CHC NEWS

For Community Health Councils

April 1981 No 65

Leaning on the community

The community must take on a greater share of the task of caring for Britain's growing population of elderly people — this is the blunt message of the Government's White Paper on the elderly.*

The main aim of Government policies is to enable the elderly "to live independent lives in their own homes wherever possible.". But in the foreword to the White Paper, Secretary of State for Social Services Patrick Jenkin and the Secretaries of State for Scotland, Wales and Northern Ireland warn that the development of services is dependent on improvements in the economy. Old people will have to rely on families, friends and the voluntary and private sector to look after them. "It is the role of public authorities to sustain and, where necessary, develop — but never to displace — such support and care. Care *in* the community must increasingly mean care *by* the community."

The White Paper covers income, housing, transport, health and the personal social services as well as ideas for encouraging old people to get more out of life.

A high proportion of health service money is spent on looking after old people. The White Paper reaffirms the Government's intention to set up a number of nursing homes within the NHS, to provide care for people who do not need treatment in hospital but are too infirm to be cared for in a residential home. Ministers would also like contractual arrangements with private hospitals and nursing homes to be expanded.

The White Paper calls for faster progress in the development of acute geriatric medicine departments and says that where

Photo: Raissa Page

elderly in-patients' recovery is likely to be slow there should be beds for them in small, local hospitals. The function of day hospitals and the service they provide should be looked at carefully by health authorities. The Government wants to ensure that the day hospital service does not duplicate the work of day centres.

There are still considerable shortages of physiotherapists, occupational and speech therapists, says the White Paper. In geriatric medicine the nursing shortage is "severe" in places.

Elderly people form the single largest group receiving psychiatric hospital care. The Government acknowledges the growing problem of caring for frail, severely mentally infirm old people. It says there should be at least one consultant psychiatrist with special training in this field in each health district and is taking some steps to encourage this. It also recommends that all those whose job it is to care for old people, whether in the private sector, the statutory services or in a voluntary capacity, should receive appropriate training.

As in the *Care in action* priorities handbook (see inside, page 11) the White Paper stresses how highly the Government values the voluntary sector and the care given by families. It also highlights joint finance, and lists night sitting services, residential homes, home helps and hospital discharge schemes as examples of praiseworthy collaborative effort between the NHS and social services.

Charities and pressure groups for the elderly have reacted gloomily to the document. "It's hardly more than a simple repetition of already known facts and Government policy", said a spokeswoman for Age Concern. "You'd expect a White Paper to herald some immediate legislation, but the proposals for flexible retirement age, equalisation of retirement age and tax credits are still in a far-off future."

The White Paper commits the Government to "ensure price protection for pensions over the years as a minimum". The Budget's promise of pension increases of 9% in November — one per cent below the Government's own estimate of inflation — was described as "mean and spiteful" by Help the Aged.

The White Paper paints a sombre backcloth to the provision of services for the elderly in Britain. In the last 20 years the number of old people has risen by one third. In the next 20 years the number of over-75s will grow by about one-fifth and the number of people aged 85 and over will go up by at least one half. A new aspect of caring for the elderly will be that some of the people who came to Britain in the 1950s and 1960s from Asia, Africa and the Caribbean are now becoming old age pensioners and may have special needs.

* *Growing older, Cmnd. 8173, HMSO £4.20. A summary of the White Paper is available free, from DHSS, (Social Handicapped Division 2B), Room B403, Alexander Fleming House, London SE1.*

● *See page three, Comment.*

CHC NEWS Publication...

CHC NEWS is to be published ten times a year, to ease the extreme overload of work on the magazine and information service. Last month's Editorial Board meeting agreed to ask the DHSS to fund an additional member of staff, and approved the cut of two issues per year as an interim measure.

... and price

The annual subscription to *CHC NEWS* has been £3.50 since May 1979, and the Editorial Board has agreed an increase to £5.00 from 1 May. The discount for orders of five or more copies per issue will be increased from 14 to 20%.

INSIDE ...

Your letters

Midwife shortage

Beryl Sloan, Secretary, North Tyneside CHC

Our small and popular GP maternity unit is facing formal closure consultation because of the shortage of midwives in the consultant unit three miles aaway. Midwives have had to be transferred there permanently because of the inability of the main hospital to attract or keep sufficient staff.

The idea that this shortage is a national problem seems to have been disproved by at least three shortage-free districts in Yorkshire.

We would welcome any comments, advice or local experiences on the subject of shortage of midwives or the closure of small maternity units. We appreciate the strong medical and financial arguments against small hospitals but this closure is based largely on the key issue of shortage of midwives. If this is not a national problem we hope to gather sufficient evidence to show that there are ways of overcoming the shortage.

Maternity statistics

Alison Macfarlane, National Perinatal Epidemiology Unit, Radcliffe Infirmary, Oxford OX2 6HE

One of the tasks given to the working group on maternity statistics, set up by the Steering Group on Health Services Information (the Korner Committee), is to identify information needed to review "the social acceptability of the care being provided".

In order to find out what information consumers think is needed we are sending a questionnaire to CHC secretaries. We hope all readers interested in maternity services will contribute their views.

What's in a name?

H L Snowden, Chairman, West Surrey and North East Hampshire CHC

I was very impressed by "What's in a name?", the article on generic prescribing by Susan Jenkins, the Secretary of Leeds Western CHC (*CHC NEWS 61* pages 8-10). This must have required a great deal of work and investigation, resulting in the adoption of Leeds Western's resolution on prescribing at last year's AGM of the Association of CHCs. Contributions such as this show the value of CHCs.

Training for assistants

Mrs P Jarrett, Assistant, Solihull CHC

Following the comments from CHC assistants in *CHC NEWS 61* page two, it may be of interest to other assistants to know that the secretary of my CHC organised a day training session for West Midlands CHC assistants in January. All but two assistants attended.

From the feedback we have received in Solihull I can't help but feel that other assistants would benefit from a similar course should one of their secretaries be able to arrange this. I certainly feel that I learned a tremendous amount and the other assistants were very keen to exchange views.

Through *CHC NEWS* I would like to thank the speakers at the training day, and my Secretary for organising it. I wouldn't have missed it for the world.

Voluntary organisation members of CHCs

Mrs A Lewis, Member, Croydon CHC

Comments in the *CHCs in England* consultative paper suggest that the number of members from voluntary organisations on CHCs may increase to half of the total. It is therefore imperative that the election procedure for these members is fair and "seen to be fair".

In July 1980 our election agents, the Croydon Guild of Voluntary Organisations, devised an election system based on the "single transferable vote". Any voluntary organisation on the "approved" list was able to nominate representatives to stand for election to the CHC. Only organisations with current CHC members were debarred. The election was by numbered postal votes. An independent body, the Electoral Reform Society, counted the votes, which relieved the agents of this task and any subsequent explanation of the results.

It was generally agreed that this was a superior method of election to that suggested by the DHSS. I propose that all CHCs think carefully about election procedures if they value their independence and credibility.

Depo-Provera

Women's Subcommittee, Brent CHC

At Brent CHC we were delighted to discover recently that the number of women in Brent using the contraceptive Depo-Provera (DP) has dropped from 32 to two. This is particularly gratifying as our local consultant gynaecologist told a recent public meeting organised by the CHC that DP was the contraceptive of the future, and was here to stay.

Our conclusion must be that the meeting, together with other forms of protest by ourselves and the local campaign against DP, were instrumental in the change in practice. We were also interested to receive a report on DP from the drug company Upjohn (see *CHC NEWS 63* page two). We would like to hear from other CHCs who have received the report, about the use of DP in their areas. We would be particularly interested to know whether its use has declined in the country as a whole. Please send information to our CHC secretary.

Mental handicap — a case for special treatment?

William Ashworth, Member Burnley, Pendle and Rossendale CHC

At MIND'S annual conference Professor Peter Mittler asked where mental handicap expertise would come from at district level after the latest reorganisation.

Our CHC has a small but significant suggestion to make to the Regional Health Authority, which could well be taken up by other CHCs. This is that when the local District Health Authority is created an extra member should be appointed to it who has a special interest in mental handicap, and knowledge of the local mental handicap hospital, Calderstones.

Health circular HC (80)8 provides that in effect there shall be six generalist members of a DHA. Of course, one of these might have some knoweldge of mental handicap, but in any case the circular says "It is also open to RHAs to propose a slightly larger membership if in their view local circumstances justify this". What better justification can there be than the presence of a mental handicap hospital in the district.

If our suggestion is accepted, it will be a small step but perhaps an extremely useful one in practical terms. One member of the DHA with enthusiasm and some knowledge of the subject could have a real impact at district level by questioning, stimulating and acting as a focal point for action on the problems of the mentally handicapped.

Artificial limbs

Jenny Patteson, Member, Tunbridge Wells CHC

Our CHC's group for the elderly and physically handicapped has been looking into the services provided by our local artificial limb and appliance centre. We would be interested to hear if any other CHCs have investigated these centres in their own districts. If so what have they found out about the fitting of artificial limbs and the provision of aids for mobility?

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

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Comment

When the Government's handbook on priorities and the White Paper on the elderly came through the letterboxes last month there was little to be heard but two muffled thuds. People working in and around the NHS seem to have been stunned into almost total silence, with reactions ranging from apathy to cynicism.

The priorities sound familiar — concentrating resources on the most vulnerable users of the NHS — the mentally ill and handicapped, the disabled and the elderly. Prevention is also important, says the Government. We have heard that before, too.

The White Paper on the elderly says that more and more old people are living longer, and everyone must pull together and look after them. If immediate families don't rally round — perhaps they live too far away — Ministers say that old people "should be able to look for support to friends, neighbours and the wider community". This will be bad news for the thousands of isolated old people who live alone. Few can share the Government's delusions that "friends and neighbours" can be magicked up overnight.

The priorities document acknowledges that in the foreseeable future we cannot have a decent geriatric service. It warns that most in-patients over 75 will have to be treated in general acute beds and that the pressure will get worse because of the growing numbers of frail old people. So what are we to make of the recommendation in last year's paper on the future of hospitals (see *CHC NEWS 56* page 11) to cut the target for geriatric bed provision in district general hospitals? The DHSS says the shortfall is to be made good in other hospitals, yet all over the country convalescent homes and small hospitals which have been used mainly by old people are being closed and sold off. Further pressure on beds is added by the overload on home help and meals-on-wheels services, day centres, old people's homes, sheltered housing and all the community care facilities which help the elderly survive outside hospital..

How are the priorities to be implemented? This must be a local matter, say Ministers. Yet they hold the purse strings and in 1981/82 their squeeze on spending could grow even tighter. Ministers seem to want to abdicate all responsibility for ensuring the delivery of good quality patient services — except for Dr Vaughan's occasional swoops to save a small hospital from closure.

There is also a pointed avoidance of measurable targets in both documents — no bed norms, no staff ratios. Yet the targets of the 1970s still exist — they are vaguely referred to in *Care in action*. Why are Ministers so loth to remind members of the new district health authorities forcefully of the standards they should aim to meet and surpass? Could it be that if everyone forgot about the targets, the Government would be spared repeated episodes of political embarrassment?

What will happen to elderly people as social services crumble and the hospitals are overloaded? It is only a matter of time before malnourished, housebound old people start dying alone in misery and squalor — in "noticeable" numbers. Families, friends and neighbours will be blamed, but with any luck the Government will have failed to deaden our senses with its whirlwind of empty documents and circulars.

● For details of the Government's handbook on priorities see page 11.

Health News

NHS will not compete for funds with charities

The DHSS is likely to amend the controversial circular on NHS fund-raising which has aroused so much wrath among major charities (see *CHC NEWS 63* page 1).

The circular (HC(80)11) encourages health authorities to involve themselves in fund-raising and offers them such incentives as interest-free loans to employ fund-raisers. Major charities were angry that they were not consulted about the circular. They claimed that the NHS would be in direct competition with them for the diminishing contributions from the public.

Sir George Young, the junior health minister, says that it was never the Government's intention that health authorities should "undermine or compete" with the charities. He considers that the circular is designed to encourage authorities to draw closer to their local communities — to liaise with voluntary groups who are already collecting money, and only engage in fund-raising themselves when there is no local voluntary activity.

Discussions about the circular are now taking place between the DHSS and the National Council for Voluntary Organisations (NCVO). The DHSS says that although there will be no substantial alternations to the circular it will almost certainly be amended to emphasise that health authorities must discuss their fund-raising plans with local voluntary groups before the plans are implemented. And wherever possible fund-raising for the NHS is to be done through local organisations.

Breathing smoky air is a cancer risk

Strong evidence is beginning to emerge that "passive smoking" — the breathing of air containing other people's cigarette smoke — can cause lung cancer. In research (1) carried out in Japan, 91,000 non-smoking women with husbands who smoked were studied for 14 years, and their lung cancer

rates were found to depend directly on how many cigarettes their husbands smoked. Women whose husbands smoked 20 or more cigarettes daily had more than double the lung cancer rate of non-smokers' wives. The Japanese finding has been confirmed by similar research in Greece (2).

1: *British Medical Journal*, 17 January 1981, pages 183-5. 2: *International Journal of Cancer*, Vol. 27, pages 1-4.

Private medicine gets a leg up

A generous package of support and encouragement for private health care has been drawn up by the Government, for implementation by health authorities.

The new circular on co-operation between the NHS and the private health sector, number HC (81)1, states firmly that private hospitals and nursing homes "are part of the health care resources of this country, and the Secretary of State is keen to encourage increased use of them by NHS authorities wherever they can contribute economically and effectively to the care of NHS patients".

"When planning the provision of NHS services", it continues in italics, "health authorities should take into account the current and planned facilities available in the independent sector in order to assess the potential for contractual arrangements". Possibilities could include short-term contracts as a way of tackling long waiting lists, and longer-term arrangements where some specialised service would be uneconomic to develop within the NHS.

CHCs are not mentioned in the circular, though it covers several subjects in which they have hitherto been expected to take an interest. On planning, it remarks that where there has been long-standing NHS use of private hospitals or nursing homes these are "as much a part of overall provision as a NHS-run hospital", and "should be integrated within the local planning processes which apply to NHS-run

Continued on next page

Photo: Scottish Health Education Unit

Health News

Continued from previous page
hospitals".

Health authorities are warned that before agreeing any contract they will need to check on standards of acommodation, staffing, care and treatment, and that regular monitoring will be needed from then on. "Hived-off" patients must be treated the same as other patients in the hospital or home, and must not be "pressed into paying for extra amenities (outside the terms of the contract) which they do not want".

The circular suggests that authorities with surplus land and property should consider selling it to the private sector, and authorities with temporarily unused buildings are asked to consider leasing arrangements. Joint purchasing schemes and joint staff training programmes are also suggested. The circular points out that it is not intended to cover the use of private contractors to provide NHS "hotel" services — a qualification which has been added since this guidance appeared in draft form (see *CHC NEWS 58* page one).

● According to consultant economists Lee Donaldson Associates, the number of people covered by private health insurance schemes increased by 27.5% during 1980 — by far the largest rate of growth ever recorded. Last month's Budget gave a further boost, in the form of tax relief for companies providing private health insurance as a "fringe benefit" to employees earning less than £8500 pa.

Pill "safe" for under-35s

Women under 35 who take the contraceptive pill are running little or no risk of circulatory disease, and there is now no evidence to support the "widespread belief" that women who have been on the pill a long time should consider this to be a possible risk factor.

These are the two major findings in the latest report (1) from the Royal College of General Practitioners' Oral Contraception Study, a continuous study of over 23,000 women who began taking oral contraceptives in 1968 and 1969.

The previous report from the RCGP research team, published in 1977, found that the risk of diseases of the circulation increased with length of time on the pill. But now that the number of deaths in the group of women being studied has increased from 101 to 249 a more precise statistical analysis has become possible, and this effect has apparently disappeared.

In non-smoking women aged 35-44 the pill causes on average one death per 6700 users every year, but in smokers the figure is one death per 2000. In women aged 45 and over the annual figures are one death in 2500 for non-smokers and one in 500 for smokers. The report says that some non-smokers in the 35-44 age group "might find the benefits of oral contraception outweigh the estimated risk, particularly if duration of use of the pill is less important than we had previously believed."

1. *The Lancet*, 7 March 1981, pages 541-6.

NHS spending will rise — if the cash can be found!

Spending on the hospital and community health services will increase in real terms by about $1^1/_4\%$ in 1981/82 and by a further $1^3/_4\%$ in 1982/83, according to the Budget White Paper (1). These figures are essentially unchanged from last year's expenditure plans, except that a further £23m at 1980 prices has been deducted from allocations to health authorities in this year's "efficiency squeeze".

Says the White Paper: "The rising costs associated with demographic change (about 0.7% a year on average) will be accommodated in the growth planned up to 1982/83 and there will be a small margin for improvements in medical techniques and desirable service developments. The process of resource reallocation to ensure a more equitable geographical distribution of health care facilities will continue, but progress towards remedying the many deficiencies in the service will depend crucially on health authorities' ability to make even better use of existing resources".

There are strong indications elsewhere in the White Paper that the importance of "volume" (ie real terms) targets is on the wane, and that in future spending plans may be abandoned if pay settlements and inflation turn out to be worse than expected. "The Government's policy is that all volume plans are to be regarded as no more than indicative working targets; their attainment is dependent on the availability of finance. It is actual cash expenditure which must be considered in relation to, and made consistent with, the Government's objectives for taxation, the borrowing requirement and the money supply".

Spending on local authority personal social services is expected to fall by £9m in 1981/82, but to rise by £29m in 1982/83. These figures are described as "tentative", since local authorities might choose to cut deeper into their other spending programmes "to protect as far as possible services for the most vulnerable".

Plans to increase the charges for NHS treatment of road traffic casualties and to introduce sight-test charges have been dropped, but dental and optical charges have been increased from the first of this month. And from October onwards some visitors from abroad will be charged for NHS treatment.

1. *The Government's expenditure plans 1981/82 to 1983/84*, Cmnd 8175, HMSO £9.30.

United campaign for the mentally handicapped

A new alliance of voluntary organisations, the Jay Action Group, has been formed to step up pressure on health authorities to provide a better deal for mentally handicapped people along the lines recommended in the Jay Report. The group wants a rapid replacement of mental handicap hospitals by a community-based service and special training of staff to support mentally handicapped people and their families in their homes. Dafydd Elis Thomas MP chairs the group, whose members include representatives of MENCAP, the Spastics Society, Exodus, the British Association of Social Workers, the Campaign for Mentally Handicapped People and MIND. Further details from Dafydd Elis Thomas MP, House of Commons, London SW1.

Debendox — a warning

A strong warning about the risks of prescribing drugs in early pregnancy will be given to doctors considering the use of the anti-nausea drug Debendox.

In a letter to the MP Jack Ashley, Secretary of State Patrick Jenkin says that the Committee on Safety of Medicines has found no reason to alter its earlier view that "there is no scientifically acceptable evidence that Debendox causes harm to the foetus". However it believes that as a "precautionary measure" it would be advisable for the data sheet on Debendox to contain a warning about its use.

The warning has been agreed with Merrell, the company which produces Debendox. It reproduces the CSM's view (as stated in its information sheet *Current problems 5)* that it is impossible to prove that any drug is absolutely safe in pregnancy. But although the warning is couched in general terms — "the use of any drug during early pregnancy should be avoided if at all possible" — its inclusion in the data sheet which goes to all doctors is obviously likely to make some of them think twice before prescribing Debendox.

Orthopaedic improvements

"No specialist orthopaedic hospital, however small or isolated, should be closed unless it can first be guaranteed that the facility planned to replace it will provide the same or a better standard of service for an equal or increased number of patients within a similar period of time". This is not the central recommendation of the Duthie Report on orthopaedic services (1), but it is one which will be of special interest to CHCs.

A particular problem in orthopaedics is that the need to treat emergency patients as they arrive means that "elective" or "cold" surgery — eg hip replacement operations — often has to be postponed. Admission of elderly patients as emergencies can also lead to "blocked beds". Staff shortages are another reason why planned elective surgery sometimes has to be cancelled.

The report looks at a variety of ways to ease these pressures and so reduce waiting lists, including day surgery, better community care, improved collaboration between specialties, and increased use of private hospitals. One chapter looks at the potential for replacing waiting lists with systems of "planned admission".

1. *Orthopaedic services*, HMSO £4.95.

A patients' practice

by Pip Sturt, Patient, Limes Grove Practice*

Like most people, I am registered as a patient with a local NHS general practice, but this is one that is rather different. The Limes Grove practice was set up in February 1976 by a group of people who wanted to work within the National Health Service, but were unhappy with the way general practices were usually run. They wanted to break down the rigid barriers between doctor and patient, to encourage people to participate actively in their treatment, and to help them learn about health.

In the early days the reputation of the practice and its commitment to people's control of their own health spread, especially among the women's liberation movement. An unusually high proportion of the patients were young, particularly young women. There are now over 2000 patients registered at the practice and this number is rapidly growing. A catchment area was decided on and these days the patients tend to be a more typical cross-section of the local residents.

The practice, however, has not become a typical local practice. As well as the doctors (two partners, and a number who work part-time, all women), there is an acupuncturist, two psychotherapists and a person who works on massage and body language. For the last two years we have held a Christmas Party in a local community centre for everyone, patients and workers, connected with the practice. There is also a newsletter for patients and workers.

Although formally it is a partnership of two doctors, the practice functions as a co-operative of workers. All workers, including the doctors, are paid on a sessional basis at an equal rate, and all share in the practical and administrative chores of the surgery. Every Monday afternoon the workers meet to discuss the daily running of the practice.

The workers at Limes Grove felt that patients should be directly involved in the running of the practice, so that the practice could evolve according to what people wanted, rather than be controlled by the doctors and other workers. The first move towards this was in April 1977, when an open meeting for everyone registered with the practice was held. Although at that time the number of registered patients was small, an amazingly high proportion of them attended the open meeting to discuss what they wanted from the practice and what they could offer it. There was a lot of enthusiasm at this meeting, and eventually it was decided to establish a "management collective" which would have open meetings that anyone registered with the practice could come to.

However in early 1980 a group of patients and workers was set up to make decisions about the management of the practice, including the employment of new workers, rates of pay etc. This group was set up as a result of frustration at trying to elicit patients' opinions at the general open meetings. It replaced the management collective. A number of patients offered to commit themselves to attend monthly meetings for one year. After that the situation will be reviewed—the ideal to aim for would be an elected group. The management group has set up a procedure, involving patients and workers, for the appointment of new workers and also a group to deal with the frequent requests for information, articles, speakers etc. Issues from the workers' weekly meetings are passed on to the management group. One issue has been whether to attempt to slow down the growth in size of the practice, and, if so, how to do this.

There have been problems. It is difficult to avoid getting "bogged down" in daily trivia with a structure involving so many people. As with many similar groups, after the initial burst of enthusiasm the numbers have thinned a little. Inevitably too, some decisions have to be taken by the workers on the spot because of the delay involved in consultation with the group. The composition of the group may well not be typical of the patients registered with the practice (more professional and articulate, perhaps) and they represent nobody but themselves. A sub-group set up to manage the finances of the practice did not work out, perhaps because this matter requires day-to-day attention and is not easily dealt with by a group.

The management group does, however, fulfill a useful role, which I see as giving some external but interested feedback to the workers' co-operative. It is an over-statement to say that the group manages the running of the practice, but it does play an active part in the co-operative structure that runs the practice. Some of the decisions, such as restricting the catchment area of the practice, must have an effect on potential patients, but by and large the functioning of the group will be invisible to the typical patient of the practice.

How does it feel to be a patient at this practice? Does the radical organisation actually affect the patients themselves? As a patient, the most important thing to me is to know that I will get the best of medical care if I need it. At other practices I have experienced being prescribed a placebo, being ushered out of the room before I had finished explaining the problem, and being made to feel that I have wasted a doctor's valuable time. Here I know that this won't happen. Secondly, and also very important to me, the wool won't be pulled over my eyes if I do have a serious problem. I know that if I ask, everything will be explained to me in great detail, that I can study my own medical notes, look up any drugs I am prescribed in MIMS in the waiting rom, later phone the worker on duty to obtain more details. The relaxed atmosphere of the place is an added bonus. Instead of the serried ranks of worried people silently eyeing you to make sure that you don't slip in to see the doctor before your turn, you can lounge on the cushions while people chat to you.

Can this sort of structure be set up elsewhere? It certainly can, but only if *doctors* are committed to it in the first instance. One cannot imagine it being initiated from the patients' end in a practice where the GP is not interested. But it does show what can be done with good will from all concerned. One hopes that by raising people's expectations they will become less tolerant of poor standards of health care elsewhere.

* The Limes Grove Practice, 43a Limes Grove, London, SE13 6DD.

Patient participation groups

The first patient participation groups (PPGs)—also sometimes called patients' committees—were started in the early 1970s, with the intention of improving communications between doctors and patients. There are now about 30 PPGs in England and Wales. Information about existing groups is available from the **Central Information Service for General Medical Practice,** 14 Princes Gate, London SW7 1PU. The **National Association for Patient Participation in General Practice** co-ordinates the work of PPGs and arranges public meetings. Further details from its secretary Hazel Ackery, 28 Heol-y-Deryn, Glyncorrwg, Port Talbot, West Glamorgan.

Some further reading:

Patients' committees are here to stay by Ruth Levitt, *CHC NEWS 33* (1978).

Patient participation in primary health care: A discussion paper by Peter Pritchard, *Health Trends, November 1979, pages 92-5.*

Book reviews

The good health guide

from the Open University in association with the Health Education Council and the Scottish Health Education Unit, Harper and Row, £8.95

It is easier to describe this book by saying what it is not than to give a concise idea of what it is. It has nothing to say about when to get your baby immunised against diphtheria or about the virtues of regular tooth brushing. It is not about illness at all. The authors have a much broader approach to health and this book is an exploration of how much control individuals can exercise over their own health and behaviour. Health is seen as being as much to do with minds as with bodies.

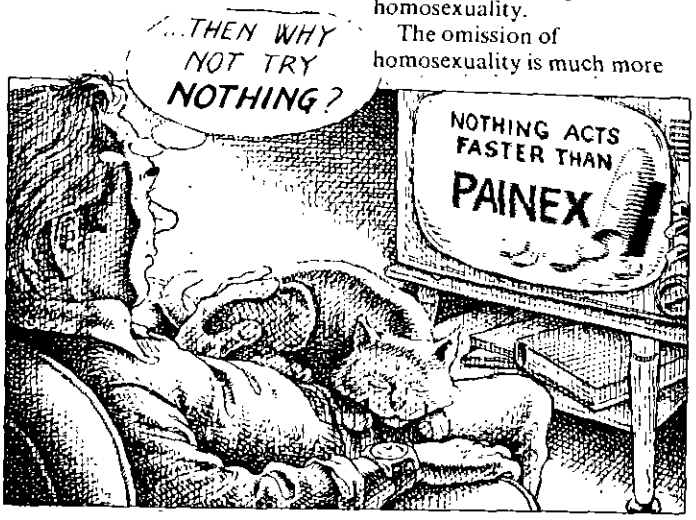
The book is an accompaniment to an Open University education course, *Health choices*. It is generously illustrated. Its starting point is that we are all at the receiving end of a variety of messages about our health. Advertisements, TV programmes, newspapers and magazines tell us we eat too much, we eat the wrong things, we drink unwisely, we smoke and we suffer from stress. They offer a choice of authoritative solutions. Stop this. Do that for an hour a day. Take these pills. The advice is often conflicting and usually sounds vaguely unpleasant — a mild form of punishment.

We are all familiar with what happens next. We resolve to turn over a new leaf and for a few days or weeks we zealously pursue an often over-ambitious goal. This often makes us self-righteous, irritable and generally hell to live with. Sooner or later the zeal wears thin and gratefully we slip back into the old patterns.

The *Good health guide* tries to steer a different path towards positive health, by going back to basics and helping us examine our patterns of behaviour and our feelings, *before we start*. When we have done that we can use this book to decide what we want to alter and look at what stands in the way between us and our new goals.

Suppose I want to lose weight. Part of the problem might be quite simply that I don't know enough. I go on innocently drinking six pints of beer a night, all unaware of its effect on the flab. Or maybe I'm afraid of changes, or I just lie to myself ("I don't care if I am fat").

Perhaps this sounds like standard health education stuff — worthy phrases churned out in a rather cheery, pull-your-socks-up voice. But this book goes much further. Its chapter *Person to person* takes self-esteem and confidence as two essential elements of individual good health. It sets out the problems of assertiveness (not the same thing as aggressiveness) and what it calls "personal space". It also goes much further than conventional health education in acknowledging that there are huge areas of our lives over



which we can have very little control.

Maybe your job gets you down? It is pretty pointless to fret about changing it, as a way to better health, when you live in a place where jobs are scarce and the dole queues long. Personal change and personal choices can only take you so far towards better health. Sometimes you have to join together with others to achieve this.

Enforcing safety regulations at work is one example of this kind of action. This book has a good chapter on work and health, covering topics such as stress, health hazards and accidents at work, and taking action on health hazards.

But there are plenty of aspects of our lives which we can tackle personally and I found the chapters on stress and emotion especially interesting. There are useful checklists to help you assess what makes you anxious, and sensible advice about managing stress. There is also a simple explanation of the signs of depression although the book warns that badly depressed people need expert help. All the tips in the world — "get up, get washed, get dressed ... check your diet ... try to stop thinking about bad times" will not be of much use when you really feel that the sky is falling in.

The chapter on sex is lively and reassuring, with pictures which get well away from the idea that sex is something for young, slim, fit, beautiful people. But if you are homosexual, you'll have the impression that this chapter is not for you at all, unless you look very carefully for the fleeting acknowledgements of homosexuality.

The omission of homosexuality is much more than just a quibble with this book. The price puts me off as well. But I would still recommend the *Good health guide*. It's packed with information and it's a great read. To this particular overweight, slack-muscled townie — it even manages to make getting healthy sound quite enjoyable!

Janet Hadley

Medico-legal problems in hospital practice

by J L Brennan, Ravenswood Publications Ltd, £11.50

Can you sue the publishers of this 106-page paperback book if you have had a heart attack on learning its price? That particular medico-legal problem is not answered, but there is much that will be of value to CHCs.

J L Brennan describes what happens when a person dies in hospital. Who has to be notified? When does the Coroner have to be informed? There are helpful case studies illustrating the circumstances in which an inquest might be held. If a death in hospital was sudden, unexpected or violent, or the relatives were dissatisfied, the coroner could exercise powers to call for an inquest.

The book is written for hospital administrators, who would probably not be legally or medically qualified. It covers removal of tissues and organs after death and the legal problems surrounding injury and disease. There is a most interesting, if rather specialised, chapter on the complex subject of cancer caused by injuries.

The writing is commendably terse and clear, as law books go. It would be a useful book for occasional reference — in the public library?

Medicine out of control

by Richard Taylor, Sun Books/Macmillan, £4.95 (paperback)

Images of high technology medicine as portrayed in the glamorous hospital environment of TV serials and feature films meet a basic human need to believe in the existence of medical salvation. Until recently there has been little serious attempt to question the validity of high technology medicine in relation to the alleviation of human suffering and the curing of disease. People have been content to accept the expertise and acknowledge the wisdom of the medically qualified person, almost as an act of faith. However a number of writers have now seen fit to draw attention to some anomalies in modern medical practice, among them Richard Taylor, who has chosen to explore the problems surrounding high-technology medicine.

Medicine out of control is a balanced, rational and well-documented account of such crucial issues as ineffective evaluation of potentially dangerous high technology procedures, the need to medicalise minor abnormalities and therefore to legitimise the use of expensive and often dangerous drugs, and the problem of super-specialisation in medicine which encourages

doctors to take a fragmented view of their patients.

Taylor has also explored the question of doctor-induced disease, caused by the use of drugs and procedures which in themselves can and do cause disease.

The author accepts that medical technology is a useful weapon in the doctors' battle against ill-health but he notes that at present technology rather than the technologist is in control. This is a book which will provoke thought, discussion and controversy.

Dr Frada Eskin, Unit for Continuing Education, Department of Community Medicine, Manchester University.

Books received

Medicines — a guide for everybody by Peter Parish (Penguin £2.25). Updated third edition of what has proved a very useful book. Guide to families of drugs and good index.

Self-help and the patient: A directory of national organisations concerned with various diseases and handicaps (7th edition, £1.20 post free) from Patients Association, 11 Dartmouth Street, London SW1H 9BN.

Health rights handbook by Gerry and Carol Stimson (Penguin £1.25). Guide to health care in the NHS — consent, medical records, confidentiality, etc.

Alcohol problems in employment edited by Brian D Hore and Martin A Plant (Croom Helm £14.95). Most problem-drinkers are employees. Why do some jobs (doctors, for example) have more than their fair share of alcoholics?

Perspectives on epilepsy 80/81 compiled by the British Epilepsy Association (£2 plus 50p post). From BEA, Crowthorne House, Bigshotte, New Wokingham Road, Wokingham, Berks RG11 3AY.

Awareness through movement by Moshe Feldenkrais (Penguin £1.95). Contains "health exercises for personal growth".

Coping with uncertainty — policy and politics in the NHS by David J Hunter (Research Studies Press £17). About the Scottish health service, and rather academic.

PLANNING IN THE FUTURE

by Chris Ham, Lecturer, School for Advanced Urban Studies, University of Bristol

A circular recently issued by the DHSS* indicates that important changes will soon take place in the NHS planning system in England.

Why are these changes taking place, and is planning really important?

The main aim of the changes is to retain the *discipline* of planning, which *Patients first* argued "has demonstrated its value", but to *simplify* the planning system. In line with the Government's wish to delegate decision-making to the local level, the new District Health Authorities (DHAs) will play a key role in the revised system. They will prepare *strategic plans*, covering developments over a ten year period or more, and these will be reviewed every five years. DHAs will also have responsibility for operational planning, covering developments over two years, and taking the shape of an *annual programme of action* setting out firm proposals for the first year and forward plans for the second year.

The role of Regional Health Authorities (RHAs) will be to prepare a regional strategic plan based on the district strategies, and to meet each DHA annually to review district strategies and to settle priorities on the forward programme for operational planning. RHAs will also meet the DHSS to discuss strategic plans and to review progress in implementing these plans.

A number of CHCs have argued that planning is not important because in some places it is simply not taking place (for example, see *CHC NEWS 51* page 13).

There are two main reasons for this. First, the constraints on NHS spending in recent years have not provided the best climate for a complex new planning system to be launched, particularly as in the past planning has been concerned almost entirely with new developments. Second, although it was the intention that planners should review existing services as well as consider proposals for growth, this has proved problematic.

As a result of these factors, planning has been given low priority in some health authorities. Nevertheless, the DHSS commitment to planning remains, and essentially the Department sees planning as the means by which national priorities are converted into local plans, and as a channel for shifting resources in favour of neglected client groups. It is for these reasons that planning is important.

Changes are taking place because the existing system is thought to be over-elaborate. This is particularly so in relation to operational planning, where concise programmes of action will replace comprehensive plans. Part of the reason why the system has been implemented unevenly is that too much was expected too soon from health authorities. A number of commentators have questioned the wisdom of the comprehensively rational approach on which the system was based. The new arrangements are considerably simpler, and will involve less time spent preparing formal plans, and a greater investment in planning as a continuous management process.

A number of questions remain about how the system will operate in practice. The first concerns the relationship between DHAs and RHAs. Earlier proposals for change, prepared under the aegis of the Standing Group on Planning, which contains representatives of the DHSS and health authorities, envisaged an extremely limited role for RHAs. This is consistent with the Government's policy of leaving decisons to local discretion. It now seems as if RHAs have been successful in winning back some of their functions. How this will be squared with the Government's intention to review the role of RHAs with an eye to limiting their responsibilities, remains to be seen.

A second question relates to CHC participation in planning. The circular states that full and timely consultation with community and other interests is important. This is likely to take the form of formal consultation on strategic plans and forward programmes, together with involvement in the preparation of policies and plans for individual services. Experience to date indicates that formal consultation has often been a ritual activity, and of little value compared with CHC involvement in planning teams. However, it is unclear whether planning teams will have a place in the new system. What does appear probable is that ad hoc planning groups will be established to examine selected issues, and it would seem important for CHCs to be involved in these groups.

A third question concerns the consequences of giving districts a greater role in planning, especially strategic planning. Clearly, this carries the risk of non-conformity to national policies — and possibly inertia. Being closer to the local power structure, it may be difficult for DHAs to make the awkward decisions on resource allocation and priorities which are sometimes necessary. On the other hand, delegation encourages local responsibility and increases the likelihood of successful implementation. Whether this will be at the expense of centrally-stated priorities will only become apparent in practice.

Finally, it is worthwhile CHCs noting that the changes outlined here have been presented as proposals and the DHSS has invited comments. If the *Patients first* consultative process is a reliable guide, CHCs with strong views may be able to influence the final shape of the new system.

*HN(81)4. *Review of the NHS planning system — a consultative document.* Published February 1981. Comments to be sent "within three months" to Planning and Information Branch, DHSS, Room A406, Alexander Fleming House, London, SE1.

CHCs AT WORK 1980

*by Christine Farrell and Jeff Adams**

In December 1977, *CHC NEWS* published a survey of the work of CHCs. A new survey has just been completed which presents up-to-date information and points to some of the changes which have taken place during the past three years. All 228 CHCs in England and Wales were sent a questionnaire in November 1980 and 194 (85%) replied. This was a slightly higher response rate than the 79% replying to the 1977 survey. As far as it has been possible to tell, the CHCs which did not reply had no characteristics which marked them out from the others. The findings presented here are likely to reflect the situation in all CHCs.

Membership

The majority of CHCs (89%) had between 22 and 33 members. Only three CHCs had 34 or more members and 18 had less than 22. The average number of members for all CHCs was 28. Thus the recommendation in the current DHSS consultative document on the role of CHCs, that membership should be reduced to 18, would represent a considerable reduction in the work force of most CHCs. Nearly two-thirds of the CHCs in the survey (61%) had extended their membership by co-option. The majority of these (42% of all the CHCs) had less than five co-opted members. Twenty-six CHCs (13%) had between six and ten co-opted members and 11 (6%) had 11 or more co-opted members. Regional analysis showed that CHCs in Wales and the South West Thames region were more likely to have smaller numbers of members than those in other regions.

Publicity

Publicity is an important part of CHCs' work, and almost all the CHCs in the survey had publicised their existence (96%). The most popular methods used were leaflet distribution (87%), posters (67%), visiting and talking to local community and voluntary associations (54%), and putting leaflets, notices and posters in libraries (51%). The media had been quite widely used, with half the CHCs putting announcements into the press and one in four using local radio. Other methods of publicising the existence of CHCs included advertisements on public transport (8%), specially printed carrier bags (10%), stalls at fetes (7%), newsletters (10%), balloons, bookmarks and booklets.

**Christine Farrell is Reader in Applied Social Studies at The Polytechnic of North London, and was research officer for the Royal Commission on the NHS. She is also vice-chairman of Haringey CHC. Jeff Adams is a research officer at the polytechnic. A full report and analysis of the questionnaires will be available in May, from Christine Farrell, Department of Applied Social Studies, The Polytechnic of North London, Ladbroke House, Highbury Grove, London N5 2AD. Price £1.00 to cover costs of reproduction and postage. Cheques should be made payable to "The Polytechnic of North London".*

Staff and voluntary workers

Almost all the CHCs had a secretary in post (97%). One CHC had a vacancy and four did not provide the information. All except seven of the secretaries were paid on Scale 9. This represents an upgrading for 10% of CHC secretaries since 1977, when only 83% were paid on that scale. Fourteen CHCs had no assistant secretary and 13 of these said that they needed one. Nearly three-quarters of CHCs (71%) said that they had some full or part-time clerical/typing help, and a small proportion (13%) had students working with them. Over half (53%) said that they needed additional staff to help carry out their work properly. The kind of extra help they felt they needed most was assistance with clerical tasks (20%) and research (15%). Some CHCs (29%) had applied to their Regional Health Authorities for extra funds to employ additional staff, but of these nearly two-thirds (63%) had had their applications rejected. One in four of the applications had been successful.

A third (36%) of the CHCs had made use of the various "work experience" schemes offered by the Manpower Services Commission, and a further 13% were considering using them. These schemes have become more popular with CHCs since 1977, when 17% of CHCs said that they had used or considered using them. One third of the CHCs also used voluntary labour. Husbands and wives of CHC members and staff, students and members of local voluntary agencies had offered (or been pressed into!) help with surveys (81%), leaflet distribution (14%) or general clerical help in the office (7%).

Accommodation

Office accommodation housed the largest group of CHCs (41%), with less than one in five (18%) in shop-front premises. A further 12% were sited in hospital or other NHS buildings, and one CHC inhabited a Portakabin. Altogether, 43% of the CHCs were in privately rented accommodation, a third were in NHS property, 17% in local authority premises and one CHC said it owned its own building. Nearly half the CHCs (49%) were in buildings which had access for wheelchair users, with a further 11% allowing access with help. The remaining premises had no access for the disabled using wheelchairs. However, three out of four CHCs (73%) considered that their premises were satisfactory. Reasons given by the others for dissatisfaction with their accommodation included: isolation from the public (13%), not enough space (7%), and bad access for the disabled (5%). Given that 77 CHCs had premises with no access for wheelchair users it is perhaps surprising that only ten of them gave this as a reason for dissatisfaction. In this, the International Year of Disabled People, those CHCs without access might wish to consider ways of changing the situation.

Complaints

The "patients' friend" aspect of CHC work has always been contentious, and this may partly explain why over a third (38%) had never assisted a complainant at a Family Practitioner Committee service committee hearing. All other CHCs had given some assistance to patients: CHC staff alone had helped in 16% of the CHCs, members alone in 2%, and staff and members had both been involved in 22%. Some CHC representatives had been allowed to address the committee (16%), and some had been allowed to advise the complainant during the hearing but not to address the committee (35%). Twenty-nine per cent of the CHCs said they had experience of taking FPC cases to appeal.

Finance

In 1979/80 the majority of CHCs had budgets of between £15,000 and £25,000 (78%). Only one had a budget of over £30,000 and two had less than £5000 a year. But in 1980/81 the position changed considerably, with a smaller proportion having budgets of £15,000 to £25,000 (53%) and a much higher proportion with budgets over £25,000 (32%). Eleven CHCs had moved into the over-£30,000 bracket. At the other end of the scale, one more CHC had reduced its budget to below £5000. No doubt inflation played its part in the overall increase in the size of CHC budgets. Analysis by region indicated that CHCs in Wales and Wessex were more likely to have budgets below £15,000, and those in the North West Thames and South West Thames regions to have budgets over £25,000.

In 1979/80 just over half the CHCs (53%) kept within their budgets, or were underspent by up to £2000. One in four (24%) overspent their 1979/80 budget but most of them by less than £500. Information on under and over-spending was not provided by a fifth (23%) of CHCs, sometimes because they had not been advised of the financial position by their Regional Health Authority. In 1980/81 less than one in two CHCs (43%) had been allocated the sum they requested from the RHA, and 30% had asked for a sum which was not agreed by the region. The remaining CHCs said they did not submit estimates to their RHAs (19%) or did not provide the information (8%). Reserve funds were available from the region to one in three CHCs (38%), and had been used for research (13%), for contingencies and inflation (9%), for conferences (3%) and for training (3%). Fifty-eight CHCs had approached their RHAs for additional funds for special projects, and half of them had been given the money.

Consultation

The statutory right of CHCs to be consulted about proposed closures imposed a considerable workload on some CHCs. Table 2 shows the proportions of CHCs to have been involved in different kinds of consultation.

The table shows that over half the CHCs were consulted when hospital closures were proposed, and a third when change of use was put forward. Where this had happened, nearly half the CHCs (43%) opposed the closures, a third agreed the proposal and a quarter (24%) opposed some proposals but agreed others. Of those CHCs which opposed the closure or change of use, one in six (17%) had not put forward counter-proposals. Half the CHCs always put forward alternative proposals, and a third worked out counter-proposals in some cases but not others. Proposals for the closure or change of use of community facilities like health centres and clinics were less often opposed, with only one in five CHCs (21%) always opposing them.

Table 2 Proportion of CHCs consulted about closures and changes of use: 1980

	Hospital closure %	Change of use (hospital or ward) %	Closure or change of use of community facilities %
CHC always consulted	55	34	44
CHC never consulted	3	4	5
CHC consulted on some closures but not on others	3	2	2
No changes proposed, or no information provided	39	60	49
100% = 194 CHCs	100	100	100

Meetings

Over half the CHCs (58%) held full meetings once a month, and one in five did this every other month. A few (5%) met quarterly, 11% once every six weeks and four once a fortnight. At these meetings, most CHCs (82%) had some arrangement for members of the public to speak. Over a third (38%) had an agenda item or a special time during the meeting allocated to the public. Twelve per cent said that the chairman invited members of the public to speak at some point during the meeting, and other arrangements included invitations to

Continued on next page

Photo: North Tyneside CHC

CHCs AT WORK 1980

Continued from previous page
speak at the end of each agenda item (2%) and allowing the public to join in throughout the meeting (2%).

Working parties

Almost all CHCs worked partly in sub-committees or working parties (96%). The most commonly established working parties were for the mentally and physically handicapped. Two out of three CHCs (68%) had working parties for these client groups. Half the CHCs (58%) had a planning, finance or general purposes working party, and children and the elderly were also popular working parties (50%and 58% respectively). Just over a third (38%) of the CHCs had a hospital working party. CHCs were not asked how often these groups met or whether they were permanent or ad hoc groups.

Surveys

Three quarters of the CHCs had carried out at least one survey since August 1977. One in four had done one, 18% two, 13% three and 19% four or more. The average number carried out by all CHCs was two. The most popular kind of surveys carried out were assessments of the need for specific services like dentistry, primary care and hospital services. Over half the CHCs (53%) had done surveys of this kind. The needs of specific client groups like the elderly and the handicapped had been surveyed by 43% of CHCs, 13% had conducted public opinion surveys about local health services generally, and 9% had collected information to help them oppose closures, changes of use of NHS facilities or cuts in service provision. One in three CHCs had done studies to evaluate the quality of particular services. Just over half the CHCs which had done surveys or research of this kind had published the results. This must represent a valuable source of information on local NHS services. A list of all the surveys mentioned by CHCs will be published in next month's *CHC NEWS*.

Major issues

Finally, CHCs were asked to name five major issues with which they had been involved since they came into existence. The most frequent activity mentioned was the promotion of better, more equitable distribution of health services. Eight out of ten CHCs had been involved in this kind of exercise. Improvement of services for the mentally and physically handicapped was the second most common issue, with 54% of CHCs saying that they had pursued this, and opposing cuts and closures had engaged the time of one in two CHCs. Maternity services and services for the elderly ranked fourth and fifth, with one third of the CHCs saying these had been major issues for them.

There were two main activities to which CHCs would like to devote more of their time if they had additional resources. Over half (55%) said they would do more research if they had more time/money/staff, and a third would like to be more involved in local affairs and activities.

Representation

Table 1 shows the proportion of CHCs represented on a range of local committees. The figures show a substantial change in representation since the 1977 survey. Twice as many CHCs are now attending Family Practitioner Committee meetings with speaking but no voting rights, and twice as many are attending Health Care Planning Team meetings with speaking *and* voting rights. However, the proportion of CHCs which wished to be represented at FPC meetings but were not allowed this was higher in 1980 than in 1977.

Between a third and a quarter of the CHCs said they were "officially represented" on other local committees not shown in Table 1. Just over a third (38%) were represented on local voluntary agencies such as the Council for Voluntary Service and Mind. Twenty-seven per cent mentioned links with local authority committees such as social services and transport. A quarter (24%) had members on regional associations of CHCs, and one in five (19%) attended Area Health Authority committees as observers.

Table 1 CHC Representation on committees: 1980

	Health Care Planning Team %	Joint Care Planning Team %	Joint Consultative Committee %	Family Practitioner Committee %
CHC represented: Can speak *and* vote	32	7	5	2
CHC represented: Can speak *but not* vote	24	11	22	37
CHC represented: Cannot speak or vote	2	-	3	9
CHC wishes to be represented, but not allowed to be	15	26	29	40
CHC does not want representation	6	12	13	4
Team or committee not set up	6	10	3	-
Other reply	5	4	3	4
No reply	10	30	22	4
100% = 194 CHCs	100	100	100	100

Photo: North Tyneside CHC

This survey would not have been possible without the cooperation of the CHC staff who completed the questionnaire. We thank them for their time and effort.

Care in ACTION

There are few surprises in *Care in action*, the Government's recent pronouncement on strategic priorities for the NHS and for local government personal social services in England*. The DHSS is playing much the same tune as in the Labour government's priorities document *The way forward*. The elderly, the mentally ill and the mentally handicapped are the groups to be favoured, and there is continued emphasis on prevention of ill-health.

But when Secretary of State Patrick Jenkin introduced the document he was at pains to stress that the old tune is now going to be played in a rather different way. Ministers insist that there must be a more diligent pursuit of "value for money", that the statutory services must seek to collaborate with the private sector and voluntary services and that — above all — this national guidance is no more than a broad policy background, to be interpreted "in the light of local circumstances". These themes run through the entire document, which Mr Jenkin commended as a "working handbook" to members of health authorities and social service committees. It is not a consultative document.

With forecasts of a growing population of very old people in Britain, the first priority is support for the elderly. The DHSS says local objectives should be to:

- Strengthen primary and community care services.
- Encourage rehabilitation from hospital, using departments of geriatric medicine as centres of local expertise.
- Keep enough acute hospital beds to meet the rising demand from the over-75s.
- Provide adequate long-term care in hospitals and residential homes.

Because of recruitment problems in geriatric medicine, planners are warned that the "major burden of provision for elderly patients will continue to fall on the general acute services".

Priority for mental illness services is maintained, along the lines set out in the 1975 White Paper and the 1980 Nodder Report on mental illness hospitals (see *CHC NEWS 52* page 3). NHS priorities are outlined as:

- Creation of a local service — reducing the catchment area of psychiatric hospitals.
- Provision for the elderly severely mentally infirm.
- Closure of big, old, remote mental illness hospitals.

Services for the mentally handicapped remain a high priority. *Care in action* refers authority members to the White Paper of 1971 and the recent review of progress on that White Paper's targets (see *CHC NEWS 62* page 7). Hope is pinned on more intensive use of joint finance arrangements, on funds released by the sale of old hospitals, and on close involvement with voluntary agencies.

Next on the priority list come the physically handicapped. Pay special attention to relief of pressure on caring relatives, *Care in action* tells authorities. The Government picks out care for younger disabled people, it wants more hearing therapists recruited, and makes special mention of the need to improve services for the newly-blind. Enabling people to live as independently and purposefully as possible is the goal, both for the mentally handicapped and the physically disabled.

Ministers want to see health authorities improving the take-up of child health services, especially in areas of "high social stress". The NHS is urged to co-operate with education authorities over the new provisions for special education of handicapped children.

Prevention of handicap and infant mortality is a goal to be achieved partly by further improvement in the maternity services, which end the list of Government priorities for special groups of NHS users.

However, prevention in its wider sense is an important theme of *Care in action*, and the stress is on the responsibility of the individual. The document acknowledges that the Government has a part to play in creating a climate of opinion favourable towards "self-health". But the DHSS highlights a "local strategy of health promotion" to be undertaken by local health authorities. It suggests that authorities should attend to:

- A policy about smoking on NHS premises and pressure on local cinemas, theatres, etc.
- More genetic counselling, family planning, better ante-natal screening and promotion of breast-feeding.
- Better surveillance and health screening of children.
- Increased immunisation take-up.
- Propaganda to promote sensible eating and exercise.
- Back-up for health education in schools.
- Measures to cut accidents at home and on the road.
- Winning local support for fluoridation of water supplies.

Care in action says CHCs have "the right to expect health authorities to show a marked and continuing investment in prevention and can help to transmit the preventive message to the public"

Photo: Raissa Page

In marked contrast to his predecessors, Mr Jenkin's guidance says nothing about desirable levels of provision. The new Scottish priorities document continues to give guidance on bed norms, day hospital places, etc**. The DHSS warns that "further progress cannot be rapid and will depend mainly on skilful use of what the voluntary and private sectors can contribute" The NHS and social services are urged to tap voluntary help, to guide it and encourage it. CHCs are said to have an important role in helping to "co-ordinate" the voluntary and statutory services.

"We should not read too much into this", Mr Jenkin told *CHC NEWS*. "CHCs are a very good vehicle for the involvement of voluntary bodies, which through CHCs can get a good idea of the local NHS. So it's communication rather than co-ordination — CHCs have no role in management."

Statutory authorities are urged to concentrate resources on community services as well as primary and domiciliary care. The role for health centres is limited to "some deprived areas". With reorganisation in the NHS upon us again, the need for collaboration and joint health/social service planning is underlined.

Everyone knows that money is tight. *Care in action* outlines other difficulties which members of health authorities must contend with, such as the shortage of doctors and nurses. Geriatric medicine, mental illness, mental handicap and community medicine are all likely to be hard-hit.

Finally the Government offers advice on improving efficiency, especially in the health service. It warns that neglecting building maintenance is a false economy. It reminds authorities that NHS auditors' duties go beyond scrutinising the books to checking that health service treasurers are spending the money efficiently. An appendix gives 13 suggestions for cost-paring — from careful control of staff numbers to using private contractors for laundry, catering and building maintenance.

Private care is welcomed by *Care in action*. "There is plenty of room for growth." NHS planners are urged to work closely with the private sector and to consider cutting NHS waiting lists by sending patients to private hospitals, sharing equipment and even staff.

The stress on local autonomy seems to mean that little will be done to pressure authorities who do not take notice of this national guidance on priorities — the stern reminder about the auditors being perhaps the only exception to this.

* *Care in action: A handbook of policies and priorities for the health and personal social services in England*, HMSO £3.30.

** *Scottish health authorities: Priorities for the eighties*, HMSO £4.80.

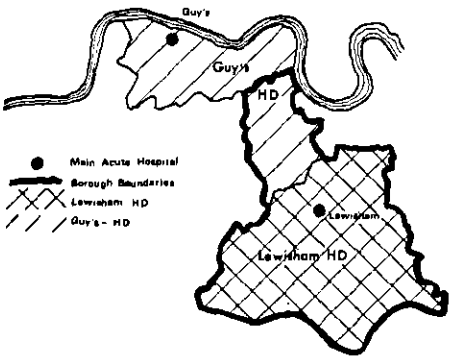
Teaching hospitals cast long shadows

by Celia Pyke-Lees, Secretary, Lewisham CHC

The power of hospitals, in particular teaching hospitals, appears undiminished. This seems to be the message of the latest NHS reorganisation. The exclusively hospital-based philosophy of *Patients first* reigns triumphant.

Take my own area for example. Lewisham health district only covers three-quarters of the London Borough of Lewisham. The rest of the borough is in Guy's health district — so named because it contains Guy's, the famous teaching hospital. This split has led to difficulties in joint planning, complications for social services departments and trials and tribulations for the community health services. What is natural for Lewisham is for its health district and local authority boundaries to be co-terminous. Even the regional health authority has been forced to agree with this. But the teaching hospitals cast long shadows, — and Guy's Hospital, scared of being left without a catchment area if Lewisham claims back a quarter of its population — is seeking a takeover bid for the whole district.

The general opposition in Lewisham to this proposal, felt by unions, MPs, the borough council, this CHC and many voluntary organisations as well as the CHC for Guy's district, is based around two main issues. First it is likely that Guy's will gradually swallow up parts of Lewisham, forcing our local hospitals to run down in order to fund Guy's specialties. This will be called "rationalisation". Secondly it is sad that an ideal opportunity for proper local authority and NHS planning will have been missed and the chance of a combined development of community services lost for ever.



The irony of this situation, which I am sure must be common to many parts of the country where hospitals appear to dominate reorganisation, is that it all appears so unnecessary. This mania for giving a hospital a suitably sized catchment area is irrelevant, given GPs' freedom of choice to refer a patient to any hospital. Many large hospitals, particularly those involved in teaching, take the majority of their patients from outside their catchment area. At Guy's over 60% of the patients come from outside the district. These hospitals have no real need for a local population — their beds are kept full enough by patients from many parts of the country.

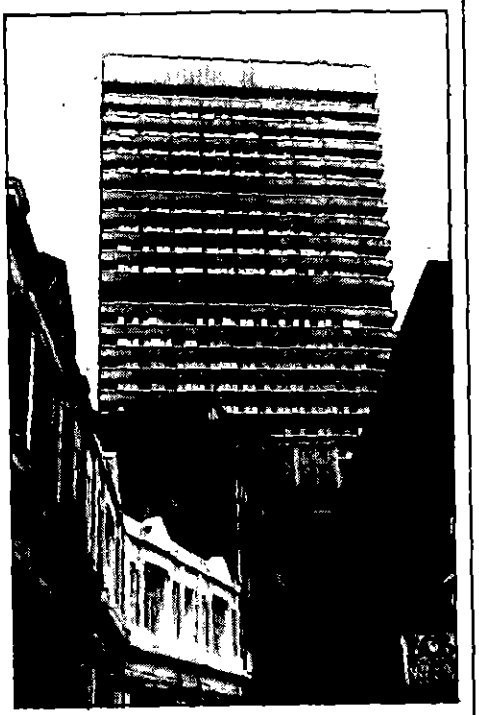


Photo: Jenny Keating

However it seems that the health service cannot accept the challenge of looking at health provision in a new light. The recent document *Care in action*, which sets out the Government's priorities, stresses the vital importance of the prevention of ill-health and the need for improved services for the priority care groups. This can only be achieved through strong links with the community, in close collaboration with social services departments, environmental health departments and schools. Yet the reorganisation being considered at the moment takes these points least to heart.

In our case a viable and recognisably valuable case for co-terminosity has been

IS THE ROLE OF CHCs BEING

by Brian Maunder, Secretary, Swansea/Lliw Valley CHC

Far from being the somewhat innocuous document which last month's *CHC NEWS* seems to suggest, I believe the new consultative paper on CHCs holds a subtle and far-reaching threat. It is an attempt to diminish our effectiveness in those areas of our work which drew strong support during the *Patients first* consultation, to ensure that when our usefulness is next questioned public support will not be forthcoming.

Consider the following quotes from the Welsh version of the document:

● The Secretary of State does not "consider it necessary or desirable to give more detailed guidance then already exists, for example, in planning and closure procedures".

Exceptionally strong views were submitted during the *Patients first* consultation to the effect that CHCs need stronger support to ensure that health authorities comply with the spirit of existing regulations as well as the letter. This response from the Secretary of State is therefore particularly disappointing, especially as it has been shown in the past that authorities only take a generous view of the regulations when external pressures are applied.

● "A request for information must be reasonable from the point of view not only of the job which the CHC has to do, but of the pressures on the authority's staff also".

This comment and the one above indicate quite clearly that past problems relating to the provision of information by health authorities will continue. Very clear evidence on the need for better information to be provided was produced during the previous round of consultation, and this low-key approach to the problem has failed in the past.

● The Secretary of State "recognises that it could be argued by CHCs that they do not have sufficient staff to work up a detailed and constructive counter proposal, and may not always possess the information needed ... but he considers nevertheless that a CHC which objects to a proposal has a duty to respond constructively."

Despite the fact that he is not prepared to ensure that a CHC receives the information it requires or has the staff available to prepare a detailed counter-proposal, the Secretary of State is clearly indicating that CHCs must undertake this very onerous task if they wish their views to be considered. Although CHCs cannot produce what is requested without the Secretary of State's assistance, this assistance is to be denied. This will devalue the comments of CHCs if it should be necessary to object to a closure or change of use.

● "The Secretary of State does not therefore propose that CHCs should extend their role formally to providing an individual service to complainants".

It would appear from this comment that the Secretary of State does not understand the function of CHCs. There is no question of CHCs *extending* their role to providing an individual service to complainaints.

overthrown by the region purely on the grounds that Guy's health district has too little population and the new district health authority would be "totally inadequate for service needs" and unable to provide "the necessary facilities for medical teaching". It is noticeable, by contrast, that where a present teaching district has no real opportunity to expand — as in South Hammersmith or North East Kensington-ChelseaWestminster district — a low local population becomes more acceptable.

Teaching hospital power seems to baffle RHAs and AHAs alike. Within the South East Thames region four mergers of districts were proposed. In each case there was a large public outcry, protesting against the attempt to introduce large DHAs remote from their local communities. In every case the recommended mergers were overturned, except where the teaching hospital was concerned. Democracy is fine — but it cannot compete against the apparent inability of the NHS to tackle fundamentally the whole question of teaching hospitals and regional specialties.

Sporadic revolts against the power of the teaching hospitals or the cost of regional specialties appear to have achieved little. Our area health authority threatened to curtail specialties, running them only to the extent to which they were funded by the region, but the threat was never implemented. Nearby Greenwich and Bexley AHA sought to make cuts and proposed the closure of a drug dependency unit which provided a regional service. The RHA told the AHA to find economies elsewhere — presumably by cutting local services.

Recognisably this a is a difficult and complex issue, but it is one which the NHS shows great reluctance even to start considering. All the Government's words about the priority to be given to health education and community care could prove valueless unless the entrenched power of the hospitals is recognised and ways sought to overcome it.

WHO IS THE PATIENT?

by Peter Moodie, Chairman, West Birmingham CHC

Two complaints recently dealt with by West Birmingham CHC illustrate how seemingly minor complaints can raise issues of considerable general significance. Both concerned a close relative (wife in one case, daughter in the other) who felt aggrieved at having holiday relief admission to hospital refused for their dependants. That there should be two such complaints in a short period of time alerted us to look again at the provision of holiday relief within the district, and the case of the wife raised further questions.

This woman wanted her quadriplegic, stroke-victim husband taken into hospital for a fortnight. She explained to the consultant that she needed to visit her elderly, sick father in Cyprus. The consultant would admit the husband only if the full details of the wife's trip to Cyprus were explained to him. The wife felt that for her husband to be told all this would only worry and confuse him.

Thus the issue was complicated because the doctor was dealing directly with two people, both of whom needed his help and who had (or were thought to have) conflicting wishes. How should the doctor have tried to resolve the conflict? Were there sides, one of which he should have supported? Is there a sense in which a "well" relative should be regarded as a patient, together with the "ill" dependant?

This last question might suggest an undue elasticity in the term "patient". But suppose the relative is on the point of succumbing to a stress-related mental illness. Should the doctor refuse a short-term admission unless this reason for the dependant's admission is fully explained to him or her, perhaps risking the health of the "well" relative?'

Such problems do not have simple answers. The CHC also has to determine whose interest it should represent. We adopted the conventional approach of helping the complainant to present her own views without indicating that we were necessarily taking her side. But the problem is considerably greater for the doctors since the core of the issue is closely related to all of the other problems produced by a defensive stance for the concept of doctor's "clinical freedom".

The rallying cry of clinical freedom stems from a laudable concern for the individual patient but makes at least two challengeable assumptions. It assumes that there is only one identifiable patient in any treatment. It also supposes that the interests of others — patients of other doctors and potential future patients — are secondary. The tendency to ignore the interests of people other than the patient has a close parallel in situations where a doctor makes expensive decisions which prevent the use of resources elsewhere.

There are other ways in which clashes of interest may occur, for example when a girl under the age of 16 asks her doctor for contraceptive advice. Whether the doctor should recognise a parental right to be informed has been the subject of considerable discussion, since a girl might not seek advice (and thereby be exposed to risk) if she thought that the doctor might inform her parents. The latest DHSS advice on this, circular HN(80)46, has many of the hallmarks of compromise. Although the guidance starts by assuming that "it would be unusual to provide advice about contraception without parental consent", it goes on to recognise in general terms the importance of confidentiality. It concludes that "the decision whether or not to provide contraception must be for the clinical judgement of a doctor".

Our two original complaints were dealt with helpfully by the district, although not to the entire satisfaction of the complainants. This leaves one final point. The complainants were not patients, nor were they complaining on a patient's behalf. Since most hospital complaints will naturally be made directly by a patient or on his or her behalf, it is not surprising that both the present guidance on complaints procedure and the long series of proposals to change the rules for complaining all assume that complaints come only from these sources.

I believe there is a need for a fully comprehensive complaints code specifically to take into account the possibility of complaints such as those which set our CHC thinking.

UNDERMINED?

because this is already a part of their existing role, as stated in appendices to circulars WHRC (74)3 and HRC(74)4. My fear is that this comment that CHCs should not *extend* their role will be interpreted as a need for CHCs' role to be *curtailed*. A valuable service to the public might be lost in this way.

● "The Secretary of State is in no doubt about the value of admitting observers and urges all Family Practitioner Committees to adopt this practice. However ... he does not intend ... to impose a formal requirement that FPCs should admit CHC observers".

This comment has been made by successive Secretaries of State since 1974, and, although the overwhelming weight of evidence put forward as a result of *Patients first* urged him to take a firm line with FPCs, once again it is not proposed to do this. If after seven years of a "softly softly" approach FPCs have still not invited CHC observers to their meetings, the continuation of this approach is unlikely to bring about a change in attitude.

● "CHCs can be fully effective without being large ... normally a maximum size of 18 ... is favoured with up to 24 in a few large districts ... there is room for reductions in the size of CHC memberships ... without loss to the representative nature of CHCs or to efficiency".

This statement is quite ludicrous. It is at present extremely difficult for CHCs, even those such as Swansea/Lliw Valley with as many as thirty members, to represent the public in their districts adequately.

● "Local authorities already have representation in the health authorities and this will continue".

Health authority representation is no substitute for having local authority members on CHCs. The difference in role between local authority members on health authorities and those on CHCs can be clearly seen at the formal meetings which take place between the two bodies.

I am very concerned about these "hidden" implications of the consultative paper.

Parliament

The new DHAs

Secretary of State Patrick Jenkin hopes to announce all his decisions on the new District Health Authority boundaries by the end of May (Tim Renton, Mid-Sussex, 3 February).

Consultants who needn't do abortions

In the years 1977-1980 some 114 consultant posts in obstetrics and gynaecology were advertised in England — but in only 37 cases did the job description include a duty to terminate pregnancies (Jo Richardson, Barking, 16 February).

The proportion of abortions carried out by the NHS in England and Wales dropped by 3% between 1978 and 1979. The DHSS is recommending the development of day-care abortion services "as a means of using resources more efficiently" (Gwyneth Dunwoody, Crewe, 18 February).

Sales of land

In 1979/80 purchasers of NHS land and property paid the 14 English Regional Health Authorities a total of £9.6m. The NE Thames and Wessex regions gathered in £1.8m and £1.3m respectively, while the Northern and SW Thames regions received £150,000 and £93,000 (Dr Roger Thomas, Carmarthen, 9 February).

Hiving off

It is for individual health authorities to decide whether to put laundry and catering work out to private contract. In 1979/80 laundry and catering contracts accounted for 14.1% and 0.2% respectively of the totals spent on those services by the English NHS (Ivan Lawrence, Burton, 16 February).

Health visitors

In September 1979, Lancashire AHA employed 316 health visitors, Surrey 269 and Hampshire 255. South Tyneside AHA employed 27, North Tyneside 36, Calderdale 34, Bury 36 and Rotherham 37. The Government is "concerned that there is still such considerable variation between health authorities in the rates of health visitors to population" (Lewis Carter-Jones, Eccles, 27 January).

Foot-care assistants

No new legislation is needed for health authorities to employ foot-care assistants. Their duties would normally include "simple foot-care and hygiene, such as the cutting of toe-nails, carried out under the supervision and on the referral of a qualified chiropodist" (Robert Dunn, Dartford, 27 January).

Home dialysis

At the start of 1980 only 12 out of the 84 kidney dialysis patients in the Wessex region were being treated in hospital. In the Northern region, however, only 78 out of 200 patients were dialysing at home. At November 1979 prices, hospital dialysis costs £15,000 per year per patient and home dialysis £9700, though there is also a capital cost of £7500 before home dialysis can begin (Lewis Carter-Jones, Eccles, 13 January).

Priorities inaction

Between 1975/76 and 1978/79, expenditure on hospital services for the mentally ill and the mentally handicapped fell from 8.5 to 8.2% of total NHS revenue spending in England (Jim Callaghan, Middleton and Prestwich, 20 January).

Bleary doctors

In September 1980, 72% of all junior hospital medical and dental staff (ie from house officer up to senior registrar) were contracted for 84 hours or more per week. For house officers the figure was 85%. Fifty-seven per cent of junior staff specialising in cardio-thoracic surgery were contracted to work and be "on call" for 104 hours or more (Dr Roger Thomas, Carmarthen, 11 February).

Maternity benefits

No radical changes to the system of maternity benefits will be made for the time being, following consultation around the document *A fresh look at maternity benefits*. Most comments favoured retaining all three benefits: maternity pay, maternity allowance and maternity grant. Of the proposed options for change, most support went to the idea of abolishing maternity pay and using the resources to increase maternity grant, with maternity allowance continuing unchanged (Tom Benyon, Abingdon, 29 January).

Rent-a-nurse

In 1979/80, the cost of employing agency nurses in the English NHS was £30.3m (Gwilym Roberts, Cannock, 3 February).

Snow White and the seven men of restricted growth?

by Pamela Rutt, Member, Governing Committee, and Secretary, Medical Committee of the Association for Research into Restricted Growth

This is not the outraged voice of yet another pressure group condemning children's stories as sexist or racist. We merely wish to point out that unlike fairies and hobgoblins, dwarves happen to be people.

As small people we tend to be labelled as "dwarves" or "midgets" and we resent this when it is done in a derogatory manner. It cannot be denied that for most people "dwarf" conjures up images of circuses, court jesters and evil little men in Grimm's fairy tales. We accept that these words cannot be erased from the language, but among ourselves, our friends and, hopefully, professionals, we prefer the use of "person of restricted growth" or "person of short stature". While seemingly trivial, this change does imply that although we are small we are still people with our own individual identity. In any case, medically speaking, "dwarf" and "midget" apply to only a few of the many growth disorders.

Ten years ago the then National Council for Social Service carried out a pilot study which showed that the needs of small people are considerable. As a result the Association for Research into Restricted Growth was formed. ARRG is a self-help group run chiefly by short-statured people and without full-time staff. Its principal aim is to alleviate practical problems which persons of short stature encounter. (Raising money for research into the causes of restricted growth is left to the Child Growth Foundation, which was set up to do this.)

ARRG's information service gives advice on aids, adaptations, employment, education, clothing and medical problems. A regular newsletter keeps members in touch, and two booklets * have been published which aim to enlighten not only people of restricted growth but also doctors, health visitors and other professionals.

Since only one in ten GPs is likely to encounter a person of restricted growth it is not surprising that growth disorders are only briefly covered in the medical student's curriculum. Hence ARRG has a medical committee whose special interest and experience in restricted growth encompasses paediatrics, orthopaedics, genetics endocrinology, obstetrics and gynaecology.

This committee co-ordinates an advisory group of hospital consultants to whom members can be referred for expert advice. Regular surveillance and the treatment of any complaints as they arise ensure an active life — though some mobility problems are almost inevitable.

Parents receive special attention. The birth of a child with any handicap is a shattering experience, but more so if the medical staff know little or nothing about the child's disorder. ARRG provides not only practical guidance but also reassurance from other parents who have faced the same problems.

Through its social functions ARRG gives a sense of belonging and involvement to those who feel isolated by their lack of height. Experiences are shared and problems are resolved through informal contact.

It is not the aim of ARRG to create its own miniature version of society — on the contrary ARRG aims to give its members the confidence to face the world on equal terms, with determination and above all with dignity.

* *The layman's guide to restricted growth*, 25p plus 15p post. *Coping with restricted growth*, 40p plus 15p post. Both available from Pamela Rutt, 24 Pinchfield, Maple Cross, Rickmansworth, Herts.

Scanner

Health research

The Office of Health Economics has produced a discussion paper called *Health research in England.* This outlines the history of health-related research and looks at its future. Medical research is comparatively well-funded — from commercial and state funds — whereas finance for research into the organisation and effectiveness of health services is relatively low. The OHE discusses the role of this area of research and considers the possibility of bringing it under the umbrella of the Medical Research Council or giving it a separate research council of its own. From OHE, 12 Whitehall, London, SW1A 2DY. (£2 inc post.)

Sterilisation report....

The Birth Control Trust says that although sterilisation is increasingly requested and in the long term is cheaper than mechanical forms of contraception, it is still not easily available in many parts of the country. In *Sterilisation and the National Health Service* the BCT discusses counselling and current medical practice and gives the results of a questionnaire it sent to health authorities which showed that in a number of areas the waiting time for male and female sterilisation is over six months and in some much longer than this. The BCT calls for sterilisation to be made available as part of the NHS free family planning service. From BCT, 27-35 Mortimer Street, London W1N 7RJ (90p plus 16p post).

...and free leaflets

Those who would like some basic information about female sterilisation, vasectomy and the chances of reversal can get leaflets on these subjects from the British Pregnancy Advisory Service. BPAS also produce leaflets on semen analysis, artificial insemination and sperm freezing. List of free leaflets available from BPAS, Austy Manor, Wootton Wawen, Solihull, West Midlands B95 6DA.

Special housing in London

Finding somewhere to live in London is a problem for anyone — but for those who are mentally ill or handicapped it is even more difficult. In an attempt to help such people the National Association of Voluntary Hostels and MIND have produced *Handbook of access to special housing for mentally ill and mentally handicapped adults in Greater London.* This contains a full list of special residential schemes and a general description of other ways of finding housing for vulnerable people — through local authorities and housing associations for example. £1.65 inc post from NAVH, 33 Long Acre, London WC2E 9LA or MIND, 22 Harley Street, London W1N 1AP.

Asian language leaflets

In recent years, groups all over the country (including some CHCs) have been translating advice leaflets into different languages to help people who do not speak much English. In order to bring these to a wider audience, prevent duplication, and illuminate gaps the Commission for Racial Equality and Citizens Advice Bureaux have tried to collect details of all the leaflets available in the main Asian languages. The *Community information (Asian languages) directory* lists leaflets on health, housing, education and social services and says where they can be obtained. From the CRE, Elliott House, 10-12 Allington Street, London SW1. (£1 inc post).

This poster makes the point that healthy exercise need not be frenetic. The other three posters in the Health Education Council's new series Action makes the heart grow stronger *show rather more vigorous activity — swimming, badminton and cycling. All four are available free from the Supplies Dept, HEC, 78 New Oxford Street, London WC1. Tel: 01-637 1881.*

Holiday jabs

Revised DHSS leaflet SA35, *Notice to travellers – health protection* tells travellers which countries require vaccinations and how and when to get the jabs. There is also brief information on preventive health measures and medical treatment abroad. From International Relations Division, DHSS, Room C511, Alexander Fleming House, London SE1 6BY (free).

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 4: Central Nottinghamshire CHC Chairman: R Chamberlain
Page 5: North Bedfordshire CHC Chairman: Mrs M Barley Secretary: Richard S Edwards
Page 7: Kensington-Chelsea-Westminster (North East) CHC Chairman: Robert Davies
Page 10: Roehampton, Putney and Barnes CHC Secretary: Ms Jenny Griffiths
Page 10: Winchester and Central Hampshire CHC Chairman: Mrs Angela Sealey
Page 13: West Birmingham CHC Chairman: Peter Moodie
Page 16: Wigan CHC Chairman: G Dewhurst
Page 22: Edinburgh LHC 29 Castle Terrace, Edinburgh EH1 2EL. Tel: 031-229 6605

Frail and elderly

Some elderly people are not considered to need long-stay care in hospital, but are refused admission to local authority residential homes because they need too much looking after. Members of the British Association of Social Workers have been looking at the growing problem of old people who end up in long-stay hospital beds because there is no other form of care available. Their report* calls for more flexibility and discussion between the NHS and the local authorities, to ease this "insidious form of misery" for old people. Brain failure, incontinence, long-standing forms of physical disability and "difficult personalities" are the main factors which make it hard to find places outside a hospital setting for such people. The social workers believe that special local authority residential accommodation with nursing care and hospital support would help to plug the gap in the service. They suggest joint funding could pay for it.

* *People: patients or residents* from BASW, 16 Kent Street, Birmingham B5 6RD(£1.40 inc. post)

Open Floor

BBC 2 will run a new series of community TV programmes, *Open Floor,* this summer. The producers promise "a sort of community debate" in which people with differing views about local community issues will air their ideas in a studio discussion. Ideas please, to Peter Lee-Wright, Open Floor, BBC TV, Wood Lane, London W12 8RT. Tel 01-743 8000 ext 3511.

Women's health

Women interested in organising basic health courses for themselves and other women might find the *Women and health course handbook* useful. It is produced by a Manchester group called TUBE (the Trade Union and Basic Education Project). The handbook covers topics dealt with in a women's health course set up by TUBE — areas such as menstruation, contraception, the menopause and vaginal complaints. Available from TUBE, 2nd Floor, 769 Stockport Road, Levenshulme, Manchester M19 3DL (50p inc post).

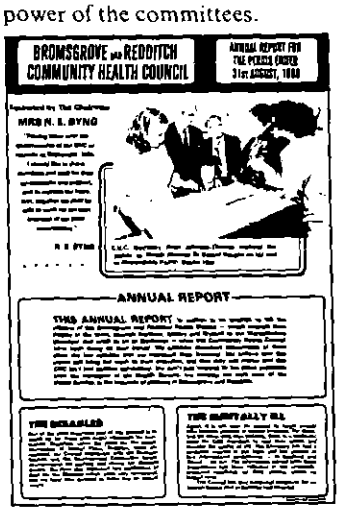
News from CHCs

☐ CHC participation has come under attack in the new DHSS planning circular, says sharp-eyed **Haringey CHC**. The CHC is worried that the new circular (HN(81)4) provides for CHCs to be consulted about district health authority plans only *after* the plans have been forwarded to the regional health authority. CHC secretary Lilias Gillies acknowledges that there will be informal consultation, but she believes that this means using CHC representation on district planning teams. "That's no substitute for comprehensive consultation", she said. The council is asking the DHSS to ensure that health authorities agree local procedures for full, early consultation with CHCs.

☐ The **Leicestershire CHCs** are up in arms about reorganisation plans for the county. The Trent region has recommended that the existing three districts be merged into one. This will have a population of more than 836,000 and will be, say the CHCs, a "flagrant contradiction" of the *Patients first* philosophy. CHC representatives have lobbied local MPs at Westminster and are now seeking a meeting with health minister Gerard Vaughan. The councils believe that resources will be concentrated on the new medical school in Leicester city and fear that community services and the "Cinderella" services will suffer.

☐ **North Hammersmith and Acton CHC** has surveyed the needs of elderly people living at home in the district. It arranged interviews with 170 people (65 men and 105 women). Almost a third lived alone. Most people depended on relatives for help and almost half had no phone. In its annual report the council points out that those interviewed represented the relatively well housebound of the district — a number of people were too ill to be interviewed. Yet of those who were questioned, "many felt isolated and could not cope with a variety of daily tasks ... we are dismayed at proposed cuts in social services and the lack of sufficient domiciliary and residential health care for the elderly, particularly the mentally confused".

☐ Disturbing details about the working of ethical committees have been unearthed in an investigation by **Oxfordshire CHC**. Ethical committees, at sector and area level, are supposed to vet proposals for medical research. They consider factors such as the benefit to patients and weigh it against possible risk and discomfort to those taking part. They also scrutinise provisions for informing patients and getting their consent. But in Oxfordshire at least, it seems that the area committee believes it only has an advisory role, and the four sector committees never meet. The CHC thinks there should be much more rigorous examination of the "quality of consent" and cost of research. It wants the AHA to provide guidelines on the scope and power of the committees.



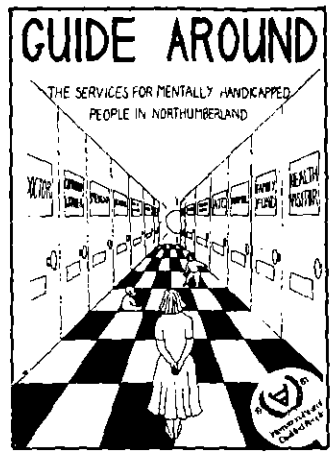
☐ *More than 50,000 copies of* **Bromsgrove and Redditch CHC's** *annual report were printed. It cost the CHC £320. The report (see above) appeared as a supplement to a local weekly newspaper and the CHC believes this was a cost-effective way of making the CHC known to as many consumers as possible.*

☐ Things have got pretty silly when child health clinic facilities are so poor that children are exposed to health risks when they attend. When a mobile clinic got into a very bad condition and the district management team failed to find alternative accommodation, **Hastings CHC** came to the rescue. The council searched for months for a permanent building that came up to scratch. Now the clinic has moved in and the take-up of services is growing.

☐ The International Year of Disabled People is getting into its stride. **Oldham CHC** is compiling an access guide to shops and other buildings in the town — measuring doorways and steps with the disabled in mind. **Cornwall CHC** is negotiating with the county council to start a long-term programme of adding drop-kerbs to pavements. This will help wheelchair users (and pram pushers!) IYDP is being marked this month by **Hounslow CHC** with an exhibition of aids for the visually handicapped and for people who are both deaf and blind. Also this month **Central Nottinghamshire CHC** will be holding a conference on housing and community support for disabled people.

☐ **Salop CHC** plans to look hard at the question of NHS spectacle frames. It is going to send questionnaires to opticians in Shropshire, asking whether NHS frames are on display in opticians' premises. It is also concerned about the sensitive issue of private frames for NHS lenses and will be asking opticians if they mark the prices on private frames.

☐ A £4.5 million European Community grant to a tobacco company, to provide a "considerable" number of jobs in Spennymoor, near Durham, has caused much heart-searching among CHCs in the area. **North West Durham CHC**, whose district has suffered the Consett steel closure, wrote to the DHSS protesting that money was being given to help a tobacco company just when £½ million is being spent by the Department persuading people of the dangers of smoking. The DHSS pointed out that jobs were being created and that as the products of the factory would be exported this would help the balance of payments — "an extremely cynical" letter, said the CHC. The factory itself will be on **South West Durham CHC's** patch and although some members there protested about the grant, they were outvoted by others who stressed the need for jobs. Secretary Ron Owens said, "You put yourself in the shoes of a man with three kids and no job. Then you think of a man with lung cancer. It is very hard to know where you should go from there".



☐ *A guide to services for the mentally handicapped has been published by* **Northumberland CHC**. *The council says it is a pilot edition and is asking those who work with handicapped people, as well as their families and friends, to comment on the 80-page booklet. The booklet was edited with the aid of a grant from the Manpower Services Commission.*

☐ The annual report of **Kensington-Chelsea-Westminster (South) CHC** contains a four-page pull-out guide to local health services. There is a map showing hospitals and clinics, details of how to begin to complain and an A-Z of local services.

CHCs are big news — in the Leeds telephone directory. The two **Wakefield CHCs**, together with both **Leeds CHCs** and **Dewsbury CHC** have arranged a full-page advertisement in the phone book. The CHCs are listed under "health".

REPORTS

☐ **Trafford CHC** has written up a report of its study day on caring for young handicapped people in the community. As a follow-up, the CHC is arranging a meeting for local parents of handicapped children.

Central Manchester CHC published a report on medical care for the single homeless in Manchester, on behalf of the now defunct Health Care for Homeless People Project. The report is available from the CHC.

Parents' views of the child health services were surveyed by **Central Birmingham CHC**. In its report *6/10 should do better* the council concludes that three out of five children fail to receive the services they ought to be getting.