ....

London's sick health service

People outside London look at the city's new teaching hospitals and high health care spending and wonder how Londoners can have the nerve to complain about their health service. In a new report, *Chronic and Critical**, a group of 18 London CHCs explain the reasons for dissatisfaction in the capital city.

Beyond the glamorous teaching hospitals stand small aging district hospitals. Resources are diverted to the teaching hospitals, which develop world famous specialties but offer only "highly selective care to the local population". Most mentally ill and handicapped people are still cared for in vast Victorian institutions in the outer suburbs. Plans for local facilities remain on the shelf for lack of money. "General practice in London is among the worst in the country" says the report.

The report says London's problems have been intensified by the cuts to the NHS in the late 1970s. Resource allocation means effective zero growth for the south east, and the London areas have lost money to other areas in the Thames regions. The emphasis on "rationalisation" has not only obscured cuts but has also led to London losing nearly a third of its hospitals between 1975 and 1979.

The report is adamant that the "solutions" on offer at the moment — private medicine, self-help, voluntary effort and management reform — will mean "more private misery for those who are not well, and more stress and more worry for those who care for them".

The London CHCs call for a freely available service whose development should be decided "by all the people who use and work in the health service and not just by doctors and administrators".

**Chronic and critical — the long crisis in London's everyday health care* from South Camden CHC, 114 Hampstead Road, London NW1, 35p plus 15p post.

Your letters

Is *CHC NEWS* too political?

D E H Russell, Secretary, West Dorset CHC

This council has been for some time perturbed by the somewhat politically tendentious presentation of *CHC NEWS*. This CHC feels that its intention to do its best towards achieving a better quality of care in a wide variety of forms in the health service is being traduced by its implied association with a publication which can do nothing but harm to the real cause of CHCs, which is totally non-political.

My council will therefore be grateful if you will cease forthwith to supply it with *CHC NEWS*, thus, inter alia, making some small saving on the colossal special funding from the DHSS of £78,900 estimated for the cost of the publication (£25,700) and Information Service for 1981-82.

Please feel free to publish this letter, which I am copying to the Rt Hon Patrick Jenkin MP, and to the Chairman of the Wessex Group of CHC Chairmen and Secretaries.

Ed: We have written to West Dorset CHC asking it to explain in detail why it has taken such a drastic step. Briefly, we feel that politics and matters of social policy are inextricably linked, and that most CHCs take an active interest in social policies as they affect the health and personal social services, so we have always seen writing about these matters as part of our job. This has at time led us to criticise the government of the day, but we have never done this in a party-political way and have never suggested that the magazine speaks for CHCs in general. The figures quoted in West Dorset's letter are forward estimates of *next* year's expenditure on *CHC NEWS* and the Information Service.

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MIND's annual conference

Joy Gunter, Secretary, Dewsbury CHC

I would like to pass on a couple of the comments on CHCs that I heard at MIND's annual conference.

- "CHCs aren't interested in mental health, in fact they are more likely to be supporting the cardiologist in his request for funds."
- "CHCs? They're useless — they never get in touch with our regional office for any facts and figures, never mind to ask what goes on locally in the mental health field."

At the conference, Professor Peter Mittler asked where mental handicap expertise would come from at district level after the NHS restructuring, and suggested that RHAs be responsible for mental handicap services, delegating to districts. He also advocated earmarking of funds as the only way to ensure progress providing mental handicap services, and stressed the need for in-service training.

Reorganisation

John Kitchen, Secretary, Worksop and Retford CHC

It is stated in *CHC NEWS 60*, page four, that in view of Trent RHA's preferred restructuring option for Nottinghamshire, "the Worksop and Retford CHC seems to be likely to disappear". This statement is misleading and inaccurate. If at the end of the consultation period the RHA decides to recommend amalgamation to the Secretary of State, then presumably both CHCs will disappear to be replaced by an entirely new council.

The outcome, however, is by no means certain given the unanimity of local opinion against the RHA's proposals and the fact that Worksop and Retford health district fits exactly the criteria for a DHA as laid down in HC(80)8. One thing is certain, the patients in an amalgamated DHA could not be served adequately by one CHC.

Ed: Sorry, an unfortunate choice of words. We should have said that a merger is proposed for the CHCs in question. We also apologise to the Isles of Scilly CHC for the same mistake.

Complaints about locum doctors

W T Evans, Secretary, Cardiff CHC

Mr Marsh illustrated a problem *(CHC NEWS 59*, page two) which most of us will have encountered and which at the same time presents very real problems to patients who enjoy a good relationship with their GP.

Much as I wish to believe that Mr Marsh's proposed solution (ensuring that all locums and doctors involved with vocational training schemes are on the medical lists of the local FPC) would overcome the difficulty, I suspect that it might not do so. Are we not faced with the problems always inherent in a principal/agent relationship? As far as I am aware the courts have always relied upon the premise that the principal is always liable for the actions of his accredited agent and I doubt whether the solution referred to above would overcome this deep-rooted precedent.

Ed: In his reply to Mr Marsh Dr Vaughan said that as the principal of a practice is responsible for the care of patients on his list he can be expected to ensure that he only uses deputising doctors in whom he has confidence. This is preferable to removing responsibility from the principal and possibly allowing less experienced doctors access to medical lists.

Optical charges

R T Pine, General Secretary, Association of Optical Practitioners Ltd, Bridge House, 233-234 Blackfriars Road, London SE1 8NW.

It is simply not true, as some newspapers have suggested, that optical charges in this country are higher than elsewhere in the world for a comparable service. Indeed the most important part of the service, the eye examination, is free to the patient.

Since the NHS Act 1946, the UK optical manufacturing industry has provided top quality lenses and functional frames to NHS specification, to enable opticians to cater for the 75% of patients who use NHS lenses and the 28% who use NHS frames.

The choice lies entirely with the patient. He chooses the ophthalmic practitioner, and whether to be examined under the NHS or privately. If prescription lenses are necessary he can choose between NHS lenses to NHS frames or private frames, and private lenses to private frames. The patient can obtain complete prescription spectacles at a cost to himself from £7.64 up to whatever he decides is within his personal budget.

Comparing the UK with countries with similar economies, private prescription spectacles generally cost less here than elsewhere in the Common Market.

Readers should know that the payment to the optician for the NHS examination is £4.50. Only £1.82 of this is remuneration — the rest being overhead costs. The average gross dispensing fee of £3.60 has not changed since October 1976. With such uneconomic NHS examination and dispensing fees, private patients will continue to subsidise NHS patients until NHS fees are self-supporting. Even so, there is a wide selection of NHS and private spectacles available to the public at relatively low cost.

Too much bumf

Michael Quinton, Secretary, Bristol CHC

In common with all CHC secretaries I have just received my usual weekly packet of bumf from the DHSS. It includes:

- Six press releases about topics such as the Medical Research Council, a hospital in Hampshire, a new AHA chairman in Newcastle and the Children's Act
- Three circulars — about spectacle case prices, container allowance payments and Legionnaires' Disease
- An advance letter about nursing

Continued on page 14

Comment

There is more to services for the mentally handicapped than funding, staffing and numbers of beds. Progress towards the standards set out in the 1971 White Paper *Better services for the mentally handicapped* usually gets thought about in those terms, and of course they are all important factors to be taken into account.

But there is another dimension, which this approach ignores — the dimension of quality of life. This *can* be improved even in a big mental handicap hospital, and it *can* be poor even in small-scale accommodation in the community.

For instance, are mentally handicapped people allowed to wear and choose their own clothes? Are their bedrooms homely, and can they put up their own decorations and keep personal possessions about them? Can they stay longer in bed on weekend and holiday mornings? How much individual attention do staff have time to give them?

CHCs have not always known what to ask about the quality of care. Since 1976, however, they have been able to make use of the stream of reports emanating from the National Development Group for the Mentally Handicapped, and finally — with its last gasp as an assassinated quango — the NDG has distilled all its good advice into an eighty-page checklist*. This can be used as an aid to assessing and improving existing services, as a means of planning new services, and as an educational tool for staff.

Although the list is subtitled "a checklist of standards" it does not lay down standards. What it does is ask pertinent questions, many of which it would be impossible to answer without thinking seriously about what standards are — and about what they ought to be. CHCs and staff at all levels can get involved in filling in the checklist, in consultation with patients' families and where appropriate with patients themselves. The NDG suggests that the checklist should be used "at regular intervals rather than as a once and for all exercise".

The list's main drawback is probably its narrow focus on the needs of patients and their families, to the virtual exclusion of the needs of staff. They are doing what our society sees as one of its "dirty jobs", often in demoralising working environments and on very low pay. They are not immune from the prevailing social attitudes towards mental handicap, which means that they have their fair share of fear and disgust about their patients, and of feelings that their work is of little worth. Left to themselves these feelings can lead to a kind of "uncaring care", based on routine and orderliness and lacking human warmth. Joanna Ryan's book *The politics of mental handicap*, which we reviewed last month, is essential reading on this.

But the checklist is such an obviously useful tool that this is almost a quibble. In the aftermath of the DHSS's new review of progress in the mental handicap services (details on page seven) CHCs should be using every tool available.

* *Improving the quality of services for mentally handicapped people: A checklist of standards.* CHCs should already have received this, but copies are also available from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs.

Health News

Abortion is back in the political arena

The Royal College of Nursing's attempt to get judicial clarification of the legality of nurses' involvement in hormone-induced abortions has disturbed the abortion hornets' nest. In November the Court of Appeal, headed by Lord Denning, overturned a ruling from the High Court that the DHSS was correct in its interpretation of the Abortion Act 1967. The Appeal Court judges ruled unanimously in favour of the RCN and it became illegal for a nurse to participate in chemically-induced abortions. However last month the House of Lords decided in favour of the DHSS and it will give its full judgement soon.

The Department of Health's guidance was published in February 1980 in response to the RCN's advice to its members not to take part in induced abortions. The DHSS stated that provided the procedure was initiated by a doctor who remained responsible for the treatment throughout, "it is not necessary for him personally to perform each and every action which is needed for the treatment to achieve its intended objective" (DHSS Memorandum CMO(80)2). After the Appeal Court decision the circular was suspended, but it has now been re-issued.

The controversy springs from the method of inducing abortions with *prostaglandins* which began to be used in 1972. This is chiefly used for late abortions (after 16 weeks). In 1978 just under 6% of all abortions were performed with prostaglandins.

Although a doctor usually starts the process of pumping the hormone solution into the womb, the pumping has to be "topped-up" and this has usually been done by a nurse or a midwife who monitors the procedure until it is complete—anything up to 18 hours. The college argued that for nurses to "top-up" contravened Section 1 of the 1967 Act and was concerned that its members might not be protected by insurance if the woman came to any harm.

The college has denied that it is politically motivated against abortion and points out that it opposed the Corrie Bill last winter, while favouring a reduction on the time limit for abortion to 24 weeks' gestation.

It will wait for the full judgement before considering whether to press for the Act to be clarified in Parliament.

Abortion may in any case be back on the Parliamentary agenda this month. MPs Timothy Sainsbury and Donald Stewart drew first and second in the ballot for Private Member's Bills and have both expressed an interest in a one-clause bill to limit abortion to 22 weeks. Mr Sainsbury is also considering a clause to strengthen the 1967 Act's provision for conscientious objection by nurses and doctors. The pressure groups on both sides are warming up for the fight.

Acid tests for the NHS?

The Centre for Policy Studies, whose founders include Mrs Margaret Thatcher and Sir Keith Joseph, has turned its attention to the health service. It has published a highly critical collection of papers, which accuse the health service of being inefficient and expensive, and argue the advantages of health insurance schemes and private health care.

A full review will be published in *CHC NEWS* as soon as possible.

The litmus papers – a national health disservice edited by Arthur Seldon, Centre for Policy Studies, £5.55.

Family practitioner service complaints

Changes to the system of dealing with complaints about the family practitioner services are on the horizon. The Government has given up the idea of any major reforms but has consulted the professional and administrative organisations about a range of "technical and uncontroversial changes". It proposes an information leaflet for complainants about service committee hearings. It tacitly admits that so-called "lay-members" of FPCs have sometimes been biased towards the professions, and FPCs are advised to stop practices such as allowing doctors to sit as lay-members on dental service committees. CHCs and the Association of CHCs have not been consulted about the DHSS's proposals, but they are published in *The Family Practitioner Services* (November 1980).

Monitoring side-effects

Doubts have been expressed about a scheme to monitor the side-effects of drugs, which has been set up by the Royal College of General Practitioners.

The RCGP's Medicines Surveillance

Continued on next page

Health News

Continued from previous page

Centre is being run in conjunction with a commercial firm, Medical Monitoring and Research Ltd, who will carry out the negotiations with the drug companies. Panels of GPs will monitor patients' reactions to drugs either before or after approval by the Committee on Safety of Medicines. The cost of the surveys will be borne by the drug companies concerned.

Reservations about the centre have been voiced by Dr Bill Inman, who is director of a new post-marketing drug surveillance unit at the University of Southampton. Dr Inman is concerned that commercial factors may lead to "trivial products" being studied to the exclusion of more important drugs. And he believes a distinction must be made between clinical trials of drugs before CSM approval, and post-marketing surveillance (PMS) afterwards. If GPs know that they are involved in a surveillance study their prescribing patterns may alter and lead to a biased sample — for PMS they should be approached retrospectively. Dr Inman is also anxious that there should be adequate control groups of patients being treated with competitive products. The Medicines Surveillance Centre says that each study will be individually designed for the drug under scrutiny.

The DHSS's attitude to the RCGP's scheme is to "welcome its objectives" and "wait and see how it turns out". Dr Vaughan recently announced that the Government is not, for financial reasons, going ahead with two pilot schemes for drug monitoring which had been proposed by the CSM.

No directs cuts for the NHS

The NHS survived the "mini budget" of late November without direct cuts. Once again the Government claims that health authorities' revenue spending will grow — this time by 1¼% to keep pace with demographic changes. But the statutorily enforceable cash limits are to be "subject to broadly the same disciplines as in local government" according to the DHSS. This would mean allowing 6% extra for earnings and 11% extra for prices. If earnings and prices rise above these limits health authorities will face more problems with their budgets.

Personal social services may be directly cut in many areas if the Government has its way with a 3% reduction in local authority spending.

Secretary of State Patrick Jenkin is "satisfied that savings of at least £25 million can be made without detriment to the planned development of the service." Another source of the "growth" money will be part of the increased National Insurance contributions.

Meanwhile Bill Darling, Chairman of the National Association of Health Authorities in England and Wales, was writing to all MPs about the association's concern for the future of the NHS. He referred to the difficulties the 14% cash limit this year made for many authorities — "Whilst they have tried to avoid harming direct services to patients, this has been inevitable in some areas... Many health authorities have had to transfer capital to revenue expenditure and to cut back on maintenance of the NHS estate and on the renewal of medical equipment".

Fag end for the voluntary agreement?

A new voluntary agreement on cigarette advertising and promotion has been announced by Social Services Secretary Patrick Jenkin — but with a distinct lack of enthusiasm. Legislation now seems much closer.

The previous three-year agreement between government and the tobacco industry expired in March last year, but was extended while secret negotiations about the future of voluntary controls continued (see *CHC NEWS 55* page three).

The new agreement which has emerged will expire in July 1982, leaving the House of Commons free to legislate on cigarette advertising and promotion before the end of this Parliament. The tobacco industry had pressed hard for a four-year agreement, but according to Mr Jenkin the "limited concessions" it was offering did not justify "tying the hands of the House" for so long.

The main points of the new agreement are as follows:

- Spending on cigarette poster advertising will be cut from £20m a year to £14m in the year beginning August 1981.
- Posters will allow 50% more room for three new health warnings: CIGARETTES CAN SERIOUSLY DAMAGE YOUR

Photo: Raissa Page

HEALTH, THINK FIRST — MOST DOCTORS DON'T SMOKE, and THINK ABOUT THE HEALTH RISKS BEFORE SMOKING.
- On cigarette packets the new warnings will be: CIGARETTES CAN SERIOUSLY DAMAGE YOUR HEALTH, SMOKING MAY COST YOU MORE THAN MONEY, and THE MORE YOU SMOKE THE MORE YOU RISK YOUR HEALTH.
- Cigarette poster advertising near schools and playgrounds will cease.
- Tobacco goods with the same name as cigarette brands will no longer be advertised on TV.
- Cigarette advertisements in cinemas will be given an "X" certificate, provided the British Board of Film Censors agrees.
- All advertising of cigarettes containing twenty milligrams or more of tar will cease.
- Average tar yields of cigarettes will be reduced by 9% by the end of 1983.

The agreement does not cover sponsorship by tobacco firms of sport or the arts. All the restrictions agreed in 1977 remain in force.

David Simpson, Director of Action on Smoking and Health, said the new agreement showed that voluntary controls are a hopeless failure. "Even after a year's hard fighting by Ministers, the cigarette companies have not conceded anything remotely capable of beating Britain's biggest avoidable cause of death and illness .... It's like the home guard trying to fight off a nuclear attack". He forecast that this would be the last voluntary agreement, and called for legislation to end all promotion of cigarettes, including sports and arts sponsorship.

Baby deaths "are not preventable"

The Government takes issue with the claim of the Social Services Committee that 5000 baby deaths and 5000 handicapped births could be averted (see *CHC NEWS 57* page three, and this issue, page 11). In its White Paper responding to the report* the Government cites one of the Committee's witnesses who said that perhaps half of the deaths are "preventable by perfect medical management" but that this is like saying all road accidents are "preventable".

The DHSS say that this country's perinatal mortality rate is higher than countries such as Sweden because of the higher incidence here of congenital malformations and low birthweight babies. According to the DHSS no way has yet been found of preventing these.

A circular will be sent to health authorities asking them to "consider" the Committee's recommendations about improving maternity services — particularly those that will cost little. However the Government believes that implementation of many of the recommendations would be much more costly than the Chairman of the Committee suggested — £60m-160m instead of £20m-30m — and it says that no extra funds can be made available. Nor does it believe there is a case for insisting that authorities earmark funds for maternity services "at the expense of other groups such as the elderly and disabled".

**Reply to the second report from the social services committee on perinatal and neonatal mortality*, Cmnd 8084, HMSO £4.60.

The first RSU opens

Britain's first regional secure unit has opened, at St Luke's Hospital, Middlesbrough. Patients needing hospital treatment in secure conditions will be admitted from mental illness and mental handicap hospitals, from courts, prisons and special hospitals, and direct from the community. The RSU has room for 30 patients, and can provide high, medium and low levels of security. Opening the unit, junior health minister Sir George Young urged other regions to push ahead with providing this long-awaited type of accommodation.

A cautionary story

by Mary Merricks, Secretary, Cambridge CHC

The Grange Maternity Unit closed on 30 April 1980. The health authorities' consultation with the CHC about its closure was meaningless. The tragedy for the CHC is that although it made every attempt to respond speedily and constructively to consultation, adequate response was rendered almost impossible by the inadequacy of the information presented by officers in support of their proposal to close. The guidance on consultation with CHCs, set out in DHSS circular HSC(IS)207, was not followed thoroughly. Further, Area Health Authority (AHA) members and officers seemed to take the view that in objecting to the closure, the CHC had simply indulged in time-wasting, causing unnecessary and expensive delays.

In December 1976, the local newspaper carried a prominent report saying that The Grange Maternity Unit in Ely would soon have to close because the landlords, the Ministry of Defence, wanted back the premises which had accommodated the unit since 1974.

... the CHC was forbidden to discuss the matter in public, even though rumours were rife ....

Between November 1976 and February 1978 the Cambridge district management team (DMT) spoke to CHC officers on various occasions about their intentions of closing The Grange, on financial grounds. All of this was confidential — the CHC was forbidden to discuss the matter in public, even though rumours were rife, following the story in the paper.

In February 1978 the DMT recommended to the AHA that the unit should be closed "no later than July 1st 1978". This news was splashed across the Cambridge newspapers. Not surprisingly, bookings for delivery at The Grange slumped.

The CHC pointed out that this date would not give sufficient time for the prescribed consultation unless a consultative document was issued immediately and the CHC agreed to the closure. The document was not published and the CHC's agreement was by no means a foregone conclusion.

At the next AHA meeting in March, members were advised that the closure on 1st July would depend on:

- The Ministry of Defence issuing formal notice to the AHA
- The publication of a consultation document "possibly in the next few days"
- A favourable response from Cambridge CHC.

That not one of these could be counted on seemed scarcely to be noticed by AHA members. The consultation document was not published for another 14 months. Notice to quit from the Ministry of Defence was not given until February 1980 — two years after the decision to close.

When the consultation document finally appeared, in April 1979, it contained some statistical and other information which was clearly misleading. By this time the AHA was so impatient to achieve the closure of the unit that even obviously inaccurate information was not questioned by its members.

The CHC issued its formal response in June. A working party of members with a special interest in maternity services in Ely had been formed the year before, ready for the consultation document. Now they had to work under pressure because the AHA wished to consider the responses to the consultation at its July meeting.

In the event the item was deferred to the September meeting when the AHA decided, on the basis of an inaccurate summary of the replies received, to confirm its decision to close the unit. The CHC was given no opportunity to comment upon the other replies received, as the circular says it should. The matter was simply referred to the Regional Health Authority. The CHC submitted a paper to the RHA about the unsatisfactory consultation process and the basis for the CHC's counter- proposal. This was not acknowledged.

The CHC argued that nearly three years of uncertainty had led to a loss of public confidence in the CHC. GPs had lost interest in the unit and conveyed this feeling to their patients. Yet mothers who had had their babies in the GP unit were wholehearted in their enthusiasm for its relaxed atmosphere and high standards of personal care. And in a district where there was extreme pressure on the maternity services it did not make sense to dismantle an excellent unit because of its underuse. Far better, the CHC argued, to take active steps to encourage its use.

When the consultation document finally appeared it contained some statistical information which was clearly misleading

It is appropriate to refer here to a report which went to the AHA in September 1979, which suggested that pressure on beds at the Mill Road Maternity Hospital would soon create a crisis.

The CHC proposed that the unit should remain open for at least another three years and that no further discussion about its future should take place before January 1982. Meanwhile, steps should be taken to tell all the local GPs about The Grange, encouraging them to send their patients there, rather than to Cambridge where pressure on beds is so great.

In a district where there was extreme pressure on the maternity services it did not make sense to dismantle an excellent unit

The RHA took its time. It appointed a working party to investigate but by December this had not met. The stress and strain of such prolonged uncertainty was seriously affecting the staff of the unit, whose enthusiastic commitment was one of its greatest strengths.

On 9 December the general practitioner who had kept the unit going during the years of uncertainty committed suicide. The RHA decided to delay its investigation for a little longer. No other GP could be found to provide medical cover to the now almost defunct unit. In February 1980 the Ministry of Defence dealt the final blow — notice to quit. Closure was inevitable.

On 27th March the CHC regretfully withdrew its opposition. There was no medical cover, no premises and no will on the part of the AHA to provide either. The unit had been closed temporarily since January and it closed for good at the end of April.

Since the closure the CHC has been assessing the validity of the proposals made in the consultation document. Neither GP deliveries in the Royal Air Force Hospital nor home confinements are happening, although the proposal assumed they would. It seems that local GPs have completely opted out of deliveries. The entire maternity service for Ely is now based in the RAF Hospital, over which the AHA has no jurisdiction.

Book reviews

Representing the mentally ill and handicapped

by Larry Gostin and Elaine Rassaby, Quartermaine House, £3.50 inc post from MIND, 22 Harley Street, London W1, and Legal Action Group, 28a Highgate Road, London NW5.

Apart from accused people denied bail, the only people in England and Wales who can be deprived of their liberty without being convicted of any offence are some of those compulsorily detained in psychiatric institutions. And compulsory patients may endure a detention of indeterminate length — only convicted murderers share a comparable fate.

This book is a very comprehensive guide to the position of patients who are compulsorily detained in psychiatric hospitals. It is subtitled *A guide to mental health review tribunals (MHRTs)* and that is certainly the central core of the book. It gives a detailed description of all the legislation under which patients can be admitted and detained, the ways in which they can be discharged, their eligibility to appeal to the MHRT, and the powers and composition of the tribunals. There is a full guide to the pre-hearing procedures and the hearing itself. Ways of presenting a patient's case are discussed and relevant factors are described. These include medical background — psychiatric terms, likely medications and their side-effects—and the importance of after-care facilities.

MIND takes a very firm stand at the beginning of this book. It contrasts two views of representing a patient at a MHRT — the one which seeks to objectively pursue the patient's "best interests" and assists the tribunal to decide what these are — and the other, the traditional advocacy role which acts strictly upon instructions from the patient and pursues the patient's stated wishes. MIND feels the first view is "highly paternalistic", and "inappropriate" for a representative at a MHRT. It believes the latter view is the only valid approach. The book is thus aimed especially at lawyers interested in this field.

However this should not lead CHCs to ignore it. The most legal parts of the book are written in a perfectly accessible way for lay people. And even if CHC staff or members have no intention of ever representing a patient before a tribunal they would — if they are at all interested in this subject or might ever have to advise someone in this situation — find this book stimulating and valuable. And as a reference book it would be a useful acquisition for CHC offices.

How many patients?

by J R Butler, Bedford Square Press, £4.50

John Butler is extremely comprehensive in his attempt to answer the question, how many patients should a general practitioner look after? While official policy aims to reduce list sizes, little is known about the effects of this on the quality of primary care. This book contains much useful background material for CHC members on GPs' list sizes, consultation rates, time spent in general practice and on the content and quality of general practice, including patient satisfaction with care.

Butler's review of the literature in each of these areas shows that there is little evidence that GPs with larger lists work longer hours than those with smaller lists. If anything, the smaller the size of the list, the higher the number of times patients consult their doctors. Nor does the amount of time doctors spend with their patients vary with list size.

Few conclusions can apparently be drawn about "quality of care" due to the difficulties in defining this term. All the literature here really contains is evidence that general practitioners with larger lists believe that the quality of their care is lower than do the GPs with smaller lists. On the other hand, patients of doctors with large lists do not appear any more or less satisfied with their care than those in smaller practices.

Butler concludes that no single list size can be identified as the optimum as so much depends on the context of individual practices.

This is an extremely informative book to be highly recommended to those wanting information on the content of general practice, although one serious drawback is the lack of an index.

Ann Bowling,
Research Officer, Institute for Social Studies in Medical Care

Accounting and financial management for charities

by Hilary Blume and Michael Norton, with Bruce Galley. £2.55 inc post from The Directory of Social Change, 9 Mansfield Place, London NW3.

Basic book-keeping for community groups

by Jim Smith, £1 inc post from the London Voluntary Service Council, 68 Chalton Street, London NW1.

Members and staff of CHCs are often involved in setting up small voluntary groups, and, since very little in this life ever happens without money, accounts will be involved and a treasurer will be needed to keep them.

These two publications are about coping with accounts, and about understanding accounts drawn up by other

people. As *Accounting and financial management* remarks, we live in a society which is much less shocked by innumeracy than illiteracy, and this can make accounts seem daunting.

A and FM comes with a set of worksheets containing practical examples for readers to try themselves. The book itself has sections on how to handle money, how to establish an accounting system and draw up balance sheets, on auditors, on financial management and forecasting cash flow, on costing a new project for fund-raising, and on Value Added Tax. *Basic book-keeping* covers much of the same ground in rather less depth, also with worked examples.

Accounts are important because if they are not right an impression of sloppiness or dishonesty can be created, and unless people other than the treasurer are able to understand accounts and take the trouble to study them figures may be presented so as to give a misleading picture. With such practical publications there is no way of asessing their usefulness without actually using them, so budding treasurers would be well advised to "suck it and see".

First aid in mental health

by Joy Melville, George Allen and Unwin £4.95

This is a practical, introductory book to problems of mental health. The title is perhaps a little misleading as Joy Melville doesn't give instructions about how to patch up your own mental condition with the psychiatric equivalents of hot sweet tea and sticking plaster. But there are chapters on depression, anxiety and stress, anorexia, schizophrenia, and the elderly mentally infirm.

The author's aim is that the book should give practical information about where to turn for help and reassurance to people who might think, "I am the only person in the world to feel as depressed as this — no-one can possibly understand". The warning signs of mental stress are easily missed, particularly if they are experienced as physical discomfort. Joy Melville writes, "We keep the mental and physical side of our lives in separate compartments; it is important to realise the effect one can have on the other".

This book is clear and simple to read though it manages to avoid the trap of over-simplifying.

Perhaps it is inclined to skate over very frustrating practical difficulties. Sheltered housing is suggested as a solution to the problems of confused elderly people who live alone, but the waiting list for such housing makes this a remote solution in most cases.

However, at least Joy Melville tells you what sheltered housing is, so that you can enquire further. That is first aid of a kind, I suppose.

Mental handicap

What progress?

Ten years ago a Government White Paper announced a plan to revolutionise services for the mentally handicapped (1). Over twenty years there was to be a massive shift away from hospital care, with local authorities building up new services in the community to take over much of the work of the large, isolated mental handicap hospitals.

Now, just halfway through this "great leap forward", a major Departmental review admits that despite everyone's good intentions the policy is failing, and asks plaintively if it should be abandoned. The review also reveals that over a third of the adults currently living in mental handicap hospitals—at least 15,000 people — are "suitable for discharge either immediately or after some training".

The new report (2) was written by DHSS officials and Professor Peter Mittler, former chairman of the now-defunct National Development Group for the Mentally Handicapped. Local authorities "have clearly given high priority to the development of mental handicap services", says the report, but it remains to be seen whether they can continue to do so given the current local authority spending cuts. "It must therefore be questioned whether, at least in the medium term, community care services can develop at the rate needed to permit changes in the hospital service. If not, the pace of discharge from hospital may slow down."

The 1971 White Paper made "over-optimistic" assumptions about the amount of cash which would be available to finance the shift into the community, says the report. "The disparity between the resource assumptions underlying the White Paper and those which must underlie planning at the present time must obviously cause us to consider ... whether the policy of building up local services should be abandoned or at least deferred so that, whilst the development of local services remained a goal, the existing pattern would remain substantially unchanged until well into the next century".

The figures behind this analysis are depressing. The White Paper proposed that in 1991 only 27,300 places for adults would be needed in English mental handicap hospitals and units, but between 1969 and 1977 the number of residents only dropped from 49,200 to 44,100. The target for places in residential homes was set at 30,000, but available places have risen from 4200 to just 11,700. The target for Adult Training Centres was 74,900, but places available have only risen from 23,200 to 38,700.

In the case of mentally handicapped children the problems are different. The White Paper's 1991 target of 5200 hospital places was "substantially over-generous" — between 1969 and 1977 the number of children in English mental handicap hospitals and units fell from 7100 to 3900. More parents now seem to be caring for their mentally handicapped children at home, partly because growth in places for these children in residential homes has been "disappointingly small". The number of places grew from 1700 in 1969 to 2200 in 1977, as against a 1991 target of 4000.

The financial analysis is equally gloomy. Between 1974 and 1977, NHS revenue spending on mental handicap in England was virtually static, but capital expenditure shrank from £431m to £328m (all figures at 1978 prices). Revenue spending on mental handicap by local authorities, over the same period, grew from 5.5% to 6.4% of total spending on personal social services, but capital spending collapsed from £23.7m to £9.6m.

An extra £4.4m of capital spending provided through joint finance went some way towards rescuing this situation, but the report insists that "joint finance in its present form is not by itself enough to bring about a major switch in the balance between health and social services for mentally handicapped people".

The failure of the local authority programme to "take off" properly has in turn had financial consequences for the NHS. "Throughout the period", says the report, "there was continuing expenditure on hospitals of over 500 beds, reflecting the dilemma faced by authorities when confronted with the need to replace engineering plant and upgrade wards in old, unsatisfactory hospitals. Such work can only be done at the expense of providing accommodation more in line with current policy".

Photo: Raissa Page

On staffing, the report notes that although the overall ratio of nurses to patients doubled between 1969 and 1977 the Jay report called for a further doubling, and the National Development Team for the Mentally Handicapped has also drawn attention to staff shortages.

Private and voluntary provision for the mentally handicapped "should at the very least maintain its position", says the report, but it must be remembered that such provision also depends heavily on public money. If non-statutory provision is to be encouraged, ways should be developed of ensuring that public money is being well spent and that "at least a minimum standard of service" is being provided. Self-help patients' groups should be encouraged, and parents should also be helped to get involved in the planning of future developments.

On the key question of whether to abandon present policies, the report says that this would be a counsel of despair. Instead the next step should be a hard look at "ways of facilitating the change to a pattern of local services" — for instance by "earmarking" funds so that they can only be spent on mental handicap, by transferring funds directly from health authorities to local authorities, or through a further development of the joint finance approach.

Social Services Secretary Patrick Jenkin says the report "provides a sound basis on which to take decisions for the future", and will be issuing a consultation document later this year. He has also announced a plan to stimulate the flow of voluntary funds for local projects to get mentally handicapped children out of hospital. The DHSS will match such donations on a "pound for pound" basis for four years, up to a maximum of £1m.

1. *Better services for the mentally handicapped,* HMSO 1971.
2. *Mental handicap: Progress, problems and priorities.* Free from DHSS Mental Handicap Division, Alexander Fleming House, Elephant and Castle, London SE1.

Photo: Andraw Ward/Report

Photo (Centre): Don Price

Photo: Raissa Page

Photo: A' Court Photographs

WHO RUNS THE HEALTH SERVICE?

*by Andy Alaszewski and Stuart Haywood**

How does the health service really work? This is a big question, and the first stage is to trace out the assumptions behind the existing structure. We believe that there have been two clear themes in recent thinking about how the health service should be organised — *centralisation* and *managerialism*.

It was Nye Bevan who established the constitutional myth that the Minister of Health was responsible and accountable to Parliament for all the activities of the health service. Until the early 1960s this myth was not treated particularly seriously, but in the early sixties there was a clear change in thinking. Large-scale capital investment, plus deep-rooted geographical and service inequalities, meant that Members of Parliament, academics and NHS staff all began to increase the pressure on the Ministry of Health to direct the service.

The machinery eventually chosen to implement this centralised decision-making was the *managerial hierarchy*, a sort of organisational pyramid with those at the top supposedly having most power and those at the bottom least. Decision-makers at the top of the hierarchy were to make the overall long-term policy decisions, which would then provide the framework for the short-term operational decisions of service providers at the base of the hierarchy.

The links between the top policy-makers and the service providers were to be *managerial*, ie they would take the form of a system of controls designed to ensure that the decisions of service providers fell within the framework set by the top policy-makers.

In fact the 1974 reorganisation involved two sorts of hierarchies — a local one, with the Area Health Authorities (AHAs) as top policy-makers, and a national one, with the Secretary of State for Social Services at the top. Power in the pre-reorganisation structure had rested with key local providers — or to put it more bluntly, it had rested with doctors — so the 1974 reorganisation meant a double shift of power. At local level it implied that there would have to be a shift of the main focus of power and decision-making from the key local providers to the new corporate managers, the administrators. Nationally it meant a shift of power from local health authorities to the DHSS at the centre.

Implicit and occasionally explicit in the debate leading up to the 1974 reorganisation was the need to control the process of *policy drift*. Under the Ministry of Health the NHS had tended to drift rather like a rudderless ship, and the prevailing "winds" and "currents" were the needs of high-technology, hospital-based medicine. All NHS investment and interest tended to be drawn into the new district general hospitals, with the consequent neglect of low-cost alternatives and "medically uninteresting" patients, especially the elderly and the mentally handicapped.

The new planning system and associated spending priorities were intended to provide the NHS with a clear "steering mechanism", with the Secretary of State as "helmsman". Thus an obvious way of evaluating the success of the 1974 reorganisation is to examine how well the new steering mechanism has worked.

We have used evidence from research done by the Institute for Health Studies, at the University of Hull, to examine the fate of the new NHS priorities issued by the DHSS in 1976, in the consultative document *Priorities for the health and personal social services in England*. Our research indicates that the wind and the currents were too strong for the new steering mechanism and the helmsman. The history of these priorities shows a steady retreat by the DHSS in the face of recalcitrance at local level.

For example, the 1976 priorities required an annual reduction in national expenditure on maternity services of about 2%, in line with the decline of the birth rate. In 1978 the Department acknowledged that "the number of births fell again but expenditure on maternity services appears not to have fallen". In 1979 the Department admitted defeat: "Expenditure on hospital obstetric services, instead of reducing as suggested in earlier guidance, should be expected to maintain its level over the country as a whole".

In our book *Crisis in the health service* we have made a detailed examination of the "local currents" that defeated the central helmsman and maintained the existing policy drift. Locally the members of the new AHAs and their senior officers, especially the members of the Area Teams of Officers and District Management Teams, were supposed to provide strong leadership. We could find little evidence that these individuals played a major role in local policy-making or in ensuring that national policies were followed. Essentially these members and officers were "rubber-stamping" decisions made in other parts of their local system. The key local decision-makers are still the local providers, especially the consultants in high-technology medicine.

However, a detailed examination of the decision-making activities of these providers indicates that it would be a mistake to underestimate the impact of the 1974 reorganisation. It did not work in the expected or intended way, but it did have an important impact on the health service locally. Local decisions were still the product of bargaining between the various interest and power groups within the service, but post-1974 the participants in this process had to learn a new language.

Our studies reveal a complex system of negotiations, in which the deciding factor is still the power of the various participants — including the DHSS — in negotiation. However, the participants now use the DHSS's policies, norms of provision, priorities and targets as "chips" in the negotiation game — playing those chips that best suit their own perceptions and interests.

The 1974 reorganisation failed because its architects did not understand the way the NHS works locally, and in particular did not understand the nature and source of doctors' power. This power has a variety of forms, but central to it is the monopoly medical practitioners have over the definition of health and disease. Health is defined as the absence of disease, and the role of the doctor is defined as fighting disease, usually after it has invaded the individual body. Hence we have a health service which concentrates on "repairing" bodies, and takes action only in response to the appearance of disease symptoms.

The DHSS in the mid-1970s attempted to supplement this dominant approach with other perspectives, eg prevention, community care and care for the permanently damaged. Its failure in this attempt was an ideological failure — a failure to convince AHA members and health service workers that these alternative approaches are practical and useful.

With this understanding of the 1974 reorganisation, we can begin to see the futility and irrelevance of the current reorganisation (for a more detailed discussion see *Another dose of managerialism?* by A Alaszewski, P Tether and H McDonnell, which will be published shortly in the journal *Social Science and Medicine).*

The new reorganisation is based on some of the assumptions of 1974, eg the importance of the "right structure", the concern with management relations and the total neglect of power relations. However the differences are also important. The stress on local autonomy and the making of decisions "close to the patient" sound superficially attractive, but does this mean that the Secretary of State for Social Services is abandoning his responsibility for priorities and service development? Is he abandoning all attempts to stem the tide of high-technology medicine?

The messages from the DHSS are a bit confusing. On the one hand the Secretary of State has stressed that existing priorities for mental health are to continue, and has

Continued on next page

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Healthline

Talking politics

Can you give any information on whether CHCs are allowed to discuss matters which are not exclusively to do with their own health district, including matters which some people would see as "political"?

There are several points of fact which need to be made on this question. The only detailed official guidance about what CHCs are supposed to do is appendix 5 of circular HRC (74)4, but this is merely a list of suggested activities which makes no attempt to set limits on CHC work. Neither the NHS Acts 1973 and 1977 nor the Statutory Instrument on CHCs (SI 1973 No 2217) would appear to prevent CHCs discussing national matters. The Association of CHCs exists to represent "as respects England and Wales" the same interests that CHCs represent locally (see SI 1977 No 874). ACHCEW's attitude is that it will only make representations to government on the basis of views expressed by member councils, so if CHCs were to leave all consideration of national matters to the association its work would grind completely to a halt. Finally, the DHSS would appear to consider that CHCs should concern themselves with national matters, since it regularly consults them about such matters by way of circulars and consultation documents.

"Cot death" groups

Is there a self-help group for the parents of babies who were "cot deaths"?

You should contact the Foundation for the Study of Infant Deaths, which should be able to put you in touch with one of its parents' groups. Write to the FSID, Fifth Floor, 4 Grosvenor Place, London, SW1X 7HD, or ring 01-235 1721.

Cervical screening

Do I have to be a particular age to get a free cervical smear test from my GP?

Yes, you must be 35 or over, unless you have had three or more pregnancies. Otherwise you could go to an NHS clinic or contact the Womens National Cancer Control Campaign (Tel: 01-499 7532).

Powered wheelchairs

What are the criteria for getting a powered outdoor wheelchair?

The DHSS supplies electrically powered outdoor wheelchairs to disabled people who need to be pushed in a wheelchair out of doors, and whose normal attendant is unable to do so because of age or infirmity, because the disabled person is too heavy, or because the area is too hilly. Any NHS doctor can recommend that such a wheelchair be issued, and the issue of wheelchairs does not affect patients' entitlement to mobility allowance.

Brush up on ... patients' rights

What has appeared in *CHC NEWS* on patients' rights?

Almost everything in *CHC NEWS* deals with this subject indirectly, but here is a list of articles and items which deal directly with patients' rights.

59, page 5, **When is medical research unethical?**., by Priscilla Alderson
58, page 14, **The Health Service Ombudsman**
57, page 5, **Going to the law**, by Liz Haggard
57 page 14, **Rights to NHS treatment** (Parliament)
57 page 14, **The Patients Association**, by Dame Elizabeth Ackroyd
56, page 13, **Keeping an eye on patients rights**, by West Somerset CHC
55, page 14, **Patients and consultants** (Healthline)
54, page 12, **Falling out with doctor**, by Mrs Gwanwyn Evans
51, page 10, **Experimenting on patients** (Healthline)
51 page 11, **Patient advocates**, by Christine Farrell
46, page 14, **Signing away your medical secrets**, by Dr R E Blundell
42, page 14, **Compulsory care**, by Christopher Hanvey
39, page 8, **Changing your GP**, by Michael Quinton
33, page 8, ***Ethical Committees***, by Joan Woodward
32, page 10, **Which ombudsman?** (Healthline)
31, page 8, **Choosing your own doctor** (Healthline)

Hospital cars

Do you have any information on how the Hospital Car Service (HCS) works?

In 1978 the HCS carried about 3,540,000 patients over 40m miles, accounting for 15-16% of the total ambulance service workload, so this is obviously quite an important part of the NHS. Unfortunately there seems to be a scarcity of information about it. We know of three relevant reports you sould look at: *Ambulance services in Devon* (from North Devon CHC), and two reports called *The role of the ambulance service* (from Lincolnshire AHA and Lincolnshire North CHC. An article about the HCS in the Oxfordshire health area was published in *Health and Social Service Journal* on 25 January 1979, page 69. We suggest you ask your own area's ambulance department for local details.

To contact the information service, write to or ring CHC NEWS, 362 Euston Road, London NW1 3BL (Tel: 01-388 4943).

Who runs the health service?

Continued from previous page

promised a new NHS priorities document. But on the other hand, when the House of Commons Select Committee for Social Services suggested a firmer policy-making role for the DHSS the Secretary of State accused it of advocating centralisation.

The current reorganisation proposals offer no alternative strategy for controlling the basic policy drift of the NHS, because to do this would involve altering the local balance of power. At the moment there are *certain very limited ways in which* groups within the community can influence their local NHS, but this limited impact will be further reduced by the new reorganisation. The number of local authority members on AHAs is to be reduced, and the continued existence of CHCs appears to be conditional on their "good behaviour".

If our analysis of power relations within the NHS is accurate then changes in structure and procedure will not in themselves alter the local balance of power. For example, even if AHAs were made committees of local authorities this would not in itself increase the influence of local groups on decision-making. Legal and constitutional rights are one resource in the local bargaining process, but there are other factors. Decisions require information, and at present doctors and administrators have a virtual monopoly on that. To influence decisions local groups need access to information, either through their own ability to do independent research or through more open access to official information.

Photo: Don Price

However, even with legal rights and good information local groups will still face the problem of ideology. The present narrow definitions of health and disease are made and maintained by doctors, and are accepted by the vast majority of the population. These definitions must be challenged if there is to be a significant change in the local balance of power. Some special interest groups have started to challenge these definitions — for example over the issues of home birth and health and safety at work. But as yet there is little evidence of any ground-swell of change.

Watching the Department

by Renee Short MP, Chairman of the House of Commons Social Services Committee

The new Parliamentary select committees have evolved out of the former Select Committee on Expenditure, which operated through a series of sub-committees covering all the important government departments. Sometimes these sub-committees had to cover the work of more than one department. Thus the sub-committee I chaired up to the last election covered two large ministries, the DHSS, and the Department of Employment. The new select committees cover only one department and no longer have to report back to a larger committee.

The expenditure sub-committee I chaired had already started to investigate the relatively high perinatal and neonatal mortality rates in England when the last election was declared, and it was not until November 1979, when the new select committee procedure had been debated and approved, that this work could be resumed in the Social Services Committee.

Our report *Perinatal and neonatal mortality* was published in July 1980 (HMSO, £5) and contained 152 recommendations to the Secretary of State. Together they would cost £25-30m to implement, though some which involve a change in the use of existing resources would cost nothing at all. Mr Jenkin's considered reply to the report has just been published as a White Paper to Parliament (see page four for details).

Our enquiry covered a wide field. We were disturbed to find that the poorest women living in the worst housing conditions suffered the greatest risk to themselves and their babies. In 1976 the perinatal mortality rate among mothers in socio-economic group five was 24.9 per 1000 — almost double the figure of 12.7 for mothers in group one. There are also marked regional variations — for example perinatal and neonatal mortality rates were higher in the West Midlands and the North West of England than in the South East.

We were equally disturbed to find that women at risk attended infrequently or not at all for antenatal care. We therefore visited hospitals and clinics and talked to mothers, doctors and nurses. We visited health centres and met GPs, health visitors, community midwives and social workers.

We saw some unattractive, over-crowded clinics where women had to wait a long time, often after a long, tiring journey, sometimes with a toddler in tow. We have made recommendations for improving this by taking the clinics to the patients and through better staffing. We are delighted that our suggestions for enabling working women to take time off to attend antenatal clinics without loss of pay have been incorporated in the new Employment Act.

We were concerned by the evidence we received about the shortage of staff — obstetricians, midwives, anaesthetists, paediatricians and neonatologists — and about the problems of small GP and consultant units where 24-hour cover is not economic or possible. We therefore made recommendations about the places where babies are born, especially those where high-risk mothers are delivered, about the staffing and organisation of care in these units. The women most at risk should be admitted to the best care available before the onset of labour.

We made strong proposals for the improvement of midwife recruitment, training and pay. Each year as many midwives leave the service as enter it. Some 27% of training places were unfilled in 1979, and the number of community midwives has declined by 23% over the period 1974-78. We also recognise the value of community care teams. In work with unmarried girls, families living in poor housing conditions and ethnic groups these teams can provide the vital link between community and hospital.

I hope all CHC members will raise these issues at their meetings. CHCs should be visiting local antenatal clinics and finding out how long patients have been waiting there to see the doctor, how far they have had to travel and how their toddlers are being cared for while they are waiting. It would be helpful too if consultant obstetricians would talk to meetings of their local CHC about how their departments work. All CHCs should study the figures for maternal deaths in childbirth, and the perinatal and neonatal mortality rates.

During the last decade many reports have been published in this field — Peel, Sheldon, Oppe and Court — but none of these

Photo: Universal Pictorial Press and Agency

were implemented by the governments then in power. Our report must not be thwarted for lack of resources.

Other activities of the select committee have included a rapid enquiry into one of the so-called "Rayner proposals" — namely the possibility that savings could be made by paying pensions and other benefits less frequently than weekly. Evidence showed that some savings could be made in the £750m spent on paying out over £15,000m in 30 different benefits to more than 15 million people and their dependents, but that the effect on sub post offices could be so serious that many would go out of business. This would hit village communities where the post office is the village store as well.

We felt that an eventual saving of £50m from reducing the frequency of paying various benefits was not really worth the upset it would cause, and we recommended that claimants should continue to have the option of drawing weekly or less frequently.

Examination of the Government's White Papers on expenditure is another important part of our work. The committee took evidence on the White Papers of November 1979 and March 1980. All DHSS Ministers were asked to give evidence before us on the expenditure of their department — the biggest spender of all the central government departments. In 1980/81 the DHSS is spending £28,500m out of a total public expenditure commitment of £74,500m. We examined the effects of spending cuts and cash limits on hospital and community health services, on personal social services, and on social security.

We were concerned that while the Department embraces the *rhetoric* of greater efficiency, it is not in a position to monitor changes in efficiency, nor can it properly assess the effects of reductions in expenditure levels on the quality and scope of the services provided.

We have asked the DHSS for details of the costs and hypothetical long-term benefits of the latest reorganisation of the NHS, and we have also requested information on the extent to which voluntary effort will be able to fill the gaps created by expenditure cuts, and on how the cuts in personal social services are affecting the NHS.

The committee has now started work on its new enquiry into "Postgraduate medical education — the career structure and supply of doctors", and is also preparing to examine the White Paper on expenditure which will be published in the spring.

When a survey brings results

by Fiona Drake, Secretary, South East Cumbria CHC

For some years this CHC has become increasingly aware of the problems in South East Cumbria for people with hearing impairments of varying degrees. We decided to find out what local people think about available facilities, how they can be improved and what additional services are needed.

After discussion with the health authorities, medical staff, social services and the education department, as well as visits to audiology clinics in the district, we began our survey. 1500 questionnaires were distributed in June 1979, the council taking as its nucleus those local people who received hearing aids in 1978. To preserve confidentiality these questionnaires were issued by hospital staff for return to the council, recipients being free to remain anonymous. If they indicated a need for help of any kind, they were invited to supply their names and addresses in confidence to the council. The vast majority of patients volunteered their identity in this way.

Questionnaires were also sent to local hard of hearing clubs, residential homes for the elderly, doctors' surgeries, libraries and to individuals who volunteered to take part in the survey. At the end of July 567 questionnaires had actually been taken away for completion. This figure was regarded as the base for survey statistics. There was a response rate of 33% — 188 forms were filled in and returned.

In October the CHC published a report on the survey, highlighting a number of problems. First there is an inadequate service for the manufacture of hearing aid moulds. After local measuring these moulds are made in the south of England. Many are poor quality and ill-fitting, causing delays to the patient waiting for the aid. Secondly, new recipients of hearing aids need counselling at home. Many aids are being discarded because of inadequate advice about how to adjust them to cope with a background of normal domestic sounds (38% of patients expressed this need). Communicator devices with "loop" systems and headphones are needed, to enable doctors and others to hold confidential conversations with the hard of hearing in clinics, wards, residential homes and so on. Finally, hard of hearing people spoke of problems watching TV and called for clearer speech, less background music with TV plays, and more programmes with subtitles.

In May 1980 the CHC arranged a conference in Kendal. We invited hard of hearing people, health service professional staff, local employers, social workers, transport and education staff and others involved in meeting those with hearing difficulties. We also organised a two-day exhibition of aids and equipment, old and new, to help the deaf and hard of hearing. This was well-attended by the public.

The CHC took up the major problems with the district management team and local voluntary organisations. As a result, the following initiatives were taken:

- A domiciliary counselling service, staffed by trained volunteers has been established by the audiology department at Beaumont Hospital, Lancaster.
- Cumbria Deaf Association organised the gathering of hundreds of signatures on a petition to the broadcasting authorities seeking better provision for the hard of hearing.
- Plans are being drawn up to provide an earmould manufacturing unit adjacent to the audiology department.
- Kendal Lions Club raised money to buy a communicator device for use in hospital clinics and elsewhere. Use of this device will be monitored and more may be purchased.

We are still pressing for replacement batteries for hearing aids to be available from local health centres and clinics. At present patients from the scattered rural communities of south Cumbria either have to travel many miles to the issuing hospital or be without their hearing aid for several days if it has been posted to the hospital.

The CHC feels this survey was well worthwhile and is glad to report some success in improving the service as a result.

FAMILY PLANNING CUTS ARE A

by Sheila Fleetwood, Chairman, Liverpool Eastern CHC, and Regional Administrator, Family Planning Association, North West of England.

Present difficulties in the NHS tempt area health authorities to look for solutions among services where cost-effectiveness is high but is less striking than the opportunity to slash costs. These services are very vulnerable and such action ignores consequences and seeks short-term solutions.

East Hertfordshire presents a blatant example — "temporary" cuts in family planning were made in December 1979 and now the AHA is recommending that the cuts should be made permanent. The CHC is strongly opposing this and I implore all CHCs to be vigilant, even in the absence of such overt threats. Cheshire AHA has asked its five districts to examine family planning budgets for possible savings and all Cheshire CHCs are alerted, especially Halton, where a clinic is threatened with closure.

My position as administrator for the Family Planning Association in the north west of England and my experience of CHC work enable me to urge the continuing need to maintain family planning through community clinics. Superficially, it looks easy for AHAs to cut clinics and leave general practitioners to provide the service. The incentive is that AHAs pay for clinics, while GPs are paid for by family practitioner committees. Such cuts ignore the fact that the final cost is carried by the NHS, which we all support through our taxes.

Such transfers of costs are false economy, financially and in human terms. The FPA can demonstrate with figures from various health authorities, that clinic-provided services in 1979 cost an estimated £8 per person. The GP-provided service cost £12.62 for a "pill" patient and £19.81 for the year when an intrauterine device is fitted. This takes no account of the fact that few GPs fit diaphragm caps and, by their own decision in 1975, none can prescribe condoms. Significantly a spokesman for Hertfordshire FPC said he "couldn't say how much extra it was costing them" to pick up the tab resulting from clinic closures (*Doctor* 23.10.80).

Reducing clinic sessions or worse still closing clinics will discourage many women from seeking advice. Tragically, many young girls will be among those who are put off. Never forget that family planning is essentially "health" not sickness based, so motivation comes from education in attitudes rather than the sheer necessity to seek a cure for an ailment. Discouragement has foreseeable and deplorable results in unplanned pregnancies,with more births imposing greater spending on ante-natal and post-natal services than family planning clinics would cost to run. And it all adds up to more human distress and social cost.

CHCs should urge health authorities not to make cuts which will expose so many women and their children to so many risks. The following basic arguments for

PRIVATE MEDICINE – better than Kentucky Fried Chicken ?

by George Johnson, Member, Newcastle CHC

It is easy to forget what it was like before 1948 when there was no National Health Service. Being ill then could mean a lot of worry about where to get medical treatment, how much it would cost and how to pay for it.

Health care in Britain is now paid for out of the money the Government raises from taxes. So we all contribute to the NHS while we are healthy, through income tax, National Insurance and Value Added Tax. What we pay depends on how much we earn and how much we spend. This method of finance allows those who have little or no money of their own — such as children, elderly, mentally ill and handicapped people — to receive treatment and care free of charge.

The NHS is a comprehensive system of health care for everyone — "from the cradle to the grave" as Nye Bevan put it. The whole ethic behind the NHS was that every citizen had an equal right to the best medical care available. The NHS was the greatest single achievement of our post-war politicians. Its destruction would be the greatest single disaster.

Private medicine is the parasite which encourages greed, selfishness and profit at the expense of those who are unfortunate enough to be ill. Profit made from ill health and suffering is immoral and despicable — health care should be free to all at the time of need.

Private medicine and hospitals are funded in a number of different ways. All rely to a greater or lesser extent on NHS facilities — be they pay beds, laboratories or blood transfusion services. In addition private medicine is further subsidised by the state and working people either by tax exemptions gained through the guise of charitable status, or tax concessions offered to employers who subscribe to the growing private health insurance schemes.

Common myths about private medicine include:

Private medicine encourages freedom of choice, while a state health service does not. Obviously freedom of choice is available only to those who can afford to pay and do not suffer from unprofitable illness. This is undoubtedly a minority. It is estimated that 60% of NHS expenditure is absorbed by those who are poor and at risk — children, the elderly, and mentally and physically handicapped people (1).

Individuals can afford to pay for health care but the country can not. Many individuals cannot afford health insurance. And countries such as France and Australia which have mainly private health care schemes end up paying a larger percentage of their gross national product on health care than Britain does (2) — with no comparable increase in the standard of health of their populations.

State services breed bureaucracy but private enterprise does not. While there is much room for improvement in the present administration of the NHS, the service does have to be administered. The idea that the NHS spends vast amounts on bureaucracy creates a false focus for its problems. Since reorganisation administrative costs for the NHS have been about 4% of the total health budget. Comparisons with countries with predominantly private services are not easy to make, but it appears that administrative costs in these countries are probably higher than in Britain.

We must realise that private medicine is now big business — it offers an even better market than Kentucky Fried Chicken, as one American businessman put it (3). In the long-term private medicine will distort health care provision. Profitable specialties will be developed and the "Cinderella" services will be left out in the cold. Crisis intervention and high technology medicine will be promoted at the cost of a socialised and preventive approach to health care.

To safeguard our children's future we must maintain the legacy we have given them — *our* NHS.

1. **Report of the Royal Commission on the National Health Service,** Cmnd. 7615, HMSO 1979, £8.00, page 337.
2. **Report of the Royal Commission,** page 333.
3. Jack C Massey, chairman of Kentucky Fried Chicken, then head of the Hospital Corporation of America, quoted in *Medicine in Society,* April 1977, page 31.

Photo: BUPA

FALSE ECONOMY

protecting family planning services should be carefully considered:

Choice of service

DHSS guidelines to AHAs in 1974 (Circular HSC(IS)32) recognised family planning as markedly different from other health service provision. The emotional aspects are significant and the element of choice is vital. The Secretary of State for Social Services has recently stated his hope that the service will develop on that basis and the Minister of Health has affirmed the need for young people in particular to have this choice.

Choice of method

At present GPs concentrate on prescribing the "pill" in preference to other methods. Whilst many women prefer to consult their own GP, DHSS figures show that a quarter of all women look for the wider range of specialised service offered by clinics. Very often they are stimulated by media-engendered anxieties about side-effects and there is evidence that more women are looking at the advantage of diaphragm caps, which seem to carry no health hazards. Family planning clinics are the main source of help with this method.

It must be noted that, for whatever reason, many East Hertfordshire women have demonstrated their preferences by travelling outside their district to obtain the service they want. They should not have to do this.

Finally, more good reasons for maintaining family planning clinics alongside GP provision:

- The increasing birth rate — 40% more school leavers in 1980 means more women at risk.
- Closing family planning clinics limits choices about contraception and creates more risk of unintended pregnancy, with the possibility of more demand for abortions.
- GPs and their traineees need specialised training to practise family planning. As yet few practice premises are recognised for training and few GPs are qualified family planning instructing doctors. How then will GPs acquire the necessary skills and how can community clinic standards be maintained?

X-ray hazards

X-rays are often very useful in diagnosis, but they also carry their own risks. Even at the low levels used in diagnostic radiology, there are still risks of cancer and genetic damage — with the latter leading to hereditary illnesses in future generations.

Two months ago (1) we published the findings of the National Radiological Protection Board's research into genetic damage caused by unnecessary diagnostic X-rays (2). To summarise briefly, the NRPB found that patients in 80 NHS hospitals were subjected to "enormously" variable amounts of radiation. Doses to patients' *gonads* — the testes and ovaries, where the sperm and egg cells are formed — were on average three times higher in some hospitals than others, for the same type of examination. Shielding to protect the gonads against stray radiation was used only one fifth as often as it should have been.

This article, based mainly on information from a recent edition of *Drug and Therapeutics Bulletin* (3), gives some more background on X-ray hazards.

It is important to get the size of the risks involved into proper perspective. For instance, out of a group of one million 30-year-old women, 10,000 to 20,000 would be expected to develop cancer of the bone marrow during the rest of their lifetimes, and 30,000 of their children and grandchildren would be expected to show signs of some hereditary illness. If the one million women were all examined using X-rays and a barium enema (to obtain X-ray pictures of the digestive tract) a further 15 cases of bone marrow cancer and another 54 cases of hereditary illness would be expected.

Similarly, one million mammograms (breast X-rays) of 30-year-old women could cause as many as 1500 extra breast cancers, in addition to the 30,000 or 40,000 which would have been expected anyway. One million 30-year-old men could be expected to produce 30,000 cases of hereditary illness in their children and grandchildren, but if the million men were all given X-rays of the hip and femur a further 180 hereditary defects would on average be expected to show up.

In women of child-bearing age, the possibility should also be considered that a foetus might be accidentally irradiated, increasing its risk of developmental abnormality, hereditary illness and cancer. In all women capable of bearing children, X-ray examinations involving exposure of the lower abdomen or pelvis should be performed within ten days of the onset of menstruation, unless postponement would lead to greater risk.

Repeated examinations involve increased risk, and so the *DTB* article concludes that the use of X-rays should be limited "wherever possible." Usually it is possible to make a diagnosis without X-rays, and then take a single X-ray to confirm it. Examinations should not need to be repeated because films are unsatisfactory or have been lost. Films should be transferred between clinics and hospitals where necessary, if this will avoid repeat examinations. "Radiologists and clinicians should be more ready to condemn unnecessary examinations", says *DTB*.

The variations in radiation exposure found by the NRPB survey appear to have been caused by differences in technique and in the types of equipment available in different hospitals. Practical methods of minimising dosage have recently been reviewed in a manual published by the British Institute of Radiology (4).

References

1. *CHC NEWS 60*, pages one and three.
2. NRPB reports R104, R105 and R106. £3 each from HMSO.
3. *Drug and Therapeutics Bulletin*, 20 June 1980. Price 75p inc post, from Consumers' Association, Dept. D/TB, Caxton Hill, Hertford SG13 7LZ.
4. *Radiation protection of the patient: A manual of good practice*, £2.95 inc post from the British Institute of Radiology, 32 Welbeck Street, London, W1M 7PG.

Your letters

Continued from page two

assistants' pay and community nurses' conditions of service

- Quarterly bulletin of circulars and other guidance material.

With the exception of the last, I cannot truthfully say that I needed any of these documents. Does anyone know how much public money is being spent each week on this indiscriminate tide of paper?

Joint consultative committees

Joy Gunter, Secretary, Dewsbury CHC

Since 1975 our CHC has been unsuccessfully requesting observer membership of the Kirklees Joint Consultative Committee. The probable change to two district health authorities from an area health authority with two districts may just provide an opportunity to succeed in obtaining representation on the JCC. I am collecting evidence to strengthen our case. I would be grateful if any of your readers who have JCC membership would get in touch with me.

NHS abortion services

Joanna Chambers, Co-ordinating Committee in Defence of the 1967 Abortion Act, 27-35 Mortimer Street, London W1N 7RJ

We are collecting information on NHS abortion facilities in Britain, and we would be very interested to hear from CHCs which have run campaigns — successful or unsuccessful — to improve NHS abortion services. We are particularly interested in day-care abortion units. We hope CHCs which think abortion facilities in their districts could be better will feel able to help us.

CHC members from voluntary groups

Barrie Taylor, Secretary, South West Herts CHC

There is one aspect of CHC membership which may affect all CHCs, whether or not changes are proposed in the forthcoming consultative document.

Many CHCs mentioned in their comments on *Patients First* that local authority nominees appeared to be heavily committed to a number of outside activities which made it difficult for them to attend CHC meetings. Currently, voluntary organisations nominate one third of CHC members. Maybe the number of voluntary group nominees should be increased — but would there be a sufficient number of organisations with an "interest in health" to fill the gaps?

In North West Thames region the number of voluntary bodies included in the RHA's lists has steadily declined. One cause of this decline has been the different ways of bringing them together for the CHC elections.

Organisations eligible to nominate to CHCs should be "voluntary" and have an "interest in health". In N W Thames "voluntary" has been interpreted as "non-profit making" and "interest in health" has permitted the inclusion of service-giving groups, health care pressure groups, fund-raising bodies, community associations and political organisations. Other RHAs may of course interpret the guidance differently.

Recently South West Herts CHC was asked for information about one of the 39 groups on its "voluntary organisations" list. Reference had been made in the group's literature to "registration with South West Herts CHC". Naturally this implies that the group has been given a particular status.

Further investigation suggests that the activities of this group are somewhat dubious. The CHC has explained that acceptance on the voluntary groups list neither implies approval of a group nor endorses its aims.

Perhaps CHCs could bear these sorts of problems in mind when they study the consultative document.

The "Domino" scheme

Alan Hicks, Secretary, Barnsley CHC

This CHC is studying the "Domino" (and similar) schemes for early discharge of maternity patients after delivery. In particular, we are interested to know whether other districts experience any restrictions, due to the ambulance service being unable to cope with short notice discharges, and what precautions are taken to guard against complications such as postpartum haemorrhaging etc.

We would be interested to hear from any CHC in whose district such a scheme operates.

Scanner

Forgotten children

Is the title of a study by North West MIND of mentally handicapped children living in long-stay hospitals in the North Western region. Not only are a number of these children rarely or never visited by their families but it also appears that AHAs and social services are confused about how many children live in their institutions. In some hospitals MIND found children whose existence was unknown by the authorities. Available from NW MIND, Suite 223, Miller House, Miller Arcade, Preston (£1.25 inc post).

Cadmium

Following earlier studies on lead and mercury the Department of the Environment has issued Pollution Paper 17 on the metal cadmium, which is used mainly for pigments, plating and batteries. Exposure to it is mostly through cigarettes and food — the average UK intake of cadmium in food is now within the World Health Organization's provisional maximum limit. As the paper explains, there are still many gaps in knowledge about the metal's toxic effects. *Cadmium in the environment and its significance to man* (HMSO £3.50).

Dangers in the home

More home accidents involved coffee tables than frying pans in a survey of non-fatal accidents presented at casualty departments in 20 hospitals in England and Wales. As well as providing such miscellaneous statistics *The home accident surveillance system 1979* discusses studies of accidents which include children swallowing medicine even from child-resistant containers, and mishaps from tin-openers, sunray lamps and spin-driers. Available free from Consumer Safety Unit, Department of Trade, Millbank Tower, Millbank, London SW1P 4QU.

Nasty tales

Another selection of cases dealt with by the Ombudsman has been published. Justified complaints include an elderly man in a psycho-geriatric ward who had another patient's teeth forced into his mouth and was sent home without underclothes; and a delay of 19 days before a psychiatric in-patient was X-rayed for what turned out to be a fractured thigh. But another patient who complained about events surrounding the safe delivery of her baby is censured by the Ombudsman for her "ingratitude". *Health service commissioner, first report for session 1980-81* (HMSO £6.90).

Of course in cases of clinical judgement dissatisfied patients have no redress to the Ombudsman and have to claim against their doctors. Examples of such cases appear in the 1979 annual report of the Medical Protection Society, the body which indemnifies doctors against claims, and advises and represents them. Medical Protection Society Ltd, 50 Hallam Street, London W1N 6DE.

Social security advice

Official guidance to the recent changes in the Supplementary Benefit regulations (see *CHC NEWS 60*, page four) is offered in the updated *Supplementary benefits handbook* (HMSO £2.40). Quite pricey for claimants, but the DHSS has also revised its free general guide to all benefits — not just SB. Called *Which benefit? 60 ways to get cash help (FB2/Nov 80)*, social security offices should have copies, or get it from DHSS Leaflets Unit, PO Box 21, Stanmore, Middx.

Child Poverty Action Group, who are soon to publish a new edition of their alternative guide to SB, the *National welfare rights handbook*, have produced a leaflet for claimants explaining that their benefits have been cut in real terms. *How the poor was robbed* is available free (send a sae) from CPAG, 1 Macklin Street, London WC2.

And from CHAR (Campaign for Single Homeless People) comes a new guide to *Supplementary benefit for single homeless people*. It deals with the particular difficulties faced by people trying to claim without a fixed address, or living in board and lodgings or resettlement units. £1.20 inc post from CHAR, 27 John Adam Street, London, WC2.

Second class NHS

"It is a political battle to save the NHS" say Counter Information Services in a hard-hitting diagnosis of the crisis in the health service.

In *NHS — condition critical* CIS compare the sickly health of the NHS with that of the "strong and growing" private sector and conclude that the NHS is being reduced to a "second class, emergencies only, service". Sections of the illustrated pamphlet discuss the power and profits of the drug industry, the campaigns against the cuts, and health services in South Wales. £1.20 inc post from CIS, 9 Poland Street, London W1.

CHC Directory: Changes

Single copies of the CHC Directory are available from *CHC NEWS* — please send a large (A4) self-addressed envelope with 25p in stamps.

Page 2: Hartlepool CHC Hartlepool Health District, 32 Victoria Road, Hartlepool TS24 7SE, Cleveland. Secretary: Douglas A Allan.
Page 3: Scarborough CHC Delete "Freepost" from the address. Secretary: John H Jacob.
Page 8: Brighton CHC Chairman: Miss Denise Greenwood
Page 8: Dartford and Gravesham CHC Chairman: Ernest Knopp
Page 9: Cuckfield and Crawley CHC Chairman: Mrs E H Ross
Page 10: Bath CHC Chairman: Mrs H L Osborne
Page 12: Plymouth CHC Tel: Plymouth 662412
Page 12: Salop CHC Tel at evenings and weekends: Telford 47570
Page 13: Wolverhampton CHC Chairman: Coun. A C Laws
Page 14: Lancaster CHC Insert "Regent Street" after "Victoria House". Chairman: Coun. Mrs J Taylor
Page 15: Manchester Central CHC Chairman: Harry Parrish
Page 15: North Manchester CHC Chairman: Mrs P A Barnes
Page 17: Meirionnydd CHC Chairman: Coun. T E Walker. Secretary: Emyr Davies
Page 19: South East Thames Regional Association of CHC Secretaries c/o Brighton CHC, 9 Portland Road, Hove, Sussex BN3 5DR. Chairman: Alan Brookes. Secretary "rotates". Tel: Brighton 71186
Page 19: Wessex CHC Secretaries Meetings c/o West Dorset CHC, Colliton Clinic, Glyde Path Road, Dorchester, Dorset. Secretary: David Russell. Tel: Dorchester 3123
Page 20: Dumbarton LHC Chairman: Coun. D Mills
Page 20: Annandale and Eskdale LHC Chairman: J Harkness
Page 20: Nithsdale LHC Chairman: Mrs M Bonn
Page 20: Stewartry LHC Chairman: Mrs I Anderson
Page 20: Wigtown LHC Chairman: W Service
Page 20: East Fife (Kirkcaldy District) LHC Chairman: Mrs C Hall
Page 20: North East Fife LHC Chairman: Mrs J Aitken
Page 20: Stirling and Clackmannan LHC Chairman: J McEwan
Page 20: Aberdeen LHC Chairman: N Wright
Page 21: Kincardine and Deeside LHC Chairman: Mrs V McDonald
Page 21: Moray LHC Chairman: Coun. J Russell
Page 21: Caithness LHC 17 Brims Road, Thurso. Chairman: Rev. W F Wallace
Page 21: Inverness LHC Chairman: Rev. N MacRae
Page 22: Midlothian District LHC Chairman: T Matthews
Page 22: Perth and Kinross LHC Chairman: R Calder
Page 22: Lewis and Harris LHC Chairman: A Nicoll
Page 22: Southern Isles LHC Chairman: I MacAskill
Page 22: North and West Belfast DC Royal Victoria Hospital, Grosvenor Road, Belfast BT12 6BA. Tel: Belfast 27156. Chairman: D K Sloan
Page 22: South Belfast DC Secretary: E Currie
Page 23: Newtownabbey DC Chairman C W W Torrance

News from CHCs

☐ **East Herts CHC** is opposing Herts AHA's plans to reduce family planning services. Clinics have already been cut on a temporary basis, but now the AHA wants to make the cuts permanent. In comments on the consultation document, the CHC says that women are having difficulty finding GPs to provide contraceptives and that in some cases GPs have prescribed a year's supply of pills or have refused contraception to unmarried women. After considerable discussion and division of opinion among members, the CHC agreed to recommend a review of the policy of providing free contraceptives. Some patients had advised CHC members that they would rather pay than see the clinics reduced.

☐ So far £200,000 has been raised by an appeal hatched and promoted by **Wolverhampton CHC** to build a 16-bed hospice for the care of the dying. The hospice will be built in the grounds of Compton Hall, a former NHS nurses' home. The RHA has provided a lease at peppercorn rent and a brand new unit will be built alongside the old house. The National Society for Cancer Relief has loaned £500,000 for building costs to a charity which the CHC has helped to set up.

Four nearby AHAs have promised to share in the revenue costs. Walsall, Dudley and Staffs AHAs will each pay for four contractual beds and Sandwell AHA will pay for one. CHC secretary Michael Domoney is the secretary to the trustees of the newly formed charity and Wolverhampton, Dudley, Walsall and Shropshire CHCs are all represented on the management committee.

☐ The system of dealing with council house transfers requested on "medical grounds" has been worrying **South Camden CHC.** At present it is up to the medical officer attached to the council to seek back-up evidence from transfer applicants' GPs. The CHC, after consulting local GPs and getting the support of some borough councillors, has persuaded housing officers to agree to change the system and to provide a standard form for GPs to fill in at the time of the tenant's initial request. But instead of distributing the forms to doctors, it seems they are only being sent out to a GP when the medical officer deems it necessary! The CHC will press on.

☐ Almost 800 patients were interviewed by **Harrow CHC** members to find out how long it had taken them to reach a health centre. **Torbay CHC** has organised an ambitious survey of the health needs of the elderly at home. Over 150 volunteer interviewers will conduct more than 1800 home visits and the survey will be processed on a health service computer. The CHC is paying out £200 and the report will be ready in the spring.

☐ A special liaison committee has been set up at Cane Hill Hospital's interim secure unit for mentally abnormal offenders. **Croydon CHC** is represented on the committee, whose task is to allay local fears about the safety of residents near the hospital.

☐ The effect of the Government's policy for smaller new hospitals is causing dismay in **Peterborough CHC.** There were plans to start building the new 690-bed hospital in 1982. Now the RHA has reviewed plans and decided that only 612 beds should be provided. The review has delayed the building start to 1983/4. The CHC's annual report asks, "If the original plans, formulated after years of study, concluded that a 690 bed hospital was needed, how can the community health council accept after only a few weeks' study that a 612 bedded hospital is the right size?" The council will continue to press for a 1982 building start.

☐ **South East Kent CHC** is pressing for joint funding to expand a pilot scheme for a soiled linen collection service from 20 homes in the district. The CHC says the scheme has proved crucial in helping to keep old people out of costly hospital beds. But the social services department is digging in its heels, in spite of health service backing for the proposal. The CHC has written to its county councillors, hoping to get their backing for the service.

Photo: Kent Messenger

☐ *A travelling exhibition of aids for the disabled came to* **Maidstone,** *thanks to the CHC and the Royal Association for Disability and Rehabilitation. CHC secretary June Ayling (far left) spoke to many of the exhibition's visitors. Prevention will be the CHC's main theme for International Year of Disabled People – it will be pressing for better genetic counselling and health screening.*

☐ "There's going to be a hell of a fight", said Cliff Vardy, **Kidderminster CHC**'s secretary, speaking about AHA plans to move 34 elderly patients into a purpose-built GP maternity unit. In September, because of the allegedly dangerous condition of an old ward block at the Kidderminster General Hospital, the district management team proposed an emergency closure of the ward, which housed elderly severely mentally infirm patients.

It planned to shift the ESMI patients to a geriatric ward and then to move the displaced geriatric patients into Lucy Baldwin Maternity Home. The Lucy Baldwin was saved from threatened closure just over a year ago. The DMT proposed to shift the maternity service to another GP unit in a converted old house.

Following CHC pressure, the AHA declared the closures and other changes to be temporary and issued a formal document for three months' consultation. At the beginning of last month the elderly patients were still in the "dangerous" building. The CHC secretary accused the AHA of flouting the consultation regulations — "They're playing a ludo game with all these changes — hoping the rules will catch up with them".

☐ A new centralised ambulance control for Kent has got them "jumping up and down" in **Medway CHC.** Local control in 17 stations in the county was replaced in February by control from two stations. The results were "horrendous" says CHC secretary Graham Hills. "The new service is now inefficient and inflexible", he said. The system was designed to be run by a computer. There is no computer. Ambulances have turned up to homes at the same time as the hearse. The psychiatric day-hospital has become almost impossible to run and now the CHC has complained to the Ombudsman.
It says the system was changed without proper preparation and without consultation.

Swansea/Lliw Valley CHC has written to Patrick Jenkin requesting "urgent reconsideraion" of the wording on the DHSS' multi-organ donor card. The CHC is concerned that the bodies of people who have signed the card may be used for medical research, even though they had believed that they were giving permission for their organs to be used for transplantation. This could lead to donors' bodies being kept under refrigeration for "an indefinite period of time", which might prove unacceptable to the donors' families. The wording should be altered so that "organs", not "parts of the body" are donated specifically for transplantation, not "for medical purposes". The CHC also suggests that a CHC representative should be included on DHSS working parties drafting such documents, to avoid similar problems in the future.