

# CHC NEWS

For Community Health Councils

March 1981 No 64

## KEEP IT LOCAL

The rights, powers and duties of community health councils have been warmly endorsed by the Government, in its long-awaited consultative paper on role and membership\*. But CHCs are to have fewer members, they can expect no overall increase in resources, and they have been told firmly that Ministers see them as local bodies without a voice in the NHS at national level.

The paper also challenges the need for the Association of CHCs to continue — just as in December 1979 the *Patients' first* consultative paper called into question the need for CHCs themselves.

Over the next few weeks of the consultation period, CHCs will have to discuss and decide on a wide range of questions crucial to their work. For instance:

- How can health authorities be encouraged to give CHCs the information they require?
- What assistance do CHCs need when drawing up "detailed and constructive" alternatives to closure proposals?
- How can the important relationship

### *Mr Jenkin's prescription for CHCs*

between CHCs and Family Practitioner Committees be strengthened?

- Should CHCs be allowed to visit private hospitals which provide NHS services under contract?
- Could CHCs cope with their work-load if their membership was reduced to 18 or less?
- Should the pattern of membership of CHCs be reversed, so that voluntary organisations appoint half the members and local authorities one third?
- Should members be allowed to serve for more than two terms of office, and should they automatically lose their seats if they have not attended a meeting for six months?
- Should the new District Health Authorities become the "establishing"



Photo: East Berkshire CHC

bodies for CHCs, and should the establishing body or the CHC itself employ CHC staff?

Rumours that the Government might seek to reduce CHCs' rights and powers have proved totally unfounded, and on the question of CHCs' power to block closure proposals the document states that "Ministers support this role of CHCs as a valuable aid to local decision-making". The document envisages that CHCs will continue in existence well beyond 1984.

Although the consultative paper offers no new rights or powers, it strongly urges other health service bodies to co-operate with CHCs in their "exacting task". Health authorities are told to "make every effort to consult CHCs on all matters of interest to them", and to provide CHCs with planning information "in good time to consider it adequately".

Family Practitioner Committees are urged to admit CHC observers—Ministers "are in no doubt about the value of this"—and health authorities are asked to allow CHC observers to remain during the "closed" parts of their meetings, unless there is a specific reason for exclusion.

The section on complaints is perhaps the most disappointing. The Royal Commission on the NHS's proposal for CHC-based experiments with "patient advocates" (see *CHC NEWS* 51 page 11) is dismissed because several other sources of help and advice are already available, and because extra funds for CHCs would not be justified.

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*For Comment see page three*

## Should long-stay patients' savings be put to work?

Millions of pounds in social security benefits are accumulating in the hospital bank accounts of long-stay NHS patients, and a way of releasing this money to improve the quality of patients' lives is now being suggested by the DHSS in a consultation paper\*.

The issue is of special concern in mental handicap hospitals, and the solution being suggested is the setting up of clubs to which patients could

subscribe income which was surplus to meeting their personal needs. Patients' clubs would make purchases and arrange activities to "improve the quality of life of their members".

Patients who were able to manage their own affairs could decide whether to subscribe, but in most cases it would be up to the "appointee"—the health authority, or a parent or relative—to decide. Clubs would be managed by committees independent of the health authority, and would not be allowed to spend money on goods or services which the NHS should provide.

Clubs could buy minibuses, adapted coaches or caravans, or equipment for recreation rooms. They could pay volunteers to help wheelchair-bound patients get out and about, they could arrange outings and show films.

In March 1980, the amount of money held for patients by AHAs in England was £25.8m, but the DHSS proposals would not affect existing balances.

\* *Patients' money in long-stay hospitals*, DHSS January 1981. Copies from Mrs Vera Demmery, Room C414, Alexander Fleming House, London, SE1 6BY. Comments by 30 April.

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#### New priorities

The DHSS has just published *Care in action* its new priorities document for health and social services in England. Details will appear in *CHC NEWS* next month.

\* *CHCs in England: Consultative paper on role and membership*, DHSS January 1981. *CHCs in Wales*, Welsh Office January 1981. Comments by 30 April.

# Your letters

## CHC NEWS and politics

Mrs Laurie Millward, Secretary,  
Edgware/Hendon CHC

I read with some surprise D E H Russell's letter in *CHC NEWS* 62. This council is highly sensitive to the need for CHCs to do their utmost to stand apart from party politics, and I have never before heard this criticism levelled at *CHC NEWS*. Any discussion of the provision by the state of health or social services is by definition political, in the wider sense of the term.

My own view, and I know that of most members of this council, is that *CHC NEWS* serves a very useful function, presenting a variety of news and educative information to members in a highly readable manner. This can only enhance the image of CHCs to outside readers.

## That fluoridation survey

Professor Neil Jenkins, Chairman,  
Newcastle CHC (but writing in a  
personal capacity), and Chairman  
of the Fluoridation Society.

Your correspondents Margaret Barnett, R J Condon and Andrew Staite (*CHC NEWS* 60 page two) make many statements about fluoridation which are either misleading or untrue.

The number of fillings of deciduous teeth in Birmingham did increase from 4367 in 1964 to 15,616 in 1975, but this must be considered in the light of the massive fall in extractions from 44,410 to 13,813 over the same period. If 30,000 fewer teeth are extracted it is not surprising that some of them develop cavities that can be filled. In Kilmarnock, the number of cavities did fall during the five years of fluoridation, and

increased back to the original level in children born after fluoridation was discontinued. It was ended not because it was ineffective but owing to misunderstandings over its cost.

It is quite wrong to state that the benefits of fluoridation are confined to children. All surveys among adults in naturally fluoridated areas show some protective effect throughout life. In Hartlepool, for example, it is still detectable even at the age of 65. Artificial fluoridation has not been used long enough to test its effect on the middle-aged.

Fluoride tablets are effective in children if their regular use can be guaranteed (which is difficult), but, unlike fluoridated water, tablets are unlikely to be taken after childhood and their long-term protection is not known. They are more — not less — expensive than water fluoridation, which costs about 10p per head per year.

Paul Castle, Public Relations Officer,  
West Midlands Regional Health  
Authority, Arthur Thomson House, 146  
Hagley Road, Birmingham B16 9PA

Predictably, the publication of opinion survey data on fluoridation has generated the stock protest letter from opponents who are now being told by a scientifically conducted national poll what they would prefer not to hear (*CHC NEWS* 60).

We set out to discover once and for all what people really think, as opposed to what the diehard opinion says they think. We sub-contracted the job to a highly reputable agency skilled and experienced in this specialised field. There was no desire or attempt by anyone to "cook the books." The 2000 respondents had no idea of our identity, so they could not have been swayed by the idea that the medical or dental profession was behind the survey.

The questions asked were devised to test knowledge and opinion — no attempt was made to pre-dispose respondents one way or the other. Some opponents argue that we should not have mentioned the issue of tooth decay in the questions, but how can you ask someone whether they support something without saying what it is for? Moreover, we were careful to use the words "if it reduces tooth decay" rather than "because it reduces tooth decay."

The genuinely impartial studies carried out over recent years show a majority in favour of fluoridation. One such study, carried out in 1976 by Winchester and Central Hampshire CHC, was reported in (*CHC NEWS* 15 page 10). Last year *Which?* magazine investigated fluoridation and concluded: "There is no other method that would ensure so reliably that children's teeth get the fluoride they need to make them strong, healthy and free from decay". In 1978 the Consumers' Union of the United States, where 100 million people drink fluoridated water, claimed: "The simple truth is that there is no scientific controversy over the safety of fluoridation. The practice is safe, economical and beneficial".

J D Robertson, Member, Northern  
Sheffield CHC (but writing in a personal  
capacity)

Fluoridation should be stopped at once, for it is plainly illegal on a number of counts. Already an action has had a preliminary court hearing in south west Scotland, and a further hearing — much overdue — is pending in west Yorkshire. The DHSS is conniving with the water and health authorities to ignore the laws made for our protection against forced medication. Fluoride is used to treat the patient, not the water. Yet the treatment of water to make it safe to drink is used as an argument to introduce fluoride — a medicine.

The DHSS's own figures show clearly that there is no protection for permanent teeth. Fluoride retards the growth of teeth and bones, and the results for deciduous teeth are in part due to delayed eruption. Teeth do not begin to decay until they have erupted and been put to work. In Bristol, which so far has successfully opposed fluoridation, five-year-old children starting school this year are 61% free from decayed teeth, while in Scunthorpe, after ten years of fluoridation, the figure is 50%.

The pity of it is that so many sincere people — including professionals who have not done their homework — accept the persistent propaganda. This stemmed initially from the industrial interest of ALCOA, the American Aluminium Corporation. The pollution of our water with highly toxic industrial waste is an offence against human rights.

## Tact and transplants

Anthony Bradford, Secretary,  
Northallerton CHC

One of our members, a driving instructor, recently pointed out that donor cards are sent automatically to everyone applying for a provisional driving licence. Members felt that this could be considered tactless, especially in the case of younger recipients, although the CHC was in favour of cards being sent to those applying for a full licence. What are the views of other CHCs?

## Dusting down Utopia

Elizabeth FitzRoy, Elizabeth FitzRoy  
Homes, The Welfare Department, The  
Coach House, Whitegates, Liss, Hants  
As the mother of a handicapped child and Welfare Trustee for the Elizabeth FitzRoy Homes, I would like to support the view of the Campaign for Mentally Handicapped People in their latest report "Even better services?" (*CHC NEWS* 60 page one). Many parents are growing weary of proposed legislation and conflicting priorities, which hold out hopes for a future Utopia but are too often relegated to collect dust on official shelves.

I am particularly concerned at the slow progress being made in transferring

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

## CHC NEWS

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# Comment

Consultation is upon us once again. The consultative paper on the future role and membership of CHCs has at last emerged.

At first sight it is an innocuous document. It confirms CHCs' right to be consulted and to attend meetings of the new District Health Authorities (DHAs). It urges family practitioner committees to open their doors to CHC observers. And it proposes changes in size and distribution of membership which follow representations made by a number of CHCs themselves in response to *Patients first*. This time it is only the survival of the Association of CHCs (ACHCEW) which is questioned.

Re-reading the paper however, the snags begin to emerge. Ministers see CHCs as local bodies "not having a role in the formation of policies at national level", their main job being to keep local health services under review. Ministers do not think it appropriate that Regional Health Authorities (RHAs) should be required to consult CHCs on certain issues, nor do they propose that CHCs should "extend their role formally" in assisting complainants.

Such negative officialese often

implies more than its face value and acts as a curb on existing activities rather than a bar to change.

It is extremely important for CHCs that this document does not have that result. Effective representation of the interests of NHS users may sometimes only be possible by pressing for Government or other national action. Ruling out the possibility of consultation between RHAs and CHCs at a time when the *precise* split of responsibility between the districts and regions is unknown could inhibit CHCs' ability to be effective — even in monitoring local health services. And any reduction in the freedom of CHCs to choose how they carry out their role as "patient's friend" will diminish one of their few *visible* public services.

Changes to the size and membership of CHCs are proposed. It is easy to calculate that a CHC which at present has 30 members, 10 of them "voluntary", could end up with 18 members, only nine of them "voluntary". Although DHAs will normally only have 16 members comparisons between the two bodies are quite misplaced — the role of CHC

members is quite distinct from that of DHA members. Reduction in the number of CHC members may proportionately reduce CHCs' ability to do their jobs. Switching the proportion of "voluntary" and "local authority" members *need* not be a bad thing, but it is worth asking what use is made of each type of member before opting for change.

Finally to ACHCEW. Obviously a national body with a campaigning voice does not fit into Ministers' scheme of things, and they may well feel that CHCs are willing to "trade in" the Association in return for a guarantee of their own security. Yet in fact CHCs already pass judgement on ACHCEW every year, by choosing whether or not to belong. There is much room for debate among CHCs about ACHCEW's performance. This is healthy, and should continue as long as need be, but it is not necessary for Ministers to pitch in and try to tip the scales.

ACHCEW worked hard in support of CHCs when Ministers challenged their existence a year or so ago. It is now up to CHCs to show what support they are willing to give to ACHCEW.

## Health News

### Paring down the planning systems

The Government's concern to pass as much NHS decision-making as possible to local levels is enshrined in its consultative circular on the NHS planning system\*. The new district health authorities (DHAs) will be the basic planning units and for the first time there will be district *strategic* plans, issued every five years. *Operational* planning will be slimmed down and instead there will be *annual programmes of action* focusing on just a few key areas selected from the strategic plan.

The division of strategic planning responsibility between DHAs and the regional health authorities is left somewhat vague in the circular. The future of health care planning teams is not mentioned. Some CHCs have been able to influence local planning through representation on these teams. Next month's *CHC NEWS* will be exploring the details of the new planning system and its implications for CHCs.

\**Review of the NHS planning system — a consultative document* (HN(81)4). The circular was issued at the beginning of February and comments are required "within three months", to the DHSS, Planning and Information Branch, Alexander Fleming House, London, SE1.

### Transports of delight?

Comments are invited on the future role of ambulance services and the transport needs of patients. A consultative document presenting various provisional conclusions

and questions has just been published by the Patient Transport Services Working Party, which was set up by Regional Health Authority chairmen in March 1980.

Contrary to popular myth there was no evidence of "gross misuse of the ambulance service" which the working party could find. But it does see a need for a clear definition of who should have ambulance transport — it suggests those who need immediate transport to hospital because of accident, emergency or serious illness; and those whose mental or physical condition precludes them making necessary journeys to hospital on their own.

Reorganisation of the health service will necessitate decisions about which health authority is to manage ambulance services — the District Health Authority, the RHA, one DHA on behalf of others, or a special health authority. The working party presents the *pros and cons* of all these options and considers that the new DHAs should be able to choose the most suitable for local needs.

The creation of a two-tier system — providing an accident and emergency ambulance service completely separate from routine patient transport — is ruled out.

Comments by 31 March to the Chairman, Patient Transport Services Working Party, c/o Trent RHA, Fulwood House, Old Fulwood Road, Sheffield S10 3TH. Tel: Sheffield 306511

### Health and the homeless

Only half the residents in hostels for the single homeless were registered with local

GPs, in a recent survey. The Association of CHCs and CHAR (the Campaign for Single Homeless People) asked selected CHCs and CHAR members across the country to monitor the health care of single homeless people — a group who "suffer certain forms of ill-health and disease to a markedly greater degree than the general population".

Many GPs in *all* areas were found to be unwilling to have hostel residents on their lists — with the result that those GPs who will take them on get rapidly overburdened.

In some of the big cities GPs conduct regular surgeries in the hostels or day-centres themselves, but overall this is uncommon. And opinion is divided about the value of these "in-centre" surgeries — many local CHAR groups believe they emphasise the stigma and isolation of being homeless.

In all the areas covered by the survey, casualty departments were used by the single homeless "as a substitute for the inadequacy or non-availability of GP services". Research indicates that this is *misuse* rather than *abuse*. And most of the survey's respondents reported problems for homeless people using casualty services — South Camden CHC said they were often "just sent away".

A draft report of the survey is available from CHAR, 27 John Adam Street, London WC2. Tel: 01-839 6185. ACHCEW and CHAR are holding a conference on health and the homeless on 25 March. Details from Maggie Warner at CHAR.

# Health News

## The ups and downs of RAWP

RAWP — the Resource Allocation Working Party's formula for gradually eliminating regional inequalities in NHS spending — seems back in favour with the Government.

In 1981/82 the "poorest" region according to the formula (Trent) should move from 9.8% below its RAWP revenue "target" to 6.6% below, and the gap between the "poorest" and "richest" regions will close from 22.2 points to 19.4.

Before RAWP began, in 1977, the gap was 29 points, and to achieve David Ennals' promise of regional equality by the mid-1980s an annual shrinkage of at least three points was needed. In 1979, the last year of the Labour Government, the gap shrank by 2.4 points, but in 1980 Patrick Jenkin's first set of allocations produced a token reduction of just 0.4 points — throwing the future of resource reallocation into doubt.

Mr Jenkin's 1981/82 allocations will close the gap by 2.8 points, seemingly pushing RAWP more or less back on course. This year the ten "below target" regions will each move an average of 2.2 points in the right direction, as against 0.6 points in 1980/81.

Yet peculiarities continue to abound within the RAWP system. The four Thames regions will each move further away from their targets with each year's allocation. Even stranger, DHSS figures appear to show that despite gaining from RAWP with each of the last three year's allocations, the South Western region has moved 1.37 points away from its target.

Figures for the East Anglian, North East Thames and Wessex regions show the same anomaly.

On 6 February Health Minister Dr Gerard Vaughan gave figures to Parliament which show that the RAWP targets themselves are shifting yearly, sometimes by quite substantial amounts. Between 1979 and 1981, for instance, the North East Thames region's target rose from 8.14% of total NHS revenue spending in England to 8.26%, and the West Midlands' share fell from 10.81% to 10.66%.

Planned growth in regional revenue spending ranges from 0.5% to 3%, but in setting cash limits for the NHS the Treasury has allowed only 6% for pay increases and 11% for increases in other NHS costs. If these limits are exceeded, planned growth will not be realised.

## London to lose over 4000 beds

Acute hospital services for Londoners should be squeezed into the capital's 23 largest hospitals and more than 4000 acute beds in smaller hospitals should be closed over the next seven years. This is the conclusion of the London Advisory Group's 11-page report\* to the DHSS. The Government has asked the four Thames regional health authorities to act on the recommendations with urgency.

The document endorses the conclusions of the London Health Planning Consortium (see *CHC NEWS* 53 page four) for a rationalisation of London's acute hospital services. It says that inner London's population is falling and closure of the

acute beds will free resources for spending on better services for the elderly, mentally ill and mentally handicapped, as well as on primary care. At present London has 15% less geriatric beds than it should have and many elderly patients are "blocking" costly acute beds because geriatric beds and community care are not available.

The report makes no specific proposals as to which local hospitals should be closed or should change their function between now and 1988. It simply names those which it considers should provide the city's acute services. There is no discussion of the impact of the acute bed loss on patients in outer London and the Home Counties who now get treatment in the capital.

Nor does the report make any concrete suggestions about where elderly patients are to go when the "blocked" acute beds have been closed. It admits that the reductions it recommends will only add to the burden being carried by the already inadequate "Cinderella" services. Almost 2000 beds were lost between 1977 and 1979 and local government cuts in London have been particularly severe.

The resource-thirsty teaching hospitals have traditionally been a major stumbling block to creating a balanced health service in London. This report includes them all in the list of acute hospital centres and says that some of the smaller post-graduate specialist hospitals should be rehoused within them.

\* *Acute hospital services in London*, report of the London Advisory Group. From DHSS, Regional Liaison Division, 286 Euston Road, London, NW1 3DN.

## KEEP IT LOCAL

*Continued from page one*

Ministers are "of the firm view" that CHCs would be more effective if they were smaller, and "do not think it right" that they should have many more members than their corresponding DHAs. A maximum of 18 members is proposed, though up to 24 might be allowed "in a few large districts".

The document notes that some local authority members have found it hard to combine CHC work with other demands on their time, and that in many places there is "fierce competition" amongst voluntary organisations for CHC seats. Ministers conclude that there is "a strong case for reversing the proportions of members appointed by these bodies so that at least half would be appointed by voluntary organisations and about a third by local authorities". To avoid "undue disturbance" any such change would not be implemented before 1984.

At present the remaining one-sixth of CHC members are appointed by the Regional Health Authorities as "individuals who can make a special contribution but are outside the ambit of the other appointing bodies", and it is suggested that this category of member should be retained,

though in future it might be better if they were appointed by the new DHAs. Trades councils are to lose their reserved place in this category, but will be able to participate in the election of voluntary organisation members. It is also suggested that one of the local authority members of each CHC could be a representative of local parish, community or town councils.

A short section on the Association of CHCs for England and Wales reads as follows: "The Association has now been in existence for several years, though not all CHCs are members. The need for CHCs to have a national association at all is sometimes questioned. Ministers suggest that CHCs take the opportunity to consider whether the Association should continue".

ACHCEW's chairman, Rod Griffiths, commented: "The Government has accepted that CHCs' activities and their demands for collaboration from NHS authorities are legitimate, which is the most important thing .... I am glad Mr Jenkin has put this Association's future into the hands of CHCs themselves, because they are best placed to know how valuable our advocacy at national level has been. CHCs have frequently asked us to look for a solution when all local avenues have been

exhausted. It is obvious that some problems can only be solved by Government action. I cannot agree that CHCs have no role in national policy formation".

A similar paper on CHCs in Wales was published a week after the English document. It takes a noticeably softer line on reducing the size of CHCs, suggesting only that "there is room for reductions in the size of CHC memberships (except in the smallest CHCs), particularly in those with more than 25 members". The claim that smaller CHCs would be more effective is replaced by the suggestion that they would not be *less* effective. There is no proposal to axe the places on CHCs reserved for trades councils, and on the need for ACHCEW the paper observes that Welsh CHCs already have their own non-statutory association. The proposal that Welsh CHCs should form sub-committees to liaise with NHS unit management is repeated, with an undertaking that "there would be no question of such sub-committees becoming house committees involved in management".

Most of the new DHAs will be in existence by April 1982, and the new CHCs are expected to begin work as soon as their corresponding DHAs are established. Guidance on timing and transitional arrangements will be announced as part of the response to this round of consultation.

# NEIGHBOURHOOD HEALTH PROJECTS

by Helen Rosenthal, Vice-Chairwoman,  
City and Hackney CHC

In 1976 a group called the Foundation for Alternatives decided to set up six neighbourhood health projects, to look at the application of community work to health education. Six people were appointed to work attached to community organisations in Liverpool, London, Belfast, Sheffield, Milton Keynes and Derry, but by the autumn of 1978 only the London project, based in Deptford, was still in existence.

Meanwhile other projects were emerging out of particular neighbourhood needs. In London, the Camden Council for Community Relations is working with local Asian women on health and dietary matters. Pitt Street Settlement, in Peckham, and the Waterloo Action Centre, each support flourishing neighbourhood health projects. Inner City Partnership funds are being allocated to the new health projects in Hackney (see *CHC NEWS* 52 page 13), and to the Thornhill Neighbourhood Project in Islington.

All these projects are based in deprived, working class, inner-city areas, and all try to counter the individual and disease-based models of ill health on which our health services are organised, recognising that ill health is actually created by society in various ways. Their activities reflect a recognition of the links between social class, poverty and health. They all employ people trained and experienced in community work, rather than in medicine, nursing or health education, to work on health issues in small geographical areas — often a housing estate.

Some of the projects have flourished and others have not. Viability seems to depend on the degree to which the project is rooted in the community. Reports from the project workers in Milton Keynes and Liverpool make it clear that they felt the collapse of these two projects, in September 1978, was due to the arbitrary way the locations were chosen. The management group was geographically distant and irregularly involved, and the expectations of this group — made up of senior consultants, GPs, academics and health educationalists — were at odds with those of the workers and

the local "host" organisations. By contrast the three established projects in south London, at Deptford, Waterloo and Peckham, have all grown out of existing local community or action centres where a range of other activities also takes place.

At the Waterloo Health Project, work with the elderly has involved introducing health topics into discussions and activities at old people's clubs and groups, and initiating new groups and projects. In one club, a series of discussions were held on topics like relaxation and exercise, diet, the uses and danger of drugs, and massage. There have been discussions on "going to the doctor", and a public meeting on rheumatism.

Work on women's health developed from a small women's group. Discussion topics included pregnancy, slimming, smoking, sex, family planning, and bringing up

children in flats. The group met a GP to discuss contraception, made bread, saw films on breast examination, the Leboyer birth method and drugs. It obtained funding for a local "drop-in" centre for mothers with toddlers, and helped set up keep-fit and yoga groups and a group for menopausal women.

Other projects have included some quite different activities, eg the Deptford project has taught massage and body awareness in a nearby GP surgery. The Peckham project has helped local people make a video film about doctor-patient relationships, which has been shown to many other community groups and groups of medical students. Each project has developed according to local needs and interests — there is no "blueprint".

So what are these projects achieving? Probably their most important common feature is

their work with small groups of local people, discussing their private experiences and learning together how to seek out and use specialist information from health professionals and the medical literature. This kind of group activity is important in combating apathy, mystification, and acceptance of poor health and poor treatment, all of which are barriers to better health. The projects are also important catalysts — they can stimulate adult education centres, schools and health education departments to set up classes and courses.

The question of developing approaches to the NHS itself is more problematic. At City and Hackney CHC we see the improvement of local health services and their greater sensitivity to the needs of local people as an important goal. We do not see our community health projects as "alternative" health initiatives. So far the main emphasis of existing projects' work has not been directed towards the health service itself. While the projects recognise the importance of NHS issues, these lie uneasily next to the very different style of work involved in neighbourhood development.

The burden of demonstrating the success of community approaches to health falls at the moment on a very small number of projects. Much of the project workers' time may be taken up with the search for funds, and they must be decisive about where and how to concentrate their limited time and resources. Evaluation is important, but community health workers must develop their own criteria for this.

If health projects are not yet demonstrating significant changes in the health of their communities that can be measured by traditional methods, it is because this is not their intention. What they are doing is creating a climate in which some of the most oppressed and deprived sections of our urban communities can find a voice to challenge the forces which determine their health and control both the quantity and quality of the health services to which they have access.

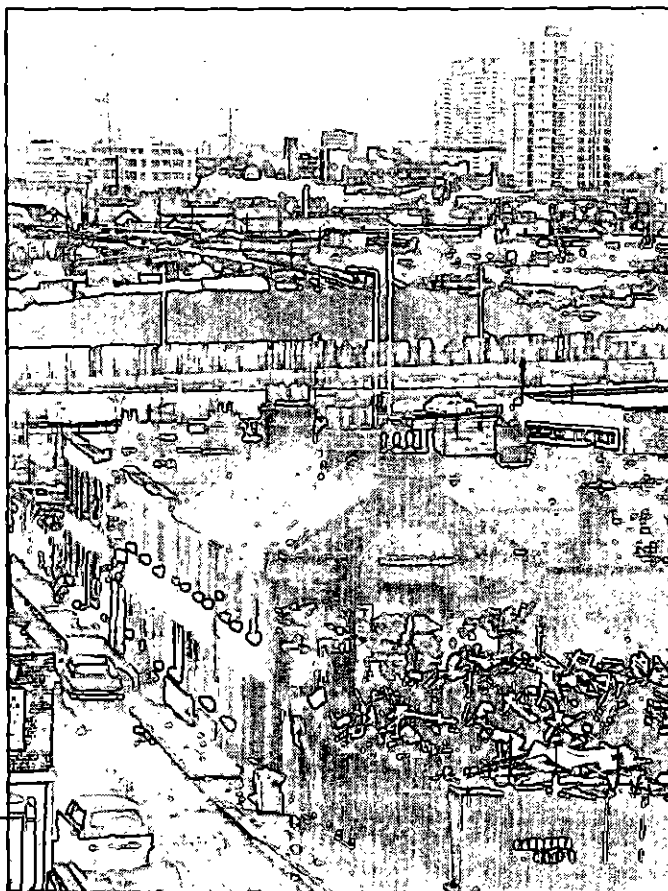


Photo: Raissa Page

# Your letters

*Continued from page two*  
mentally handicapped people, including children, from hospital to appropriate provision in the community, and at the Government assumption pointed out in your columns by Ann Shearer that there will always be a need for long-stay hospital care (*CHC NEWS* 60 page 11).

The Elizabeth FitzRoy Homes Trust came into existence 18 years ago, because of our belief that the mentally handicapped of all ages and disabilities can live in small family units integrated into the community. We now have seven homes and more in the pipeline. Not only is this kind of life the basic right of mentally handicapped people, as the Jay Report emphasised, but it is a Christian precept which we have proved to be both practicable and financially economic.

The unique position of CHCs, poised somewhere between the heights of Government and local authorities and the grass-roots of life as lived by those who look after the handicapped, surely gives them special responsibility to press the planners for a more humane attitude towards the most defenceless members of our society.

## Double drug trouble

*Pauline Phillips, Secretary, East Hertfordshire CHC*

My CHC has had a complaint from a lady who feels she has been overcharged for a prescription. She had been put on a course of *Cyclo-Progynova*, which consists of two different types of tablet packaged together in a "duo-pack". She was charged for two items and considered that this was wrong, as the tablets could not be taken separately and were in her eyes a single prescription.

The Family Practitioner Committee confirmed that according to the regulations a double charge for a duo-pack is correct. The lady then wrote to her MP, who replied that he found the regulation unfair and would be taking it up with the Secretary of State. She has asked my CHC to support this attempt to change the rules, but we feel that one CHC alone would carry little weight. Do any other CHCs feel strongly about this issue, and if so should we approach the Association of CHCs to seek its help nationally?

*Michael Quinton, Secretary, Bristol CHC*

*Migraleve*, a treatment for migraine, attracts a double prescription charge because it entails the use of two separate drugs. The two tablets are packaged together and have to be used together — neither is effective on its own. This seems to be a totally unfair situation for migraine sufferers. Are any steps being taken to get this charge reduced to that for a single prescription item?

*Dr Andrew Herxheimer, Editor of Drug and Therapeutics Bulletin, writes:* The double prescription charge for *Cyclo-Progynova*, *Migraleve* etc is logical but needlessly rigid and obviously unsatisfactory for patients — as well as for manufacturers, doctors and pharmacists. The manufacturers must bear

part of the blame, since they knew the rules when they introduced these products. None of these products is in my view essential — many doctors see no need to prescribe them at all. However, I think the DHSS should be pressed to make the application of prescription charges more equitable than it is at present. Perhaps there is a case for a medical committee to advise whether particular duo-packs should be available for a single prescription charge.

## Your funeral or your life!

*Bernard Ineichen, Member, Bristol CHC*

The Association of CHCs' call for a substantial increase in the death grant deserves all the support it can get. Such an increase would go beyond merely providing financial security for those coping with the death of relatives — it would have a marked influence on the way large numbers of relatively disadvantaged people spend their money.

Recently I interviewed some 200 twenty-year-olds who had grown up on a large council estate. About one in three had some kind of life insurance policy. There was little evidence that this was the best form of saving for them, and they seemed to have done very little "shopping around". Misunderstandings, misjudgments and subsequent loss of capital were frequent.

Families of the mentally handicapped also appear to make extensive use of life insurance. About a quarter of a sample of fifty families interviewed recently had taken out a life insurance policy on their mentally handicapped relative, invariably to cover funeral costs, and others had attempted unsuccessfully to do so. Raising the death grant to a realistic sum would make many life assurance policies redundant — these families need every penny they can get for living.

## Please tell us ...

*Hazel Jones, Secretary, Enfield CHC*

Local information suggests that use of NHS resources for private out-patient consultations is not always officially arranged with hospital managements. In this district no regular check is made on the use of NHS facilities for private consultations, and we feel that it would be reasonable to require consultants to complete a monthly return about this. It would be helpful to hear from other CHCs whether any system of checking takes place in their district, and whether they feel that there is a need for DHSS regulation on the above lines.

*Doris Pirt, Secretary, Solihull CHC*

For some time this CHC has been concerned at the inability of our AHA to attract qualified nursing staff, despite the two extensive publicity campaigns it has run. We feel an answer to the problem would be to encourage nurses who left to have children to return to the service, by providing "child minding" facilities. However, the AHA has dismissed this idea, saying that the demand would be

insufficient to justify the cost. We would very much like to hear from other CHCs which have this facility within their area. Is it an aid to recruitment, what is involved in terms of buildings, staff, etc, and is the scheme self-financing?

## Our ethical entrée

*D Margaret Ross, Secretary, Hastings CHC*

Area Health Authorities should be encouraged to consider choosing a CHC member as the lay representative on their ethical committees. Perhaps our experience may prove a useful pointer for action.

When the DHSS circular HSC(IS)153 was issued, in 1975, we asked our District Management Team to consider appointing a lay member to the ethical committee. A list of desirable attributes for a lay member of an ethical committee was agreed, and it then seemed natural to look first to the CHC for someone who would "fit the bill". There was no difficulty in identifying a CHC member willing to serve, and the CHC's nomination was supported by the DMT in a submission to the AHA.

Over the years, whenever a new lay member has needed to be appointed, this agreed procedure has been followed. Each time there has been a CHC member able and willing to act as the lay representative and the resulting appointment has proved appropriate. It is of course implicit in our arrangement that if for some reason it became necessary for the AHA to look beyond the CHC for a lay representative, this would be accepted.

## Friends by Post

*Mrs Ilse Salomon, Friends by Post, 6 Bollin Court, Macclesfield Road, Wilmslow, Cheshire SK9 2AP*

For the past 20 years our organisation has arranged about 22,000 postal friendships for lonely people of all ages and all walks of life. The idea behind it is that a letter is the simplest and cheapest weapon in the fight against loneliness.

We now feel we can expand further and reach out on a nationwide scale to perhaps the loneliest of all, the long-stay patients in hospitals and homes, as well as the disabled living alone. Amongst them are many who have retained a lively mind but have no one to communicate with.

We already have a list of letter-writing helpers eager to correspond regularly with patients. But so far we have no patients for them. Patients would not, of course, write to us of their own accord but need encouragement from those who look after them.

We have address labels to be passed on to patients who could benefit by a regular letter exchange. So nurses etc have only to contact us for the labels. The patients could then send us a stamped addressed envelope and we will send them our explanatory leaflets. Apart from the SAE there is no charge.

We would be grateful if CHCs would bring our service to the notice of nursing staff, social workers and wardens.



# How the doctors have their say

The history of the NHS has also been the history of hospital consultants' attempts to defend and extend their influence, and to speak with a single voice despite the increasing specialisation within medicine.

Before 1948, consultants worked in the voluntary hospitals for little or no pay, in return for the use of private beds, and so could usually expect to get their own way. The municipal hospitals were administered by medically-qualified medical superintendents. But in the new NHS, hospitals were taken over by Hospital Management Committees and Boards of Governors — predominantly lay bodies with lay administrators.

Medical Advisory Committees and Hospital Medical Staff Committees began to spring up in response, and in 1953 their existence was recognised in a Ministry of Health circular. But in the 1960s the feeling grew that large committees of consultants, meeting as equals and jealous of their clinical independence, were just not up to the tasks of forward planning, resolving disputes between specialties and working out corporate medical policies.

In 1966 the Ministry of Health and the Joint Consultants' Committee set up a Joint Working Party on the Organisation of Medical Work in Hospitals, to "consider what developments in the hospital service are desirable in order to promote improved efficiency in the organisation of medical work". Chaired by the then Chief Medical Officer Sir George Godber, this committee produced reports in 1967, 1972 and 1974 (1). These quickly became known as the "Cogwheel" reports because of their cover design of four interlocking cogwheels, symbolising the need for coordination between hospital medical specialties.

The committee argued that because medical factors "play a decisive role in a very high proportion of all important general policy decisions" doctors must begin to take a "leading part" in management. Individual doctors' clinical freedom was important, but "arrangements must also provide for the planning,

coordination and control needed to ensure that limited resources are effectively employed".

To achieve these goals, it was recommended that medical staff in the various clinical specialties should be grouped into Divisions, eg medicine, surgery, anaesthetics, obstetrics, pathology. For instance a Division of medicine might include general physicians, paediatricians and geriatricians. Members of each Division would send representatives to meetings of a *Medical Executive Committee* (MEC), which would consider reports from the Divisions, review major policy and planning issues and "coordinate the medical activities of the hospital as a whole".

Consensus views about preferred policy options and the best use of resources would be worked out in the MEC and later argued for, if necessary, with dissident Divisions and consultants. The chairman of the MEC would act as the "chief medical spokesman" for the hospital or hospital group.

The recommendations were taken up fairly enthusiastically, but with some patchiness and local variation. By 1972, Cogwheel-type structures were established in 114 out of 181 large acute hospital groups in England and Wales, though in some cases Divisions existed without MECs. In some hospitals consultants also continued to meet in Hospital Medical Staff Committees, and in other places Divisions were established but later fell into disuse.

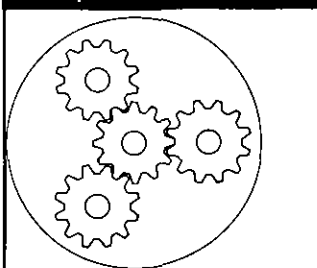
Cogwheel was never intended as a rigid formula, and the variety of structures that have developed makes it difficult to generalise about the current "state of play". According to one recent account (2), the MEC chairman is now often also the consultant member of the District Management Team (DMT). MEC meetings are often the focus of intense lobbying during disputes between specialties, and "advocacy, tact and plain 'horse trading' are often required". Some MECs also

act as ethical committees, but this is not good practice because it prevents lay involvement.

Divisions regularly consider "all activities which concern the general welfare of the patient", eg they look at waiting lists, lengths of stay, use of theatre time and out-patient facilities, patient transport and complaints. Other Divisional business includes deciding on new and replacement equipment, monitoring working hours, duty rotas etc, and making training recommendations.

Further complications arose in 1974, when the "Grey Book" plan for NHS reorganisation introduced District Medical Committees (DMCs) and Area Medical Advisory Committees (AMACs). DMCs were

First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals



intended to serve as a forum in which representatives of GPs and hospital doctors could meet to develop integrated policies for medical care in their districts, and AMACs were supposed to advise Area Health Authorities on medical policy.

The Grey Book suggested that MECs should be relegated to optional sub-committees of the DMCs, but the final Cogwheel report argued strongly that MECs and DMCs had complementary roles to play. In practice MECs have often continued, with their chairman sometimes serving as one of the two DMC representatives on the DMT and sometimes also being chairman or vice-chairman of the AMAC.

By the time of the Royal Commission on the NHS's report, in 1979, it was clear that existing professional advisory

machinery and arrangements for medical involvement in management were over-elaborate, overlapping, time-consuming and confusing. Parts of the system had fallen into disuse, and simpler ad hoc solutions were growing up locally. There was a strong body of opinion that the new DMCs were a failure.

In December 1979 the *Patients first* consultative paper agreed with the Royal Commission that a simplified structure was needed. Proposals for this were published recently for comment (3), and if implemented these will probably tend to strengthen the Cogwheel structures. A *District Hospital Medical Committee* (DHMC), either directly or through an MEC, would elect a consultant representative to serve on the DMT. There would be no district equivalent of the AMACs, DMCs would be done away with and GPs and hospital doctors would exchange views instead by "cross-representation" between the DHMC/MEC and the Local Medical Committee (the local professional body for GPs). Ironically, the final Cogwheel report considered just such proposals in 1974, and dismissed them as "betraying a misunderstanding of the respective roles of the DMC and MEC" (4).

These are complex issues to assess, but the potential influence of Divisions and MECs on patient care and the allocation of resources is clearly such as to make the Cogwheel structure a legitimate subject of interest for CHCs.

## References

1. *Reports of the Joint Working Party on the Organisation of Medical Work in Hospitals*. First report, 1967; Second report, 1972; Third report, 1974. All HMSO.
2. *Medical management of hospitals*, by Dr R W Burslem, July 1980. Price £2 inc post from Health Services Management Unit, University of Manchester, Booth Street West, Manchester.
3. *Medical advisory machinery in the reorganised NHS*, report by the Joint Working Group on District Management Arrangements. Published in British Medical Journal, 17 January 1981, pages 239-42. Comments are invited on this report, by 31 March.
4. See the third Cogwheel report, pages 17-19.

**What's the good of being prepared to be the patient's friend if the patient has never heard of you? While some CHCs are well known in their communities, others have a lot to learn about publicity. The problem has been debated from time to time by the Association of CHCs, and last year's annual general meeting called on the association to ensure "powerful effective national publicity" for the work of CHCs. Publicity and how best to get it has been a theme of continual discussion since CHCs began. We asked Nick Harris, Beryl Sloan and Phil Topham to shine three very different spotlights on the issues involved.**

### The ungentlemanly approach

by Beryl Sloan, Secretary, North Tyneside CHC

Community is a vogue word. Health — well that's familiar. Council — well they come round for the dustbins, don't they? To most people, "What is a CHC?" is an irrelevant question. Yet in the CHC world it's a popular fallacy that publicity is directed towards that question. Publicity would be better aimed at the question "Why should I want to know about your organisation?" If the public don't know we exist, how can they offer comments or ask advice? How valid are we as consumer representatives if we only represent the personal views of 26 people? Much of our influence comes from our privileged and statutory background, but ten times more comes from our public feedback.

Publicity entails a commitment of time. To a busy CHC secretary it is difficult to keep on giving priority to publicity when surrounded by the pressures of CHC meetings, working groups, getting and giving information, consultation with the area health authority and so on. No-one complains if it isn't done. How can they complain when they don't know what they are missing?

Priority is the key word. Any CHC can do publicity — itself or through experts — if the priority and time is given by the secretary and backed by members. Personally I doubt if any publicity is as good and thorough as a speaking engagement, when a captive audience can be sold the goods on offer.

There are a multitude of other well-known publicity methods such as posters, leaflets, and display boards, but the second most valuable means of communicating our message to the public must be through the press, radio and television. With this in mind I offer the following homely hints:

#### 1 Learn to write press releases

Send out press releases on subjects you rate worthy. Monitor the way the papers treat them. If they publish them, see how they have changed what you wrote. Learn to do it their way next time. Always include your name, title and home and office telephone numbers at the end of the press release, as well as those of the persons quoted. Use double-line spacing and continue on a separate sheet if necessary. Our single most effective press release so far netted 234 column-inches of press cuttings.

#### 2 Cultivate the local press

A lunch-time drink is favourite in Whitley

Bay. There should be no difficulty in persuading journalists to spend time with you if they understand anything of the value the CHC can be to them as a source of news stories. Keep with you at all times a list of all names, addresses and phone numbers of the local newspapers, regional newspapers, local radio stations and local television centres. Also all the principal freelance agencies and the Press Association. Note the names of the reporters you speak to at each place. Learn which reporters you can speak to in confidence and give "background" to. And which ones will trick you. Most local reporters come into the first category. On the phone don't talk to a reporter like a committee meeting, be concise and to the point and appreciate his or her deadlines. Note and learn the deadlines for news of each of the local media, and guide your members to organise their comments and activities so that they can dovetail with these.

Be generous with background material, but insist on a mention of the CHC if a story has been based on an item in your minutes, or if you have had to put extra work in to provide the information.

#### 3 Learn what makes a news story

"Our maternity group is having its meeting next Monday afternoon" is not news. "Our maternity group is having a special meeting next Monday afternoon, to begin investigations into the closure of the maternity hospital" could make a few lines in a local paper. Points which the CHC has felt strongly about for months may or may not have been reported but they will get a great deal of mileage if included in a report — especially if that report is to be sent to the health authority, MPs and so on. "Mrs Smith thinks that the North Tyneside perinatal mortality rate is too high" will not grab a headline — "CHC report calls for new AHA attack on baby deaths" will.

Remember, you're not after the Nobel prize for literature. You're not even building an image. You're selling a name, and piece by piece the role that goes with it.

#### 4 Always use quotes

Preferably these should come from members particularly interested in the subject of the press release. Check with them that they are agreeable to the quote being attributed to them, especially if they didn't actually say it! Don't think I'm being cheeky — you have to chase every angle. Check the press releases with the CHC chairman. It is the chairman who must carry the can in the long run if the CHC comes under fire.

#### 5 Be prepared

When a big story develops suddenly, be

ready to leave everything else and milk every drop of publicity. By 11 am on the day of the surprise closure of our area's only accident and emergency department, full information and CHC comments had been cleared with the chairman and given to two local newspapers, two regional newspapers and two local radio stations. Two television stations had camera teams on their way for a CHC interview.

Well, does all this sound aggressive? Ungentlemanly? Time-consuming? Too much extra work? Not worth it? A waste of time? If you know a CHC whose answer to any of these questions is "yes", then perhaps it's time you realised why CHCs are still a secret society to the majority of the great British public.

### A national backbone for CHC work

by Phil Topham, Secretary, Canterbury and Thanet CHC

CHCs were the only complete innovation in the 1974 reorganisation of the health service. They have a specific role — to represent the public and also to provide a source of advice and help. Perhaps one of the biggest failures of that reorganisation was the failure of the Department of Health to "launch" CHCs with a full-scale publicity campaign. CHCs have had to labour under the effects of this lack of public awareness ever since.

Generating good publicity is one of the activities of CHCs which they are least well equipped to undertake. They lack the expertise, the money and the time to do the job properly. Publicity, or more generally public relations, includes a wide range of activities. There are certain things which can only be done properly by each CHC at its local level — such as giving talks about the CHC, organising conferences on local issues, taking part in demonstrations, carnivals and summer shows, as well as obtaining local press coverage. Yet many of these local activities might benefit from a little expert advice on techniques and organisation.

There are also some types of publicity activities which would be best handled on a national scale. They could not be undertaken by CHCs individually, primarily because of the sheer scale of the work involved. National activities might include the use of radio and television networks as well as the national press and magazines. National publicity work might also cover the production of professionally designed posters, leaflets, exhibition material, cine and video films, as well as slide presentations with accompanying notes for speakers.

If wide agreement could be reached on a standard logo for CHC stationery and signs, this would give the public an identifiable and consistent image for CHCs throughout the country. I would opt for a range of materials, from which CHCs could choose according to their needs and requirements.

Another idea which might be explored is the Post Office's mailing service for

# PUBLICITY



delivering standard literature through every letterbox. This was used by the Government in the run-up to the referendum on the Common Market. The cost is not as great as you might imagine.

It would be difficult to overstate the influence of television. Public service broadcasts similar to those done for the Blood Transfusion Service could be devised for showing on all channels. Advertisements could also be made for the commercial channel. Programmes could also be arranged for the community service series, *Grapevine* and *Open Door*. We could arrange "plugs" for CHCs on general entertainment programmes, particularly those with large followings such as *Coronation Street* and *Crossroads*. This would help increase awareness of CHCs as public bodies which exist to help people. Perhaps it is not too ambitious to envisage the creation of a specific programme all about CHCs. People's interest in health issues can be stimulated, particularly when it can be shown that their own lives could be affected.

The principal advantage of national CHC publicity would be that councils would have high quality, professionally designed material produced on their behalf. This would save the time, effort, and expertise of CHCs, and in particular of their staff. They could spend more time on the "bread and butter" work of representing and helping the local public. National publicity would therefore complement and complete local efforts rather than compete with them.

I do not believe the Association of CHCs should itself go directly into the public relations job. It should use its influence to obtain resources from the DHSS. The forthcoming second reorganisation provides the opportunity for the Department to make good its serious omission in not providing publicity when CHCs were launched.

The resources required need not be large in NHS terms. They could possibly be supplemented by small contributions from willing CHCs. For example, £50 wouldn't hurt any CHC to contribute, and if 200 CHCs did this £10,000 would be available — a substantial amount which would be well spent on national publicity.

### Ask the Professionals

by Nick Harris, Secretary, Manchester Central CHC

Six thousand pounds is a pitifully small amount for three CHCs to try and get their message across to people who might wish to use the local health services. At about 1p per person each year, the money needs to be well spent if the CHCs are to compete successfully with all the other people who are trying to catch the consumer's eye.

We need the publicity because we feel it is necessary that the public knows we exist, not just to legitimise our role but so that they can be aware of how we can help them and so that they can help us. Publicity advisers are necessary, in my view, to help the CHC be clear about who it is aiming at.

Continued on next page



# Healthline

## CHC members' expenses

What expenses are CHC members allowed to claim? A new member of our CHC wants to claim for the cost of meals eaten while on official CHC business. The Area Health Authority seems a bit vague about the regulations.

CHC members are entitled to claim for expenses incurred while on official business on the same basis as members of health authorities. The regulations are *The National Health Service and Regional Nurse — Training Committees (Travelling Allowances etc) Determination 1975*. The rates of payment are updated from time to time in the DHSS series of PM circulars. The most recent update was PM(80) 37.

Members may claim travelling expenses, subsistence allowances, and payment for financial loss such as loss of earnings and baby-sitting expenses. The subsistence

allowance is intended to help pay the cost of meals.

## Don't look now: CHC observers

What are the rules about the observers from the CHC at Area Health Authority meetings? Our AHA refuses to let the CHC members observe the confidential parts of the meetings and will not allow them to see the documents for the secret parts of the agenda. Also, we think they are putting far more topics into the closed session than is really necessary. The official guidance about CHC observers at AHA meetings, DHSS circular HSC(IS)194, gives AHAs wide discretion. It says that CHC observers should not be automatically excluded from those parts of the meetings not open to the public and the press. But AHAs are allowed from time to time to ask the observers to leave the meeting.

CHCs should receive papers for all the sections of the

agenda which the AHA is going to let them observe "and should normally be free to discuss AHA papers with their CHCs although such discussions should be held, when appropriate, without the press and public being present".

Not surprisingly, these broad guidelines have been interpreted very widely. Some AHAs have aroused suspicions that they may be abusing the "closed session" option. On the other hand, Humberside AHA has allowed CHC secretaries as well as CHC member observers to sit in on the entire agenda.

In Kent the AHA demanded a written undertaking of confidentiality from CHCs before it would allow observers to attend closed sessions and receive the relevant papers. West Sussex AHA ruled that an observer from Cuckfield and Crawley CHC should not discuss confidential papers with the CHC — the CHC contested the ruling. (See CHC

NEWS 42 page 16, 43 page 3 and 52 page 16.)

## More about the price of dentures

In Healthline last November CHC NEWS 60 page 10) we gave information about the charges dentists are entitled to ask for re-lining dentures. The administrator of Lincolnshire Family Practitioner Committee has sent us a leaflet which the FPC issues to explain to patients why they may have to pay for this service. Copies of the leaflet *Re: Provision of dentures immediately following extractions* could be obtained from Lincolnshire FPC, 92 Newland, Lincoln LN1 1TP. Also we were wrong when we said that £8 is the standard fee for relining. It is of course the maximum statutory fee for such a course of treatment. Sorry.

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

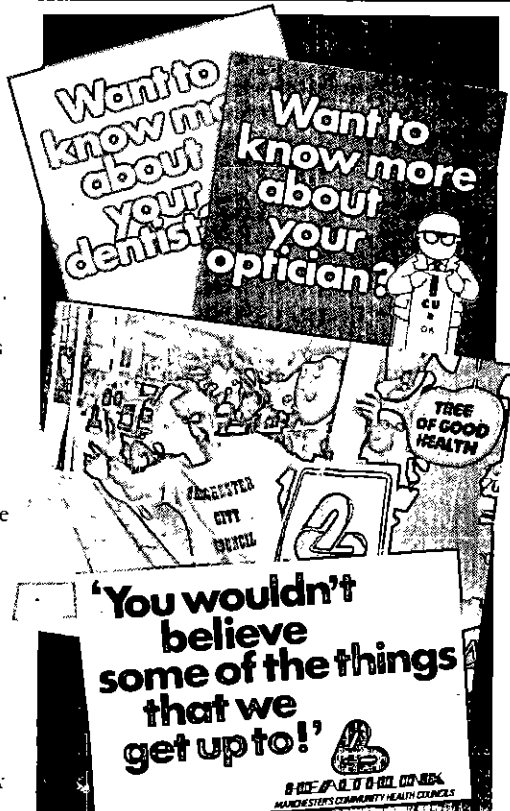
## Publicity

Continued from previous page  
why, and how the target audience can be reached.

Effective publicity demands good technical advice, and the Manchester CHCs' joint publicity committee has used professionals in a number of different ways. During 1978 we worked closely with a public relations firm, Axon and Garside, as advisors to the committee. We have also used professional companies to make our CHC film and to copywrite our newsletter. Secraprint, a local print firm, acts as our print buyer for all publicity material.

Axon and Garside's involvement with the CHCs forced us to analyse our various "markets" carefully, and to look closely at what we wanted to say to them. The first outcome was a recommendation that the CHCs should adopt a brand image, based on the publicity name of *Healthlink*, coupled with a logo and printing in red and blue. Unfortunately there was an early disagreement between the three CHCs as to the exact positioning of the word *Healthlink* on the publicity material. This took nearly twelve months to resolve and held up progress on the publicity campaign considerably. Nevertheless a corporate image has been adopted and is used on all CHC material.

Involvement with the consultants also forced us to think more carefully about the information content of the material we produce. It is much briefer and simpler than items we might otherwise have produced. Also, I think, it has forced us to think more



carefully about our various audiences. Material designed for the general public aims at informing them about the advice and information role of the CHC, the area of our work which we feel is likely to be most relevant to them. Information aimed at professionals working in the health and social services contains more information about the working of the CHC. Our newsletter is an example of this.

As a result of our work with PR

professionals the CHCs now have a full range of publicity material available, although distribution is sometimes a problem. After an experimental period we have sometimes abandoned ideas, such as the mass campaign we had at the 1978 Manchester show. We are continually reviewing publicity material and exploring new ideas. For example, at present we are discussing the possibility of using a news agency to handle all our media contacts, to try and increase our exposure. We are also planning a two-page insert, with the AHA's health education unit, in the local civic newspaper. This idea will cost over £1000, which is a cheap form of publicity when one considers that over 200,000 copies of the paper are printed.

I believe that our involvement with professionals has enabled us to look at publicity in a much clearer way and present ourselves more clearly to the public. It is difficult to know whether we are being effective as we also believe that we are considerably hamstrung in our efforts by the lack of a consistent public image among CHCs as a whole, by our inability to use regional sources of publicity such as radio advertising, and also by the lack of an effective national publicity campaign for CHCs. Although the committee stopped using Axon and Garside, this was partly as a result of internal disagreements between the CHCs. The CHC secretaries have recently been reconsidering the issue, and we have continued to use the other professionals.

● The Association of CHCs is taking several new initiatives on the national publicity front. For details see page sixteen.

# COMPENSATION

The fight by parents of thalidomide-damaged babies to get compensation for their children's injuries received a great deal of publicity in the early 1970s. Public concern was aroused, and in 1973 the then Conservative Government appointed the Royal Commission on Civil Liability and Compensation for Personal Injury — chaired by Lord Pearson and known as the Pearson Commission. Although it is now two years since the commission published its final report\* the issues it raised remain unresolved.

The Commission was appointed "to consider to what extent, in what circumstances and by what means compensation should be payable in respect of death or personal injury (including ante-natal injury) suffered by any person —

- in the course of employment;
- through the use of a motor vehicle or other means of transport;
- through the manufacture, supply or use of goods or services."

Of the estimated three million injuries which result in four or more days off work or the equivalent in the United Kingdom every year, over a million are outside these terms of reference. They are mainly injuries occurring at home.

The commission looked at the main sources of compensation for injuries — principally the tort system, and state social security benefits, but also private insurance and employers.

About a quarter of the total compensation paid for injuries every year derives from tort. A tort is a wrong against someone for which damages can be claimed in a civil court. It is not normally sufficient to prove that the defendant caused the injury — negligence (when an adult's behaviour falls short of "the standard of the reasonable man") must be proved. There are a few statutory exceptions to this, eg injury caused by nuclear installations. Here strict liability applies to tort claims — the defendant is liable irrespective of negligence if it can be proved that he or she was responsible for whatever caused the injury.

Social security benefits already amount to half the compensation paid for injuries

every year. They are "no-fault" payments, ie there is no need to prove that anyone caused the injury in order to obtain them. They include sickness benefit, industrial injuries benefits, invalidity pensions and the various allowances available to the disabled.

"It is clear to us", says the commission "that the two systems (tort and social security) have for too long been permitted to develop in isolation from each other, without regard to the fact that, between them, they meet many needs twice over, and others not at all".

The commission recognises two main questions — "How far no-fault should be extended; and whether tort should be abolished". Its terms of reference precluded it recommending no-fault schemes for all injuries so it discusses whether it should be extended to particular categories of injury. "It was clear to us that social

security should be regarded as the primary method of providing compensation — it is quick, certain and inexpensive to administer, and it already covers a majority of the injured".

The commission spells out the criticisms of tort — its delays, expense, complexity and its emphasis on the cause of the injury rather than the loss suffered. However in no area of its report does the commission recommend removal of the right to tort compensation — instead it envisages a gradual diminution of tort's role as social security provision becomes more comprehensive. Relevant social security benefits should be fully off-set against tort awards.

Turning to specific areas of injury the commission looks at work injuries. It recommends that the existing wide-ranging no-fault industrial injuries scheme be retained and extended. The self-employed should be brought into the scheme and injuries suffered while travelling to and from work should be covered. The scheme would continue to be financed from National Insurance contributions with a

Government supplement.

Motor-vehicle injuries should be incorporated into a no-fault compensation scheme similar to the industrial injuries scheme. It would be administered by the DHSS but financed totally by a levy on petrol.

The introduction of strict liability for tort claims for work and road injuries is rejected by the commission. However when it comes to claims for damage resulting from defective products — either natural or manufactured goods — it suggests that strict liability be introduced. It does not recommend a no-fault scheme for product-related injuries.

Defective products cause a relatively low number of injuries and these include drug-related injuries. A product is defined as defective "when it does not provide the safety which a person is entitled to expect, having regard to all the circumstances including the

presentation of the product".

Defects may occur in either the manufacture or the design of the product. Liability would be placed on producers of finished products and of components — but not on the distributors. The commission's definition of defect gives producers a defence that an injured person did not take heed of warning notices (eg on cigarette packets) or instructions.

It would not be a defence for the producer to have withdrawn or attempted to withdraw the product — nor that the "state of the art" at the time of development would have made it impossible to predict future risks. And approval by the Committee on Safety of Medicines would be no defence for a drug company.

The commission goes on to consider medical injury, which it defines as impairment by a physical or mental condition arising from an accident in the course of medical treatment. A great deal of evidence about the difficulties of proving medical negligence was presented. However the commission believes that the introduction of

strict liability for medical accidents would lead to an increase in over-cautious medical practice, and rejects it — except in cases where volunteers for medical research or clinical trials suffer severe damage as a result of their treatment.

No-fault compensation for medical accidents is looked at. Existing schemes in New Zealand and Sweden are discussed but the commission reluctantly concludes that such a scheme would be impracticable in the UK for the time being.

In a separate chapter it is proposed that the Government be strictly liable in tort for vaccine damage.

The commission makes a special recommendation for a new non-taxable disability allowance for all children with severe handicap who are under 16 and living at home. It estimates that there are 100,000 such children, 90,000 of these suffer from congenital disability whose cause can seldom be ascertained. The commission believes that children with similar handicaps should have similar benefits, irrespective of the cause of disability.

The commission's report has been criticised by disability groups for taking a legalistic approach and preserving the financial advantage that accident victims have over other disabled people. Professional medical bodies expressed concern about a proliferation of unjustified claims against drugs and a possible reduction in the development of new drugs.

The Pearson proposals remain in abeyance. A scheme to pay compensation to vaccine-damaged children was set up but the Association of Parents of Vaccine-Damaged Children continues to fight for strict liability against the Government.

The DHSS says that the Pearson recommendations "are still being looked at". The Government is at present trying to modify the strict liability proposals in the draft EEC Directive on product liability, and will not introduce any legislation until this has been settled.

\*Royal Commission on Civil Liability and Compensation for Personal Injury. Vol 1. Report 1978 (Cmd 7054-1) HMSO £7.60.

## Pearson's verdict

# Feet first

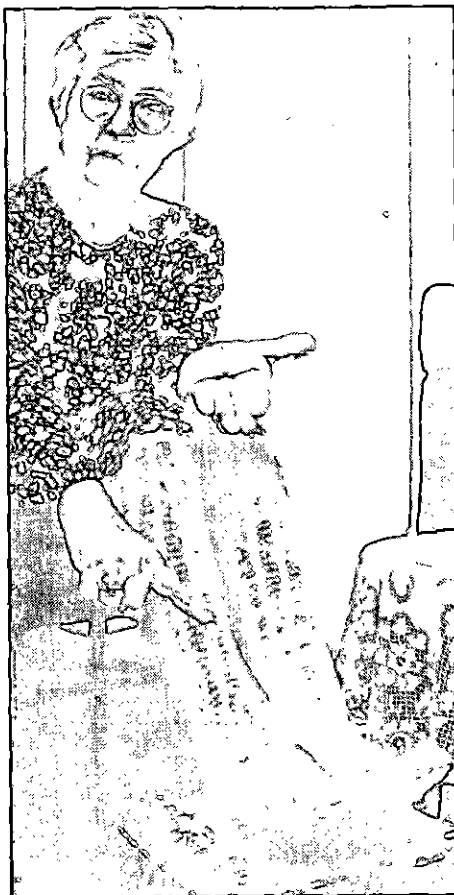
by June Ayling, Secretary,  
Maidstone CHC

In 1976 one of the new members of Maidstone CHC was Kay Swingland, Women's Royal Voluntary Service (WRVS) organiser in the Malling section of our health district. One of the great deficiencies she brought to the notice of the CHC was foot-care. She had a long list of people who needed toe-nail cutting and foot-washing.

The WRVS organise voluntary help for the elderly in Malling. In the other section of the health district a thriving branch of Age Concern assist the elderly on a daily basis. I introduced Kay to the Age Concern organiser and she spent some time in the foot-care clinic run by trained nurses at Age Concern. From these early meetings Kay planned a campaign to provide foot-care in Malling.

The first hurdle was the local district chiropodist because, very sensibly, Kay felt that although her volunteers would only provide foot-care they needed to recognise those foot conditions which should be referred to a trained chiropodist. After he had been convinced that foot-care assistants were not going to threaten his profession he was most co-operative. Without actually training the volunteers he allowed them to sit in on clinics and see what he did. Regrettably the Society of Chiropodists got to hear of this and said "no more training sessions of any kind".

By this time the number of volunteers was increasing and so were the clients and the clinics. A meeting of involved organisations was held with the then area chiropodist and we evolved a code of practice which described the scope of the volunteers' work—routine foot-care for those no longer able to do it for themselves—and clarified the volunteers' relationship with the area chiropody service. We agreed that before



offering foot-care volunteers would take care to check whether patients were at risk because of conditions such as diabetes. If they were, the volunteers would only provide foot-care after full medical consultation.

From then on, January 1979, the clinics have continued to flourish—the WRVS do about 100 sessions a month.

Patients need treatment about every six weeks. It takes about 15-20 minutes. Their

feet are washed and their toe-nails cut. Cream is massaged into their feet and pressure-pads applied if necessary. Any serious conditions are referred to a qualified chiropodist. The patients have to pay because of the costs of dressings, equipment, telephone, petrol and the hire of halls. The charge to patients is 75p which barely meets overheads. Various fund-raising events are staged to maintain finances.

The foot-care clinics have become so popular that we came up against the training problem once again. Despite previous agreements between the area chiropodist, the Society of Chiropodists and the volunteers, changes in staff had blurred the agreements made in 1979.

In November 1980 a further meeting was held with representatives from the relevant organisations, including the CHC, the district community physician and area chiropodist. Very real progress was made, and for the first time—outside of GPs who use the service regularly—a two-way exchange of statutory and voluntary care was established. I quote from the minutes "... when a chiropodist saw a patient he would decide the form of treatment required and the optimum intervals between treatments. If this indicated that the patient did not require the services of a chiropodist but those of a foot-care assistant then the chiropodist would advise the individual concerned to approach one of the voluntary organisations for that purpose. Likewise if an operative in a voluntary clinic was uncertain as to the treatment a referral to a state-registered chiropodist would be made".

It was also agreed at this meeting that the area chiropodist and area specialist in community medicine would contact the Society of Chiropodists for further guidance about training.

My personal thanks to Kay Swingland and her WRVS team and to Age Concern Maidstone for having made it possible to keep so many more elderly and disabled people mobile.

We are happy to provide further information to any interested CHCs.

## A FAIR HEARING - OR

by Judy Hague, Secretary,  
Kensington, Chelsea and  
Westminster (South) CHC

When I first attended a medical service committee hearing of a patient's complaint, I found my perspective was similar to that of the person making the complaint. I was discouraged by the atmosphere, and if I had been the patient I think I would have felt this even more strongly.

A service committee hearing is held if a complaint cannot be cleared up informally. Until the hearing itself the complainant is usually happy with the procedure and feels his or her complaint is getting a thorough investigation. Family Practitioner Committee (FPC) staff are extremely helpful to members of the public wanting to make a complaint. Before the hearing the

patient receives written notification of the procedure to be followed. The FPC has made every effort to make this information clear and concise, but it still does not prepare the complainant for the actual experience of a hearing.

The service committee is made up of a lay chairman, three practitioners (ie doctors, dentists, opticians or chemists) and three lay members of the FPC. At the hearing, despite efforts by the chairman to put complainants at their ease, they feel very much like outsiders. Two of the three professional members of the committee are from the same area as the practitioner against whom the complaint is being made. They probably know each other professionally, and maybe even personally. An atmosphere of professional *bonhomie* reigns.

The professional members of the committee should sometimes make more effort not to use jargon and technical terms without explaining them. This is necessary not only for the patient and friend, but also for the lay members of the medical service committee itself. Attempts to disorient the complainant by irrelevant questions and remarks should not be permitted. Unfortunately, such tactics are sometimes resorted to.

We have also noticed that at dental hearings the professional members do not always accept the report of the independent inspector who is called in to inspect the state of the patient's mouth. As inspectors are independent witnesses there is no reason why the validity of their evidence should be called into doubt.

The hearing has the appearance of a

# A site for sore eyes

by Mrs Madeleine Baigel,  
Chairman, Bury CHC

In the summer of 1979 we were excited by the news that Bury Area Health Authority had found a site which was considered to be suitable for the new district general hospital. We fully supported the AHA's decision to recommend that the new hospital should be built at Higher Spen Moor Farm, an undeveloped site on the western side of the borough. This seemed to us preferable to the original intention to build the new hospital on the site of the existing Fairfield General Hospital. A new development on the Fairfield site would have meant the demolition of existing buildings, causing noise, dirt and the decanting of patients. Because of sloping terrain there would also have been difficult planning problems involving access.

As soon as it became known that this new site was being considered, we found ourselves faced with a well-informed and vocal opposition to any hospital

development there. Our neighbouring CHC in Bolton considered that because of the proximity of Higher Spen Moor to the Bolton boundary, a new hospital would attract patients and staff away from Bolton and would adversely affect the timing of the planned Bolton district general hospital. Officers of the two councils met to listen to each other's viewpoints. It is disappointing that the NHS is organised in such a way that competition for scarce resources can bring into conflict two CHCs which are both working sincerely for the benefit of patients. It is after all a national health service.

The other main opposition to Higher Spen Moor came from a local residents' association. Its members had successfully fought a campaign to prevent the building of houses by the owner of the land. They did not wish to see a hospital development there either. They did not want to lose the amenity of Higher Spen Moor Farm as an attractive open space for local people. Following a series of letters to the

press in which the residents' association expressed its points of view very forcefully, we invited its leaders to meet us so that we could discuss the situation in a friendly way.

We appreciated that they did not want to lose an open space in an area which was being increasingly built up. However, we felt it was our duty to explain to them how vital it was that Bury should have a new district general hospital. We also argued that the site was a far better proposition than piecemeal development at the present general hospital. The residents' association became aware of the history of deprivation which Bury had suffered over the years in its NHS capital development. Members of the association expressed their concern about this, but felt that there must be other suitable sites available in the borough. The CHC took steps to assure itself that Higher Spen Moor was indeed the only alternative to development of the Fairfield site.

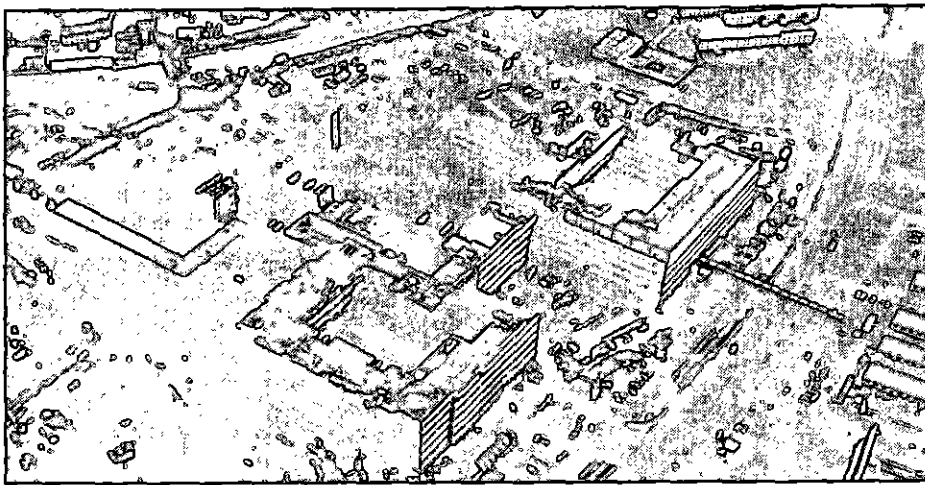
We therefore continued campaigning. We felt it necessary that public opinion in favour of Higher Spen Moor should be marshalled, to counteract the well-organised campaign of the residents' association, which represented only a minority of the population. We invited organisations and individuals to write in support of the new site to the planning authority, the Greater Manchester County Council.

Planning permission had to be granted before the North Western Regional Health Authority could decide whether to buy the site for building. Bury Borough Council had voted in favour of the Higher Spen Moor site, but the vital decision lay with the planning authority. At a meeting of the Greater Manchester Council planning committee in February 1980 it was decided not to grant the planning permission, though the RHA was given more time to explain why the site was preferred to Fairfield.

The CHC was very disappointed. Our disappointment increased when we became fully aware that the region was not really prepared to commit itself to developing Higher Spen Moor Farm. The planned developments at Fairfield could be guaranteed, but if the sites were now switched — with the consequent planning and building delays — there was a chance that everything would be indefinitely postponed in the current climate of restriction on public spending.

With regret we accepted the decision. We shall try to make sure that the Fairfield development begins on time, and that the inevitable disruptions for patients and staff are kept to a minimum while the work is going on.

We have seen the development plans for the next decade, and we intend to be vigilant to see that Bury will in the end have the fine new hospital departments which have been promised, and which the community deserves.



## JUST A FARCE?

tribunal and yet the complainant soon gets the feeling that, in reality, it is not unbiased. Many complainants feel demoralised at the end of a hearing and tell us that they thought it was a farce. Complaints are rarely made lightly, and both patient and respondent should emerge from the hearing believing that the complaint has been thoroughly investigated. From the patient's point of view this cannot be said of the medical service committee hearing. How can it be unbiased when the respondent is "judged" by his peers, when the patient is made to play the role of both prosecutor and accused and when the evidence of independent witnesses is sometimes treated with scant respect?

The system should be changed. Service committees should be made up of members from a different area, and the evidence of

independent witnesses should be accepted. If there are witnesses to the event which forms the subject of the complaint their evidence should be asked for by a third party — the responsibility should not be left to the defendant to gather the evidence.

Every effort should be made to put complainants at their ease and to ensure that they leave the committee satisfied that their complaint has been given a fair and considered hearing. Inevitably, it is often difficult for the committee to reach a clear decision about what happened. In practice the results of the hearings are usually fair, given the available evidence. Nonetheless, complainants should have the satisfaction of a thorough and judicious hearing at which they feel that their complaint has been properly aired.

# Parliament

## Blood for sale?

The Government has considered bringing in commercial management for the Blood Products Laboratory at Elstree — the main centre for developing blood products in England and Wales. Health Minister Dr Gerard Vaughan explained that although the laboratory was being modernised it would still be unable to meet all the future needs of the NHS, so the Government had looked into ways of developing it further. However it had concluded that there is no place for a commercial company in the management of a service which depends on volunteer donors (Garry Waller, Brighouse and Spenborough, 26 November).

## Psycho-surgery

There is no evidence, says junior health minister Sir George Young, that psycho-surgery is being used other than in the best interests of the patients concerned, nor that doctors are not following established good practice in obtaining fully informed consent from patients. Studies indicate that the patient's consultant can weigh up the probable benefits and risks of

psycho-surgery against the benefits and risks of other or no treatment, taking into account the wishes and condition of the patient. (John Cartwright, Greenwich Woolwich East, 11 December).

## Induced births

In 1978 an estimated 36.3% of all deliveries in NHS hospitals in England and Wales were induced. And out of all the births that year 33.4% were hospital inductions. The perinatal mortality rate for these induced births is "not readily available" says Sir George Young (Lewis Carter-Jones, Eccles, 9 December).

## Child health

In 1979, 45% of children aged between one and five attended child health clinics, and 75% of this age-group was seen by health visitors. The Government hopes to improve on this figure, says Sir George Young, but has no plans to mount a national campaign to stress the importance of periodic health surveillance. The DHSS has suggested ways of improving take-up of available services — such as health education in schools, and more accessible and attractive clinics (Dr Roger

Thomas, Carmarthen, 28 November).

## Bed losses

Between 1 January and 30 September 1980, decisions to permanently close hospitals or parts of hospitals resulted — or will result — in a total loss of 1713 beds. By 30 September 1980 the DHSS had been further notified by AHAs of closure proposals which, if implemented, would involve the loss of another 3002 beds (W Hamilton, Central Fife, 16 December).

## Three-wheelers

Most of the 11,500 disabled drivers who still use three-wheeler invalid vehicles could manage an ordinary car with the kind of adaptations already available. This is the main conclusion of a Government-commissioned report by the Motor Industries Research Association on the transport needs of disabled people affected by the gradual phasing out of three-wheelers. The Government does not believe that MIRA's findings support the case for a successor vehicle to the three-wheeler.

Although the rate of transfer to the mobility allowance scheme for the invalid vehicle

scheme "is not slackening", stocks of invalid vehicles and replacement parts are "healthy" so those who wish to go on using their vehicles should be able to do so for at least another five years. For those who do want to switch to mobility allowance but do not have a driving licence, the Government proposes to change the law so that they will be able to keep their three-wheeler for up to six months and receive the allowance while they learn to drive a car. There are also proposals to allow 16-year-olds who get mobility allowance to hold a driving licence for a car (John Hannam, Exeter, 18 December).

## Detained patients

The total number of patients detained in NHS hospitals for more than 20 years is not collected centrally. On 30 September 1980 101 patients had been detained in a single special hospital for over 20 years, but the number who had been detained in more than one special hospital for that length of time is "not readily available" (Dudley Smith, Warwick and Leamington, 27 October).

## Helping kidney patients

by Elizabeth Ward, President,  
British Kidney Patient  
Association

The British Kidney Patient Association (BKPA) is the only national association dedicated to the welfare of patients with kidney failure throughout the British Isles. Of course the ideal must be in the years to come that, through the triumphs of research, *transplantation* and *dialysis* become words of the past. But there are many thousands of people for whom those words have a very real meaning and they need our help now.

The presence of a kidney machine in the home, or the need for chronic dialysis in the hospital, can make huge inroads into the family purse. The BKPA spends thousands of pounds every year on patient aid. We cover rent arrears and gas bills, buy clothes for the children, put much-needed cars back on the road, and help to furnish flats. We will consider generously any grant application through the patient's social worker or member of staff in whose care they are — except telephone bills, court fines and home improvements. It is often that unpaid bill that is the last straw that breaks the camel's back. The patient sits on the edge of the bed preparing the machine

for the umpteenth time, only too aware of feelings of inadequacy and domestic pressure, and thinks: "No, I just cannot go on, what is the point?". It is then that the BKPA can step in and make life seem possible again.

Once treatment starts for a dialysis patient, holidays like so many other things can become joys of the past. The BKPA understands the desperate need for a break from the demands of dialysing someone you love, week after week, month after month, and all too often year after year. Holidays for dialysis patients and their families are top on the list of the BKPA's priorities. By covering the cost of treatment and, in cases of real need, the cost of the holiday as well, we have enabled a number of patients to enjoy the relaxation of holidays abroad.

The need for holidays for the child kidney patient is in a sense almost more important. Not only are children denied the fun and freedom afforded to their healthy peers but their families so often share these restrictions. In April 1980, at Earmley on the West Sussex coast, we opened the first international holiday centre for children with kidney failure in Europe. This caters for 30 dialysis children and their families during the school holidays. During the term time it is open for adult patients and their partners.

When I formed the BKPA in September 1975, I wanted the chance to make the lives of patients more tolerable but I never for a moment envisaged that we would literally be in the position of saving lives. Early in 1979 the BKPA wrote a cheque for £30,000 to save the Hammersmith Hospital Transplant Unit from closure. This sum kept the unit fully operational for six months, giving the authorities a chance to find the necessary funding thereafter. About twenty transplant operations were carried out on patients, some of whom would have died without them. Earlier this year we paid a bill for £80,000 from the Lewisham Area Health Authority, for 16 transplant operations being carried out at Dulwich Hospital, where the transplant unit was closed for three months.

In addition to these two rather dramatic examples, the BKPA is now committed to raising more than £160,000 over the next five years for essential staff salaries. We are currently funding the posts of three renal social workers, a nurse co-ordinator, and two consultant nephrologists. We have also both paid and offered thousands of pounds to cover the costs of new renal units.

The plight of renal patients is sometimes a desperate one, but at least now there is some light at the end of the long dark tunnel through which many of them have to tread.

*The British Kidney Patient Association,  
Bordon, Hants. Tel: Bordon 2021/2.*



# Scanner

## Volunteering to be out of pocket

A survey of arrangements for insurance cover and the payment of out-of-pocket expenses shows that volunteers are often treated as second class citizens, claims the Volunteer Centre. Its recent report, *The cost of volunteering*\* showed that only half the voluntary and statutory agencies questioned refunded expenses to all paid and voluntary staff. Many agencies appeared to be unaware of the need to amend Public Liability Insurance policies so that volunteers are insured against risks incurred in the course of their work. Statutory bodies had a worse record than voluntary organisations. \*From Volunteer Centre, 29 Lower King's Road, Berkhamsted, Herts HP4 2AB (80p inc post).

## NHS Handbook

Sixteen articles covering topics such as planning in the NHS, the work of FPCs and NHS finance are contained in a new guide to the health service. It is published by the National Association of Health Authorities with newly-appointed health authority members in mind, but could be useful for new CHC members too. The section on consultants and the glossary of NHS financial jargon seem especially helpful for those needing a crib to the workings of the NHS. The handbook is a looseleaf binder — revised articles and supplements are planned. From NAHA, Park House, 40, Edgbaston Park Road, Birmingham B15 3RT (£6 inc. post, or 10% discount on orders of 10 or more copies).

## Liberal view of CHCs

The Liberal Party's health panel is circulating a discussion document about CHCs, for general consideration within the party. The Liberals propose that CHCs should have the same rights of information from all public bodies as they do now from health authorities, and make suggestions as to how best CHCs can make themselves aware of, "but not subservient to" public opinion. The panel believes CHCs should have around 30 members and should broadly reflect the local population. This might, says

the report, involve taking positive action to adjust the current "over-representation of the articulate middle-class" and of elderly people in CHCs. The main author of the report is Martyn Smith, secretary of West Birmingham CHC. *Community health councils — a developing role* from Martyn Smith, 65 Birmingham Road, Great Barr, Birmingham B43 6NX.

## Increase the death grant

In August last year the average cost of a funeral was almost £400. Even a modest funeral costs about £300. The DHSS death grant, originally intended to meet the expenses of a "decent" funeral, is just £30. *Beyond our means*\* describes the plight of families for whom funeral costs create hardship and great distress. A DHSS survey of funeral expenses in 1974 showed that one third of the bereaved were pensioners, increasingly having to meet the costs of burying or cremating their parents. The report calls for the grant to be revalued and then inflation-proofed.

\* From Age Concern England, Bernard Sunley House, Mitcham, Surrey CR4 3LL, (£1.70 inc. p and p).

## Dial UK

Is an organisation set up by disabled people for disabled people. It is an advice and information service run by local groups of disabled volunteers. A national association provides groups with back-up information and up-to-date reference material. A list of branches and details

about setting up a Dial service, from Dial UK, Victoria Buildings, 117 High Street, Clay Cross, Chesterfield, Derbyshire. Tel: Chesterfield 864498.



## You'll need more than orange squash

*It can be very difficult for people with children to attend meetings and conferences and generally take an active part in community affairs — unless there are good creche facilities. The trade union NALGO has published a concise guide to Organising a creche, which it believes should be "an integral part of your planning for a meeting or event". The guide gives practical suggestions about rooms, staffing, equipment, and safety. From NALGO, 1 Mabledon Place, London WC1 (free).*

## Asthma Society

The Asthma Society and Friends of the Asthma Research Council has been launched. It aims to educate patients, parents and the public about asthma and help patients

to lead as normal a life as possible. Details from 12 Pembroke Square, London W2 4EH. Tel: 01-229 1149.

## Recent reports

*Hospital In-patient enquiry 1978 — preliminary tables* statistics used in resource allocation, planning hospital buildings etc. OPCS Series MB4 no 11, HMSO £4.20

*Cancer at work: dyes*, warning of danger for those who work with dyestuffs, from Cancer Prevention Society, 102 Inveroran Drive, Bearsden, Glasgow G61 2AT (35p + 15p post).

*Promoting the use of seat belts in Wessex*, a pilot campaign by Wessex Regional Health Authority failed to persuade people to "belt-up", in spite of massive and favourable press coverage. The RHA now wants Parliament to make belt-wearing compulsory. From Wessex RHA, Highcroft, Romsey Road, Winchester SO22 5DH.

*Disability rights handbook 1981* — updated version of this excellent guide to benefits and services. From The Disability Alliance, 1 Cambridge Terrace, London NW1 4JL (£1 + 25p post).

*Suicide and self-harm* discusses the recent rise in the suicide rate, which contrasts with signs that the incidence of non-fatal overdoses is falling. It considers the role of the GP in identifying potentially suicidal patients. From Office of Health Economics, 12 Whitehall, London SW1A 2DY, (60p inc. post).

## Perinatal mortality: HC(80)13

Encloses the report of the House of Commons Social Services Committee on perinatal and neonatal mortality, and the Government's reply. Details of these reports were published in *CHC NEWS* 57 page 3, and 62 pages 4 and 11. Asks health authorities to examine the Social Services Committee's 152 recommendations carefully, drawing their attention in particular to the proposals about "humanising" aspects of maternity care. The DHSS will be laying down minimum standards for maternity care after further consultation.

## CHC Directory: Changes

The latest CHC Directory was published in November 1980. It contains details of Scottish Local Health Councils and the District Committees in Northern Ireland, as well as CHCs. Single copies of the CHC Directory are available free from *CHC NEWS* — please send a large (A4) self-addressed envelope with 25p in stamps.

Changes to the directory are published on this page — please tell us of any alterations in address, phone number, chairman or secretary of your CHC.

**Page 6: North Hammersmith and Acton CHC** Chairman: Mrs Joy Mostyn

**Page 9: West Surrey and North East Hampshire CHC** Chairman: M Holmes

**Page 10: Swindon CHC** 43a Bath Road, Old Town, Swindon, Wilts SN1 4AS. Tel: unchanged

**Page 15: Salford CHC** Secretary: Michael J Walbank

**Page 24: Association of Scottish Local Health Councils** 29 Castle Terrace, Edinburgh EH1 2EL. Tel: 031-229 5782

# News from CHCs

□ A public service announcement about CHCs has been appearing several times a week on Tyne Tees Television, following negotiations between TTV and the **Northern Regional Association of CHCs**. The script of the 40-second announcement, worded by the regional secretaries' association, emphasises that CHCs can get answers to questions about the NHS and can take up individual problems. **North Tyneside CHC**, which has been coordinating the application for free air-time, estimates that the announcements have been equivalent to £150,000-worth of advertising.

□ The joint publicity committee of the **Manchester CHCs** has arranged for a two-page insert about CHCs to appear in *The Mancunian Way*, a local authority newspaper distributed free to every household in the city. The cost of just over £1000 will be split 3:1 between the CHCs and the area health education department. The joint publicity committee has also distributed 75,000 prescription bags, advertising the CHCs, to chemists' shops and hospitals.

□ Leaflets in four Asian languages have been produced for the parents of children going into Birmingham Children's Hospital. The leaflets have been jointly prepared by **Central Birmingham CHC** and the National Association for the Welfare of Children in Hospital. The leaflets explain what parents should do on admission day and what a child will need during its stay. They also mention some of the emotional problems the child may face in hospital and on returning home.

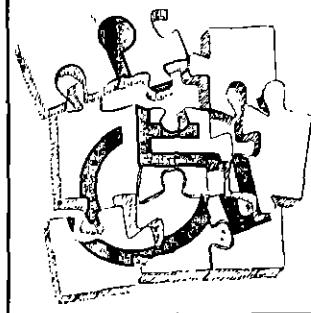
□ **Cornwall CHC** is to carry out a survey of public opinion about ante-natal care. In a district as large as Cornwall women face very different problems according to where they live, and the CHC wants to uncover these specific difficulties. Transport is likely to be a crucial factor. The CHC will contact pregnant women through the clinics, and mothers with young children through pre-school play-groups.

□ A night-sitting service has been set up in Halifax following pressure from **Calderdale CHC**. The service is a pilot-scheme funded for 12 months with joint finance. Elderly people are offered the kind of care they might receive from sons or daughters — *not* nursing. So far the response has been disappointingly low. Referrals should come from GPs, health visitors and community nurses, and the CHC is trying to ensure that these are all fully aware of the scheme.

□ Members of **Ealing CHC** now have their own guide to the CHC and the health service. The CHC's *Members handbook* describes the aims and functions of CHCs and explains what the secretary and members actually do. It also contains facts and figures about local health care provision and gives a useful glossary of terms like DGH and JCC which may mystify new members.

□ Several CHCs are organising special projects in response to International Year of Disabled People. **Haringey CHC** has compiled a pamphlet on *Services for the disabled* (shown below), covering everything from easy-to-use can-openers for people with rheumatism to building house extensions to meet the needs of wheelchair users. **Cambridge CHC** is looking into how people who

## Services for the Disabled



have to wear caliper supports feel about the service. The CHC's survey will cover attitudes to design, fitting and repairs, and will also ask wearers and their parents about problems with finding suitable shoes. **Medway health district's** contribution to IYDP is being coordinated by a small committee formed under the auspices of the CHC. Activities will include fund-raising for equipment, exhibitions in local

libraries and shopping centres, seminars, hospital open days, access surveys of shops and public buildings, and publicity highlighting employment opportunities for the disabled.

**Weston CHC** is compiling a guide to facilities and services called *Weston made easy for the handicapped*. Survey work for the guide is being carried out by six "job creation" workers funded by the Manpower Services Commission, and in June the guide will be launched with "a blaze of publicity to make the general public aware of the problems of the disabled and their desire to be accepted as an equal in society".

**Dewsbury CHC** has asked the Association of CHCs to write to airport authorities suggesting that IYDP is the opportunity to abolish supplementary charges for the disabled. There are no charges of this kind at the Yeadon airport, which serves the Leeds and Bradford areas, but at Heathrow there is a charge of £15 each time a disabled person is carried from an aircraft to a wheelchair on the tarmac.

**Salford CHC's** disabled working group will be looking at facilities for disabled people in local NHS premises, and **Northern Sheffield CHC** is asking local planning authorities to keep the needs of the disabled in mind — not just in public buildings but in shops and offices too.

□ Is there a need for psycho-sexual counselling in Salisbury? At present it is done in a very fragmented way and the CHC is going to contact all local GPs to see if they think there is sufficient demand to justify regular counselling sessions. Salisbury CHC would be interested to hear if any other CHCs have followed up this area of need.

□ Retired secretary of **Southend District CHC**, Mrs Molly Hart, will now be seeing her CHC from the other end of the table — she's been nominated to the CHC as a member by Essex County Council.

□ In **West Cumbria** the AHA took up the CHC's suggestion of a course for stammerers. The CHC was "delighted" at the AHA's help for "an often neglected section of the public".

## You, yes YOU have a say in your health service

through your community health council



*National publicity for CHCs may be modelled on this poster — in use since 1975 by CHCs in the Yorkshire region. The Association of CHCs, which has been pondering publicity on and off since 1978, has finally decided to produce a poster "incorporating a message from a nationally known personality, which can be purchased by CHCs requiring it". The association also plans to explore the possibility of free announcements about CHCs on radio and TV and an "Open Door" programme on BBC TV, to organise regional workshops on the use of the media, and to hold a publicity exhibition and seminar at its next annual meeting. ACHCEW secretary Mike Gerrard is assembling a library of publicity material, and CHCs are invited to contribute.*

□ A plan for community-based housing for mentally handicapped adults has been drawn up by **King's CHC** as an alternative to the district plan for a large residential home at one end of the district. The CHC proposed a number of family-sized houses throughout the district which would provide varying amounts of support depending on the needs of the residents. It has even found suitable houses for sale and illustrated its shop-front window with pictures of them.

However the CHC finds itself isolated in its desire to house the mentally handicapped throughout the community. It says that both social services and the local branch of the society for mentally handicapped children and adults believe that the problems involved make such a scheme impracticable. The CHC still hopes that some form of compromise plan can be devised.