CHC NEWS

For Community Health Councils

May 1981 No 66

Action on Black spots

Photo: Raissa Page

A group of CHCs is determined that at least one key recommendation in last year's Black Report — *Inequalities in health* — should not be allowed to fade into obscurity. The report (see *CHC NEWS 59* page six) proposed that there should be an experimental programme of extra help and funding for ten of the "special areas" with the highest mortality rates and deprived social conditions in the country.

Spurred on by Bolton CHC, 11 CHCs from the ten special areas met in London on 30 March to discuss plans for a campaign to get this extra help, and then meet with MPs from the areas concerned. The CHCs who sent representatives were Bolton, Durham (on behalf of the other Durham CHCs), Gateshead, Liverpool Central and Southern, Liverpool Eastern, North Tyneside, Salford, Tameside, Tower Hamlets, Wirral Northern and Wirral Southern.

The CHCs decided not to present a "shopping list" of financial demands but to campaign for special measures for the "Black" areas. This would include regional health authorities (RHAs) diverting more resources to the "Black" areas, possible use of EEC social funds for health schemes, making housing eligible for joint finance, extra help for the disabled and an enlarged health education programme. They also want the married man's tax allowance to be converted to an infant care allowance.

Two regional groups of CHCs were formed — June Corner of Bolton CHC will co-ordinate those in the north west, and Joe Hennessy of Durham CHC, those in the north east. Tower Hamlets, the only southern CHC involved, will travel north to meetings of the groups. Representatives of both groups will meet twice a year to discuss national strategy.

The CHCs intend to rally support for their campaign by lobbying voluntary organisations, trade unions, the Royal Colleges, social services, health authorities and local authorities. They hope to arrange local seminars, contact the media and organise local pressure for better preventive measures and health education.

The meeting with the "Black" area MPs was attended by MPs of both major parties. June Corner says it was "very productive". Only seven of the possible 38 MPs came but 15 sent apologies and expressed interest in the campaign. The idea of RHAs diverting resources to the "Black" areas was well-received, and junior social services minister Lynda Chalker said she would investigate the possibility of getting EEC social funds. The MPs agreed to form an ad hoc group of "Black" area MPs, and Bolton West MP Ann Taylor will liaise between them and the CHCs.

Secretary of State Patrick Jenkin recently took issue with the Black Report for saying that health inequalities are linked to the social class structure but remaining "largely silent" on the nature of these links. He also disputed the report's claim that poor people have less access to the NHS than the better-off, but agreed that there is a need for "a great deal more study" of this issue.

● On 4 June the Association of CHCs is organising a seminar for CHCs on the Black Report. It will be held in Coventry and speakers will include Professor Peter Townsend, one of the authors of the report. Further details from Mike Gerrard at ACHCEW.

INSIDE

The future for family practitioner committees

The way in which the services provided by doctors, dentists, chemists and opticians will fit into the reorganised NHS is now open for comment and consultation. DHSS circular HN(81)10 sets out options for the future relationship between district health authorities (DHAs) and the family practitioner committees which administer the contracts of GPs, dentists and so on. At present there is one FPC to each area health authority.

The choices are:

● To retain present relationships — some FPCs and DHAs would share the same boundaries — but some FPCs would have to liaise with between two and six DHAs.

● To grant the FPCs full statutory authority. This would mean new arrangements for FPC funding but would allow the committees to make their own decisions about administrative staff and accommodation.

● For the regional health authorities to take over the current role of the area health authorities.

The first option would mean the least upheaval, but would be cumbersome to operate, says the Department. The second is the one preferred by the FPCs and the professions, judging by the comments on *Patients first*.

Comments by the end of May, to DHSS, Section RL 1A, Room 1406, Euston Tower, 286 Euston Road, London, NW1.

Your letters

Should CHCs publicise Toxic Shock Syndrome?

Ms Chris Bennett, Member, Rochdale CHC

Toxic Shock Syndrome (TSS) is a disease which involves sudden high fever accompanied by a bright red skin rash, vomiting and diarrhoea, followed by a sharp drop in blood pressure which leads to shock and in some cases to death.

All the women who have suffered from TSS were menstruating, and many were reported to have been using a new, super-absorbent type of tampon containing synthetic fibres. One theory is that TSS is caused not by the materials in the tampon but by its super-absorbent qualities. Tampons block off the vagina, allowing the bacterium *Staphylococcus aureus* to multiply. Because the new tampons are so efficient they can be left in place longer than traditional types, allowing more time for the bacteria to multiply. The bacteria then release a toxic substance which causes TSS.

This type of tampon has only recently come onto the British market. Some makes contain a deodorant which, apart from being unnecessary, can cause irritation, and some come complete with a plastic "applicator" which can scratch the vagina, allowing toxins to enter the bloodstream more easily. Moreover these plastic applicators are non-biodegradeable — they block up sewage systems and will eventually litter our coasts and beaches.

I feel that these tampons should be withdrawn now, but I expect they will remain on sale until the Government feels that the connection between super-absorbency and TSS has been proved. GPs and clinics have been asked to report all cases of TSS, but meanwhile more women will suffer from TSS and risk death until these investigations are completed. After all, women have no choice about buying sanitary protection each month.

CHC NEWS

MAY 1981 **No 66**

362 Euston Road, London NW1 3BL
01-388 4943

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CHC NEWS is distributed free of charge to members and secretaries of Community Health Councils in England and Wales. It is also available to subscribers at £5.00 per annum (less 20% discount if five or more copies of each issue are ordered). Overseas rates on application.

CHC NEWS is published by the Association of Community Health Councils for England and Wales. It is designed by Ray Eden and printed by Feb Edge Litho (1979) Ltd., 3-4 The Oval, London E2.

An extensive publicity campaign is needed to discourage women from buying potentially harmful products, and to educate young girls in particular about the safe use of tampons. Has any CHC taken up this matter successfully in its own district? Can we cooperate in any way as a national network?

One way to reassure organ donors

Norman Colledge, Member, Central Derbyshire CHC

The DHSS's multi-organ donor card, indicating that any part of the body may be used for medical purposes after death, is something that people should carry around with them at all times.

Nevertheless, I do urge that the proviso "Provided an EEG (electro-encephalogram) has been carried out" should be added to the cards, with an exception being made in the case of eye donation. This would give further assurance to donor card carriers that both moral and medical standards have been observed prior to any transplant operation being commenced. It would prevent many people destroying their cards.

While the present wording remains on the multi-organ cards, individual donors may wish to write the EEG proviso onto their own cards, as I have done.

For use when visiting

Dag Saunders, Secretary, Salop CHC

I was a little surprised recently to learn that members of some CHCs do not always receive copies of the SH3 forms for the hospital or hospitals to which they have been allocated as CHC visitors. I would suggest that any member who does not receive this form should ask his or her secretary for it. The SH3 is a simple breakdown of information such as the number of available beds, the number of discharges, the number of outpatient appointments etc. The information on the form must of course be considered in the light of other factors, but when looking at the services of an individual hospital form SH3 should always be used.

Inner city health

Sue Leigh, Secretary, Inner City Forum, Mea House, Ellison Place, Newcastle upon Tyne NE1 8XS

I was interested to read Helen Rosenthal's article on neighbourhood health projects (*CHC NEWS 64* page five) and to note the difficulties which such projects have in relating to the NHS itself.

In Newcastle upon Tyne the Inner City Forum, a group of voluntary organisations, has tried to adopt a two-fold approach to the question of unequal health, and access to health services.

Firstly the Forum has been concerned to support the work of existing health groups, and to initiate new developments. Thus, on the one hand we have been working closely with Newcastle CHC and encouraging more voluntary organisations and community groups to learn about its work and become involved with it.

On the other hand we have helped initiate two proposals for neighbourhood community health projects, based on existing projects in two inner areas of Newcastle. We hope that both these projects, will, if successful in securing funding, develop the kind of work outlined in Helen Rosenthal's article and complement the second part of our work.

This involves a research project into the availability and appropriateness of primary health care provision. It will establish the physical distribution of all primary health care services and carry out an investigation of consumers' responses to their local health services. The objective of the research is *both* to come up with findings relevant to health service policy-makers and to carry out some informal educational work with consumers.

Already the research has attracted the attention of the city council and the area health authority — and the latter has taken the opportunity to develop more strongly a residual interest in the question of primary health.

Of course the conservative professional interests of doctors still hold sway in our local health services. But it is interesting to note that a small group of "outsiders" can make some impact on a health authority within quite a short space of time and it argues the importance of organising at the policy, as well as at the neighbourhood level.

Depo-Provera and CHCs

Lewis Carter-Jones MP, House of Commons, London SW1

I hope that CHCs which responded to my circular letter asking for information about adverse reactions to drugs, and in particular to the injectable contraceptive Depo-Provera, will accept this letter as my "thank you" for their superb cooperation.

With very few exceptions the replies were helpful, and in many cases they were also extremely informative. The detailed information some councils sent has enabled me to put specific questions to the DHSS and the Committee on Safety of Medicines. May I wish CHCs every success in the future.

● See Health News, page four.

More good births?

Sheila Kitzinger, The Manor, Standlake, Near Witney, Oxfordshire

I am well on the way to the birth of a second edition of my book *The good birth guide*, with masses of new material and information about the relaxation of rules and regulations in many hospitals. In some cases the changes in practice have been quite radical. Unfortunately I recently learnt that my publishers, Fontana, do not plan a second edition after all.

I am determined to go ahead with a new edition, and I would be very grateful if CHC members would advise me. What form should the new version of *The good birth guide* take? Can they offer any help? And do they agree that it is worthwhile going ahead?

Comment

Soon we shall know what CHCs will be allowed to do in the reorganised NHS. The proposals in the consultative papers on CHCs in England and Wales are open to various interpretations. Positive thinkers point to the various pats on the back the documents give CHCs, but those of a more wary disposition may agree more with Brian Maunder's article in last month's *CHC NEWS* — that the proposals are "an attempt to diminish our effectiveness .... to ensure that when our usefulness is next questioned support will not be forthcoming". Though the fact that CHCs are still in business at all, following the challenge of *Patients first*, does at least prove that ultra-pessimism can *sometimes* be mistaken.

The real problem is how to distinguish between a feeling on the part of Government that the role of CHCs should not expand, and a wish to see it shrink. One clue may have emerged during the Association of CHCs' recent lobbying of Health Minister Dr Gerard Vaughan. On the question of CHCs not being allowed to "extend their role formally to providing an individual service to complainants", the ACHCEW representatives reminded Dr Vaughan that many CHCs already spend a good deal of time doing this, and that the role of "patient's friend" is already firmly enshrined in circular HRC(74)4. Apparently Dr Vaughan's reply was along the lines of "Oh well, if you're doing it already it's all right to carry on".

Even so, the unhelpful tone of some crucial parts of the consultation papers does remain worrying. Surely a Government which wants to be aware of the effects of its national policies on local services should be encouraging a feedback of views from CHCs, not warning them off? Who on earth can have advised Ministers that CHCs would be more effective if they had fewer members? And why rule out compulsion on the question of CHC observers at Family Practitioner Committee meetings, when it has long since been clear that in some places nothing less than compulsion will usher in this "valuable" practice?

Lastly, why bother to call into the question the need for the Association of CHCs — which at the end of 1980/81 had 216 member CHCs out of a possible 228? Support is flowing in from CHCs and from national bodies such as MIND, Age Concern and RADAR. Local authorities and health authorities are in no doubt about the benefits of having national-level bodies, so it would seem grossly unfair to withhold these benefits from CHCs.

If nothing else, *Patients first* and the present consultation have at least begun the process of educating Ministers about what CHCs really do. We hope they will look carefully at the report of our latest "CHCs at work" survey (see pages 8-10 of last month's *CHC NEWS*) — which should leave them in no doubt about the energy, imagination and perseverance that CHCs have poured into their work.

Soon, however, the present whirlwind of consultations will subside, leaving many CHCs with some catching up to do. Major problems for the NHS — imposed by cash limits, by the cuts in local authority services, by smaller-scale local management, and by the Government's stream of support for private health care — are all beginning to make themselves felt. It will be a testing time of a different sort.

Health News

Overseas visitors to pay for treatment

Every time anyone wants free NHS treatment they will be asked to say where they have lived in the UK for the last three years, if new DHSS proposals* for charging overseas visitors are implemented.

Under the new regulations, which according to the DHSS should save about £5m, overseas visitors would only receive free treatment in very limited circumstances. These include accidents but not subsequent admission to hospital as an inpatient, sexually transmitted diseases if caught here, and certain specified conditions such as TB and polio. Otherwise overseas visitors will be required to pay the same charges for treatment as private patients.

It is also intended that visitors should pay for other services such as family planning and the ambulance service, but the DHSS foresees problems in recovering payment. GPs, dentists and opticians would be "expected" to charge overseas visitors.

The new regulations would not alter the position of people from EEC countries and other places with whom the UK has reciprocal health agreements. And free NHS treatment would continue for people who are "ordinarily resident" in the UK — though this is not defined and its interpretation will be a matter for the courts. "Overseas visitors" who have been here three years or more would be exempted from charges and the DHSS suggests that everyone be asked "two or three simple questions" about where they have lived in the UK for the previous three years "supported by such evidence as may be necessary".

The DHSS admits that there might be problems for people who *look* as though they "could be of foreign extraction" but presumes that "common sense" will prevail. The Commission for Racial Equality feels that "if people with black or brown skins think that they may have to show their passports they are even less likely to come forward for treatment".

*Health notice HN(81)13 *NHS treatment of overseas visitors* and draft regulations are available from Health Services Division 2C, Room 1117, Hannibal House, Elephant and Castle, London SE1 6TE. Tel 01-703 6380 ex 3680. Comments to this address by 15 May.

During International Year of Disabled People the DHSS is placing extra emphasis on publicising the range of aids, services and benefits available to help disabled people and their families. Booklet HB1, Help for handicapped people, *plays an important part in this campaign, and a poster encouraging people to use the booklet is now also available from the Department. For copies of the poster and booklet write to DHSS Leaflets, PO Box 21, Stanmore Middlesex HA7 1AY.*

London's teaching hospitals

The future of the 12 specialist post-graduate teaching hospitals and their associated research institutes has been considered afresh — this time by the London Advisory Group*. Six are to remain, each with its own board of governors, (Bethlem Royal and Maudsley, Moorfields Eye, National Heart and Chest, National Hospital for Nervous Diseases, Royal Marsden and the Hospital for Sick Children). The group proposes that two — St Peter's (urology) and St John's (dermatology) should be rehoused and managed by a district health authority. The future of the rest (Eastman Dental, Royal National Throat Nose and Ear, and Queen Charlotte's Hospital for Women) is still open — pending London University's decisions about the undergraduate medical schools.

Continued on next page

Health News

Continued from previous page

Do-it-yourself amputations seem to be the University's prescription for the medical schools, according to a report which was recently approved by the University's governing bodies. Several medical schools have been told to sort out mergers between themselves, and the final outcome is still far from clear. Government spending cuts oblige the university to save 10% of its annual medical school budget. *The Lancet* (4 April 1981) reported "worry and disappointment" among the Deans.

**Management arrangements for the post-graduate specialist teaching hospitals,* report of the London Advisory Group. From DHSS, 286 Euston Road, London NW1.

Put London's money into primary care, say CHCs

The current health service reorganisation is a last chance to get things right for London's patients, according to a report by a group of London CHCs and the Association of CHCs*. The report identifies poor primary care as the capital's main problem and says that the new district health authorities should have the same boundaries as local government. It argues that the strategy of closing acute beds (see *CHC NEWS 64* page 4) won't help, and the CHCs believe that the influence of the teaching hospitals continues to distort the planning of services. Health visitors should be integrated into the community medicine structure, says the report. It also suggests that as acute beds are closed, hospital nurses should be offered retraining and posts in community nuring.

* *The management of health services in London* from Association of CHCs, 362 Euston Road, London NW1.

Objecting to hospital closures

CHC objections to hospital closure proposals stand a poor chance of being upheld by the Secretary of State, according to statistics released by the DHSS. During the three years beginning October 1977, thirty-three closures were referred to the Secretary of State following CHC objections, but only five were rejected. Twenty-six were approved, and another two were converted into changes of use.

The 33 cases include 29 whole closure proposals (24 approved, three rejected, two changes of use), and four part-closures (two approved, two rejected). Over the same three years the Secretary of State considered three change-of-use proposals, approving two and rejecting one.

The DHSS points out that rejection of a closure proposal by the Secretary of State does not *necessarily* mean that he agreed with the CHC's arguments. It should also be remembered that area health authorities sometimes withdraw or modify closure proposals in response to CHC criticisms — sometimes even before the CHC has made a formal objection.

The DHSS also points out that Secretary of State Patrick Jenkin is rejecting a larger proportion of disputed proposals than his predecessor David Ennals. In the first 18 months of the present Government six closure proposals were accepted, three rejected and one converted into a change of use. In the last 18 months of the previous administration, 20 closures were approved, two rejected and one converted to change of use.

CHCs find the gaps in drug monitoring system

Women who have been given injections of the controversial contraceptive Depo-Provera have experienced "far more widespread and severe" side-effects than those which have been reported through the official drug monitoring channels. This is MP Lewis Carter-Jones' conclusion, following what he calls a "very limited research project" carried out with the help of CHCs.

Last year Mr Carter-Jones wrote to all CHCs, asking for their views on monitoring adverse reactions to drugs and whether they had information about Depo-Provera (DP). More than 80% of the CHCs responded, many by sending reports of patients who had complained about being given DP on post-natal wards, sometimes without any warning about possible side-effects. About half the councils agreed with Mr Carter-Jones' suggestion that the scope of CHCs should be extended to monitoring suspected adverse reactions to drugs.

However the most immediate conclusion which can be drawn from the investigation is that there is a big gap in the system for picking up patients' adverse reactions to medicines. The CHCs reported more than 50 cases of women who had suffered in the last two or three years from disrupted and sometimes severe menstrual bleeding, headaches, depression, marked weight gains and feelings of nausea — often for months after a single injection. Yet from 1973 to February 1981, the Committee on Safety of Medicines (CSM) had received only 40 reports of suspected reactions to DP, sent in by doctors using the official "yellow cards".

Mr Carter-Jones is angry that the CSM will not agree to look more closely at the use of DP, and accuses it of "hiding behind protocol" in refusing even to consider the CHCs' evidence. Although it is widely admitted that the current post-marketing surveillance machinery is far from perfect the CSM's case is that it cannot take account of "anecdotal" evidence, unless this is verified by the patient's doctor. It argues that "professional judgement is essential in assessing whether the patient's condition is likely to have been caused by the drug".

Mr Carter-Jones believes DP should be withdrawn "until the authorities have at least looked at all this information — which comes from very reliable sources". Health Minister Gerard Vaughan's position is that "there is no reason to justify taking any action which would have the effect of restricting the freedom of doctors to prescribe Depo-Provera".

● Changes have been agreed at the other end of the drug safety machinery — simplifying the procedure for allowing new drugs to be tested on human beings. The idea is to give drug companies a chance to find out earlier if a new drug is worth pursuing, and now the CSM will require fewer tests to have been completed on animals before trials begin with human volunteers (see *CHC NEWS 64* page 4). The Government has been concerned that drug companies have been increasingly transferring research funds and other investment out of Britain, and attributes this to the companies' dislike of the British drug research regulations. The Association of CHCs is worried that the new regulations may increase the risk to patients.

Ethical committees should be gingered up, says BMA

Local ethical committees with no lay members or without a GP member should be reconstituted, a report from the British Medical Association has recommended (1).

A survey carried out by the association's Central Ethical Committee, based on information from 73 of the 98 health areas in England and Wales, turned up 141 ethical committees — some based on hospitals and some area-based. Thirty-seven had no lay member and 84 had no GP.

The BMA is concerned that there is no model constitution for ethical committees, and wants to see the committees' monitoring role extended beyond hospitals to cover "research in all fields of medical practice". The report recommends that ideally an ethical committee should have two senior hospital doctor members, one junior hospital doctor, two GPs, one representative of community medicine, one nurse and one lay member. After further professional consultations the report will be sent to the DHSS "for implementation".

1. *British Medical Journal*, 21 March 1981, page 1010.

RADAR puts the brake on cuts for the disabled

Over 2000 disabled people have contacted the short-term project aimed at enforcing the Chronically Sick and Disabled Persons Act, set up by RADAR and other major charities last October (see *CHC NEWS 61* page three).

According to RADAR, the project's intervention has caused "numerous" local authorities to change their minds about not assessing applicants' need for services available under the Act. On many other occasions authorities have reversed decisions not to provide services such as telephones and assistance with holidays. The project is still prepared to take authorities to court if needs be, but so far this has not proved necessary.

Because of the response to the short-term project a full-time welfare rights officer is to be appointed to carry on the work. For the time being the person to contact is Peter Mitchell, c/o RADAR, 25 Mortimer Street, London W1. Tel: 01-637 5400.

An Open Letter

from Joan Woodward, ex-member, Central Birmingham CHC

Dear Regional Health Authority Chairman,

"Medicine is in the hands of experts and sets it own path ... not really for the rest of us at all", said Ian Kennedy last year in the first of his Reith Lectures. He went on to tell us some good reasons why we should all take a hand in setting the path of medicine.

For ten years I have been learning ways a lay person can affect the health service, first as a hospital board member and then in a six-year stint on the CHC. This article is partly a thank-you for that opportunity. It is also a reporting back to the regional health authority at a time when it will soon be responsible for guiding district health authorities (DHAs). I hope this "open letter" will stimulate other retired CHC members to enter the debate.

Re-organisation has been so time-consuming that some important issues have not been tackled. I have selected four "nettles" that I hope DHAs will grasp firmly.

Doctors' unreasonable share of power

This is an issue no-one as yet knows how to alter. Criticism of the medical profession gets louder, but we do not want the United States of America pattern, where wealthy patients can intimidate their doctors! We need to ensure that no single group holds an unreasonable share of power. Even some doctors do not wish to retain the present state of affairs. This imbalance helps to maintain another one — between the hospital service and the primary care services.

Nothing is gained from "knocking" doctors, nor under-estimating the importance of their role, which should be put in the context of a team. Doctors need reminding that they are *in the main* as dependent on patients as their patients are on them, but this is rarely felt to be so at the point of contact.

The greatest hurdle in equalising power is the medical profession's lack of accountability. Why should "clinical freedom" only be given to doctors?

CHC members need to be knowledgeable if they are to be effective in expressing the patient's voice. Members need to share expertise more widely. If CHCs compile leaflets about local services it helps patients make informed choices. Members need to be active on all possible committees, including research and ethical ones, so that the lay viewpoint is heard. Patient associations at family doctors' surgeries need encouraging. Perhaps the British Medical Association will one day be persuaded to reverse its recent decision to keep medical records secret from the patient.

Current shape of planning

CHC members are familiar with the incredible bulk of plans that come from all levels of management for perusal and comment.

The strangest feature I have noted is this concept that "to have a plan" holds some validity of its own. Thousands of pounds are spent on plans that have little bearing on reality. As proposals for buildings, upgradings or staffing often fail to reach fruition, more time might usefully be spent on considering some changes that could be made with greater reliability.

All plans seem dependent on budgets, which may or may not be forthcoming. This tends to leave everyone in an "Alice in Wonderland" type of existence, which can be experienced as near-tragedy by people who have devoted years to planning a hospital or department that is suddenly axed.

If time was given to looking carefully at how every department or ward could be improved *without* expenditure there would be a great shift of emphasis from the material aspects to the caring ones. I believe the source of ideas for such changes could lie in the patients and the "less exalted" members of staff, but at present these sources are rarely tapped.

Ask a small child what he or she wants in hospital. The child will answer — a parent. Unrestricted parental visiting of child patients could be instituted universally tomorrow, without costing a penny but it requires a change of attitude. This is what cries out for greater management attention.

Appointment of senior staff

In the past some decisions about NHS appointments were made in an amateurish way with little appreciation of the consequences of certain appointments. Complicated ramifications can arise out of the appointment of a surgeon with special interests for example, working with severely handicapped babies. This may lead to an apparently wonderful increase in survival rates, but also to serious new demands on the community services and on families. Devastating effects can follow a "wrong choice" of head of a department, senior nursing officer or administrator who blocks change, lowers morale and leads to rapid turnover of other staff.

A bigger group of people need to be involved in making senior appointments. Professional skills in psychology and management-matching needs to be applied, combined with longer periods of probation. First, however, we need an open acknowledgement of just how damaging to the health service poor appointments at the top can be.

Nursing shortages

There is now such a critical shortage of nurses that child patients with curable diseases die while on waiting lists because intensive care units cannot accept patients. Sometimes new wards cannot be opened. I believe too many aspects of the nursing profession have become old-fashioned — nurses are subject to unnecessary reprimands about their personal appearance. Some women find it impossibly difficult to reconcile the attitudes to them in the nursing role, with those attitudes gaining strength in society outside.

Many small investigations could be made at the places of greatest nursing shortage, to hear directly and confidentially from the nurses themselves about the factors that are operating in that particular unit. New, imaginative thinking is needed to solve such problems as "too much responsibility", "too much stress". Solutions are posible, but too easily get lost in the vicious circle of fewer nurses leading to increased strain, faster turnover and greater strain on those that remain.

I believe that however DHAs may work in the future, they are going to need CHCs to provide, in responsible form, the essential voice of the consumer.

ARE THERE ENOUGH NURSES?

*by Jillian MacGuire**

We know how many nurses there are in post, in each grade, in different types of hospital and in the community. But how do we know that these are the right numbers, and in any case what do we mean by "right"?

This article is about attempts to use research to work out *nursing establishments* — the number of nurses needed in a ward, unit or hospital. The problem of how to measure and meet the daily requirements of patients for nursing care is one which faces managers, ward staff and researchers alike. It is particularly complex in acute hospital wards, where the rapidly changing patient population makes fluctuating demands on nursing staff time.

How many nurses?

In community nursing there are DHSS guidelines (1), relating establishments to the size and age structure of the population served. But these guidelines are not mandatory, and the numbers of health visitors and district (ie home) nurses per 100,000 of the population show considerable variations both between and within regions.

In new hospitals or new wards the number of nurses is determined locally with reference to finance and local practice, taking into account the type of hospital, the number of beds in each ward, the types of ward and department, night duty, time off and holiday requirements. This allows for the total nursing establishment of a new hospital to be built up on a ward-by-ward basis, and reflects the special staffing requirements of specific wards such as coronary care and intensive care. In agreeing nursing establishments for new capital developments, Regional Health Authorities and local managers aim to allow about 30% of the revenue consequences of capital expenditure to go to nursing.

In existing hospitals, however, ward and departmental establishments are set by a combination of precedent and financial constraint, with the bargaining strength of the various interested parties being another important factor. The DHSS does not issue "norms" for hospital nursing, but it does from time to time give advice on "minimum tolerable" staffing levels (2). In hospitals where there are student and pupil nurses the General Nursing Council holds a watching brief on staffing levels.

Jillian MacGuire, a sociologist with a particular interest in nursing, is now a student nurse.

How much work?

The notion of an appropriate nursing establishment figure embraces ideas about the amount of work that has to be done, the quality of that work, the time it takes for the work to be completed, and thus the number of nurses who will be needed. Common to all research in this field is an attempt to quantify the work of the nurses concerned.

The most important factor determining the workload of a ward might seem to be the number of beds, on the theory that more beds equal more work. But the relationship is not so simple. The number of occupied beds may change from day to day in any given ward, and this can have a dramatic effect on nursing workload. The balance between the proportions of very ill, partly recovered and "well" patients is probably the most important single factor.

In the mid-1960s a researcher called Barr began to look at how far patients had to rely on nurses, and showed that patients could be usefully grouped on the basis of their "nursing dependency" (3). Patients who were confined to bed, were on intravenous drips, needed regular turning or had to be fed made more demands on nursing time than those who were "up and about".

Proper determination of patient dependency involves more than a "snap judgement" about how ill a patient is. It involves an assessment of the patient's condition over the preceding 24 hours. Barr has devised a form onto which a sister or staff nurse can enter the details of 30 patients' conditions in only ten minutes. The total of each patient's "dependency score" gives a "ward score" which is a measure of that ward's total workload, as shown in the table below.

Dependency category		Number of patients		Workload (nursing units)
1	×	4	=	4
2	×	7	=	14
3	×	6	=	18
4	×	3	=	12
5	×	6	=	30
		26*		78

** 4 empty beds*

Ward scores can then be added up to give a workload total for the whole hospital. While the "hospital score" may show little variation from day to day, particular wards may vary considerably. Over a period one ward may have scores consistently above average, while another has a workload which is below average.

Photo: Green College, Oxford

How many staff?

While measurement of workload may indicate which wards are better or worse off, it does not of itself tell us how many staff are needed. In her book *Dependency and establishments,* Olive Senior describes a method which does just that. By observing the amount of nursing time given to patients when wards were clearly over-staffed, she was able to establish empirically a time value for each unit of nursing care in a particular hospital. Using this value the number of nurses required can be calculated for each ward on a daily basis. For example, in a hospital where each unit of the nursing workload takes 30 minutes to complete, a ward with a workload of 78 units will require 39 hours of nursing time per day.

To this figure must be added an allowance for administrative, domestic and clerical work carried out by nurses, which should include time for personal relaxation. This allowance must also be arrived at on the basis of what happens in a particular hospital. A further allowance must be made for night cover. The ward in the example above would need nine nurses for each 24-hour period, and to cope with weekend working, holidays and training requirements a full complement of 19 nurses would be required.

In general, the number of full-time nurses needed in a ward on a particular day can be worked out using the following step-by-step formula:

1. Multiply the ward workload score for that day by the time required per nursing unit in that hospital.
2. Add to the above total the number of hours allowed for

other work and night cover.
3. Divide by the number of hours in a full-time nurse's day.

This formula can be used to arrive at a nursing establishment in any ward or hospital. Ward workload scores can be calculated relatively easily by staff in post. Time values for the units of nursing workload must be measured systematically by "activity analysis" in each hospital. Time values for one hospital do not necessarily hold good for any other hospital

How useful is the method?

Too much should not be claimed for any method. This approach cannot tell us anything about the "right" number of nurses in the country as a whole, though it does begin to answer questions about what is the right number for a particular ward or hospital. Its great merit is that it is firmly grounded in the situation of each hospital and the working conditions of each ward. The method is the same but the values — nursing workload and time per unit — are established locally. It can be readily understood by ward staff and enables them to state in objective terms how much work there is in their ward. It provides a rational way of redistributing staff within a hospital on the basis of the workload, but within that hospital's own mode of operation. It enables nurse managers and ward staff to use a common language and to reach a mutually acceptable answer to the question "Are there enough nurses to care for the patients in this ward?"

References

1. See DHSS circular 13/72, which gives guidance on establishments for district (ie home) nurses and health visitors. There is no guidance on midwives.
2. See the Department's "Dear Secretary" letters DS 86/72 (on mental illness hospitals) and DS 95/72 (geriatric hospitals), and "Regional Hospital Board Chairman" letters 10/69 and 10/70 (mental handicap hospitals).
3. *Measurement of nursing care,* by A Barr. Oxford Regional Hospital Board, 1967.
4. *Dependency and establishments,* by Olive Senior. Royal College of Nursing, 1979. £3 inc post from Publications Department, Rcn, 1a Henrietta Place, London W1M 0AB.

Book reviews

Health protection in the urban environment

by Frank Sugden, Associated Business Press, £11.50

This is a readable book for CHC members and it brings out the fact that prevention of disease is important not only because disease causes suffering but that it also makes economic good sense. When prevention is pursued, in almost any form, the NHS reduces its curative expenses.

The book deals with the historical development of environmental health control. There are chapters on water supply, drainage, sewage disposal, solid waste, air pollution, noise, occupational health, housing and food.

It is disappointing for CHC members that the book lacks details about how, by means of joint consultative committees, etc, the work of the NHS is integrated with wider preventive health measures. But the author does show how pressure groups have influenced the development of environmental health policy and this might be heartening for CHC members.

I think this book provides essential and informative reading for people involved with the health service.

W G Davies
Montgomery CHC

Services for the mentally handicapped in Britain

by Nigel Malin, David Race and Glenys Jones, Croom Helm, £6.95 (paperback)

The title of this book is misleading. It goes well beyond describing services. The value of the book is that it examines the rationale behind services, is not frightened to take sides, and finally suggests good ideas for the future of the services for mentally handicapped people and their families.

The reader will find out about available residential care, loan services, money, voluntary effort, family support and how management works. All the information is clearly expressed and the book is supplied with good summaries and details of where to look for further information.

I have a special interest in the history of the provision of services in this country. The first chapters of this book discuss not only causes of handicaps, the names used and how many handicapped people there are, but also give a fascinating and very readable account of how services began and what they are like today.

It is a pity that the story finished with the "euphoria raised by the setting up of the NDG (National Development Group)". Because today, 1981, the NDG no longer exists. But historically speaking, who can be surprised? Certainly not those who nurture and care for the mentally handicapped members of British society.

Alfred Boom, Member
West Berkshire CHC

Aspects of alcohol and drug dependence

edited by J S Madden, Robin Walker and W H Kenyon, Pitman Medical, £16.50

This collection of articles, all by experts, quoting other specialists and surveys, full of tables and lists, is based on the proceedings of an international conference. The language is often technical as the authors came from the fields of medicine, psychiatry psychology and sociology.

The studies include those on adolescent drinkers in England and Ireland, British heroin addicts, Malaysian drug users, alcoholism among doctors, comparisons of treatments and alcoholic liver disease. There is a great deal here for professionals to learn but any CHC members interested in the subject can glean something.

Margaret Campbell
Oxford CHC

Parliament and health policy: the role of MPs 1970-75

by Stephen Ingle and Philip Tether, Gower, £11.50

The authors of this book attempt to assess the influence of Parliament on policy-making by considering a number of issues in detail. The particular policy area that they have chosen is health, which makes the book of more interest to members of CHCs than would otherwise be the case, but the general issues raised are almost certainly applicable to other areas of policy.

Parliament and health policy is primarily concerned with the NHS re-organisation Bill of the early 1970s. It also looks at some of the issues which were considered as part of that Bill — though one might think that issues such as pay beds and birth control were not necessarily anything directly to do with re-organisation.

The book as a whole gives a somewhat depressing view of the impact that MPs are able to make on the detail of policies. It is of interest to note that most of the few successful changes that were proposed related directly to the establishment of CHCs. The authors suggest that this was because the Government had no fixed ideas on the subject and was looking for advice.

This book will provide much useful ammunition for those who feel that if our form of Parliamentary democracy is to survive, a strengthening of the role of the individual MP is required. It is a pity that the text is marred by so many typographical errors.

R M Southern,
ex-Stockport CHC

Books received

The Which guide to family health edited by Michael Leitch (Consumers' Association £7.95). Disappointing mixture of keep-fit hints, description of how the body works and a rather perfunctory list of common ailments. The bulk of the book is taken up with the lavishly-illustrated keep-fit section "Stay healthy". The last part is devoted to "Survival" — useful for those who want to know about how to deal with attacks by enraged animals or escaping from a submerged car.

Basic nursing care (2nd edition) by Shirley W Hutton and Yvonne Nielsen (Bailliere Tindall £2.25). This is subtitled *A guide for nursing auxiliaries* but it would also be a helpful guide for someone looking after chronically sick friends or relatives. It gives a wealth of practical information about a range of problems such as caring for an incontinent patient, looking after the elderly sick and dealing with cardiac arrest.

Principles of economic appraisal in health care by M F Drummond (Oxford University) Press £4.95)

Operational research applied to health services edited by Duncan Boldy (Croom Helm £15.95).

PATIENTS' COMPLAINTS

by Elizabeth Ackroyd, Chairman, The Patients Association and Vice-Chairman, Waltham Forest CHC.

An accessible complaints procedure, seen to be fair by complainants, is the hallmark of good consumer service. The NHS does not meet these criteria. To most people the machinery for handling complaints in the NHS is a closed book. Family practitioner committees, hospital administrators, even the health Ombudsman (the name may be familiar but not the functions) and alas, also CHCs, mean little to the public. The Patients Association's contact with patients demonstrates that.

The one body whose name does ring a bell is that of the General Medical Council — presumably because of the lurid cases of errant doctors which come its way. The General Medical Council however has no relevance for the bulk of cases which CHCs and the Patients Association handle.

I am not arguing that vast numbers of patients are being victimised by the NHS. The Patients Association mostly hears only complaints, but we are aware that on the whole people rub along alright with their doctors. Secondly, complaints procedures are irrelevant to many of the problems patients experience.

About 10% of the complaints recorded by the Patients Association over the last five years or so, referred to inadequacies in the way they were handled. This is quite a high figure given that most people are not much interested in procedures of any kind.

In the case of family practitioners — GPs, dentists, opticians and chemists — the procedure applies to the limited field of their "terms of service" with the NHS. In the case of hospitals there is no universally applied structure at all. And in both cases, complaints about "*clinical judgment*" — *doctors'* decisions about treatment — are effectively ruled out of bounds altogether, except through the courts.

Family practitioners

A GP's contract with the NHS states that the doctor must "render to his patients all necessary and appropriate personal medical services of the type usually provided by general medical practitioners" (Statutory Instrument 1974 No. 160). This yardstick has not been more precisely defined and family practitioner committees (FPCs), who deal with complaints against "family practitioners" seem in practice to regard it as ruling out complaints about doctors' medical knowledge or attitudes towards their patients. But complainants don't regard these factors as irrelevant. As one of the correspondents said, when complaining about the "indifferent attitude" of her doctor, she felt that attitude is an "important part of a GP's role". The FPC replied that it was "concerned with what practitioners actually do and can only look at facts". But much of what doctors do is classed as clinical judgment so that consideration of it is ruled out.

Another complainant was told that her questions about the GP's medical knowledge were "irrelevant to proper consideration of the case". In both these cases the complaints were dismissed, leaving both complainants with a lasting sense of injustice and a poor opinion of the system.

The DHSS has made spasmodic attempts to improve the procedures of FPC hearings, but not their scope. Enthusiasm for the task has steadily waned. After some false starts, proposals were put forward in 1978 to meet some of the main criticisms, in particular by extending to six months (from eight weeks) the time limit within which a complaint must be lodged. The DHSS also emphasised that lay members of the "service committees", which hear the complaints, must really be "lay". There were plans to give the committees power to demand case notes so that complainants could examine them, and to allow oral complaints under certain conditions.

The Patients Association liked these proposals. The medical profession did not share its view. For whatever reason, the DHSS dropped the scheme. Last year the present Government concluded that the procedures were not in need of radical alteration and therefore the 1978 proposals would remain on the shelf. Some "relatively minor changes" are now being canvassed. They include acceptance of oral complaints and renewed emphasis on the "layness" of lay members.

The health Ombudsman cannot deal with complaints against GPs or about the FPCs' formal procedure for handling complaints, but he can investigate complaints against FPCs arising from their informal handling of a complaint.

Hospitals

The prevailing official guidance on dealing with complaints is a 1966 Department of Health circular (HM (66)15). This was criticised in 1973 by the Davies Committee on Hospital Complaints Procedure, on the grounds that it was almost entirely internal and that the hospital authorities were in fact left free to decide their own procedures, subject only to guidance on broad principles. This criticism remains valid today.

The Davies Committee proposed a code of practice which left nothing to chance. It could be argued that it was too meticulous for its own good. But the code did grasp the nettle of clinical judgment. The committee recommended that independent investigating panels composed of both professionally qualified and lay members under a legally qualified chairman, should be used to assist in the investigation of any complaint that could be the subject of litigation — whether or not doctors were involved.

In 1976 the Government issued a consultative document (HN(76)107) based on the report's recommendations, with the exception of the clinical judgment issue. That was referred to the Parliamentary Select Committee on the Ombudsman. The MPs committee recommended in 1977 that the Ombudsman's remit should be extended to clinical judgment.

The next stage in the saga was yet another consultative document from the DHSS, (HN(78)39), which proposed a simplified version of the Davies code, again omitting medical treatment which, it was promised, would be covered by another document. Since then, deathly silence from the DHSS. Complaints continue to be handled on the same general lines as before. That is, the patient writes to the hospital administrator. If the answers are not satisfactory, the patient can call in the Ombudsman. If *clinical judgment is involved, the only* options are to haggle for compensation or to go to law. In practice, most complainants throw in the sponge.

Meantime the medical profession has been fighting what it regards as "intrusion" into clinical judgment by the Ombudsman — or indeed anyone other than doctors. The profession offers a system under which a complaint would, if not settled by the consultant against whom it had been made, pass to the regional medical officer, and finally, to two independent consultants chosen by that officer. The predominant tone of the document setting out this scheme is one of complacent benevolence, with the accent on reassuring the misguided patient that "all proper steps had been taken *and appropriate skill exercised*", and making sure that any material which *might* be used in a court case is kept under wraps (1).

This scheme is now with the DHSS and I hope they will reject it*. The Patients Association has asked them to do so.

Going to court is not a satisfactory answer in most cases, though some people feel driven to it in desperation, such as the widow who said to us "I would not besmirch my dear husband's memory by claiming damages, but if recourse to the law is the only way to obtain a hearing, I am prepared to consider it". Proving negligence is a daunting undertaking, compounded by the difficulty of obtaining expert witnesses to testify against colleagues.

The Patients Association believes that to remove the hassle from the *situation, in the interests of the doctor* as well as the patient, there should be a no-fault compensation scheme. A recent letter to the Patients Association says it all: "I'm realistic enough to see that mistakes happen and I don't feel any animosity against the surgeon who 'nicked' me". (The complainant had suffered a mishap during an operation.) She asked us, "Have I any grounds for claiming compensation because of having to give up my job and if so would it go against the surgeon concerned in any way?"

A national no-fault compensation scheme would need government backing. The present Minister for Health has shown no enthusiasm for it. So, I believe, the Ombudsman should be brought in. He couldn't award compensation but he would take the investigation of a complaint about clinical judgment out of the claustrophobic atmosphere in which the medical profession envelopes it.

Action

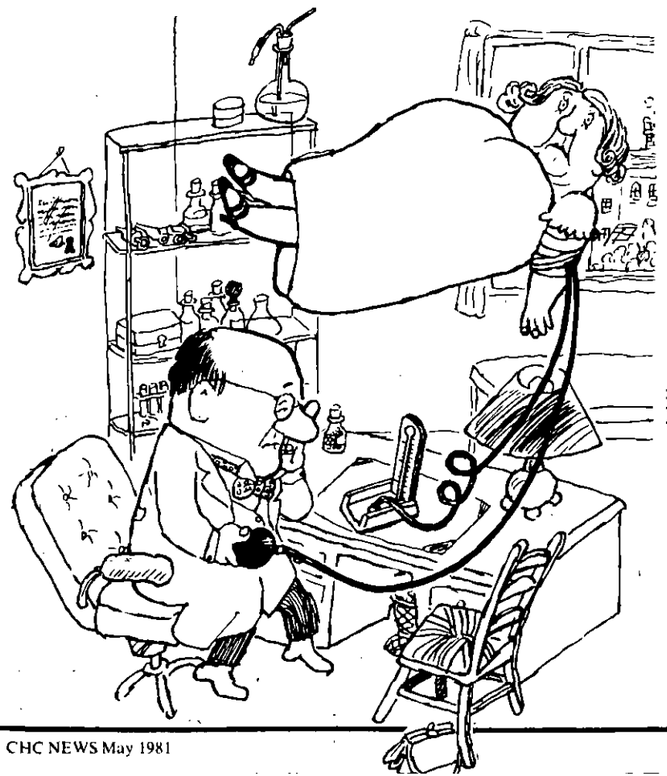
I hope that CHCs will support the Parliamentary Select Committee's recommendation that complaints involving clinical judgment should be included in the Ombudsman's remit. CHCs have been warned off national issues in the DHSS' consultative paper on their role and membership. The action I propose will be done most effectively through local MPs, buttressed with examples of local cases where patients have run up against a brick wall.

I hope CHCs will also ensure that they are involved in the selection of really lay members of the FPC service committees and will press for an extension to the time limit for complaints about GPs, dentists and so on.

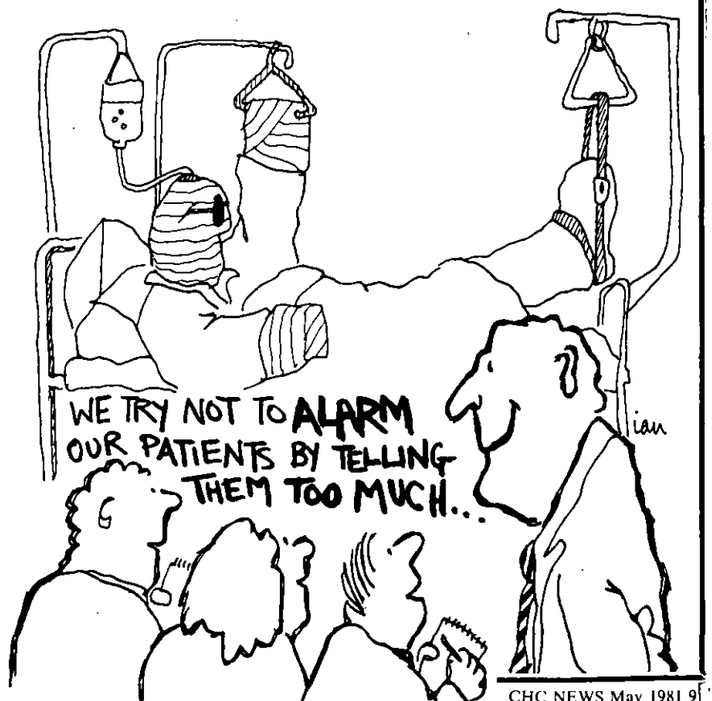
It sounds unambitious? But if it were achieved, it would mean the removal of a lot of unnecessary aggro for a lot of people.

Reference

1 *British Medical Journal*, 22 November 1980. See also *CHC NEWS 62*, page one.



* *Ed: Since Elizabeth Ackroyd wrote this article, the DHSS has accepted the scheme.*



Cartoons: Ian Hering, Liverpool Central and Southern CHC

CHC surveys

Last month we published an article by Christine Farrell analysing the results of the questionnaire on CHCs' work which we sent to CHCs in November. CHCs were asked about the surveys they had carried out. Christine Farrell has already described the broad characteristics of these surveys (*CHC NEWS 65* page 10), and we are now publishing the complete list.

We asked CHCs to list surveys they had carried out since August 1977 when we last sent a questionnaire to them. For a list of the surveys we were told about then see *CHC NEWS 30* page 9.

Out of the 228 CHCs 194 responded to our questionnaire, so the list of surveys is not absolutely complete. In two instances where we knew that CHCs had done surveys not mentioned in the questionnaires we have added them to the list.

Where a survey covers two subjects we have either mentioned it under two of the subject headings or referred readers back to the main subject heading.

For reasons of space we cannot give the full titles of the surveys. Where it seemed particularly helpful we have added brief details in brackets after the name of the CHC. Readers can have a list giving the full titles if they send us a large SAE. But for more details about individual surveys they should contact the CHC concerned.

A

Abortion services

N Tyneside, Liverpool Central and Southern, Exeter and District, E Dorset, Basingstoke and N Hants, Harrow, N Hammersmith and Acton (day-care).

Accident and emergency services

General W Birmingham, NW Regional CHCs, W Essex and District, Kingston Richmond and Esher, Cardiff and Vale of Glamorgan (minor casualty services).
Use of A & E services, Rochdale, Wigan, Guy's, Haringey (reasons for attendance), S Warwickshire (access in rural areas), Stockport (attitudes and expectations of users).
Patients' views about closure of A & E department City and Hackney.

Alcoholism

GP referrals N Camden
Need for services, Haringey

Alternative medicine

W Birmingham

Ambulance services

Kingston Richmond and Esher, S Nottingham, Islington (outpatient services).

B

Back pain

Darlington (how services could be improved).

Breast feeding

Haringey.

C

Chemists

Closure of small chemists, W Cumbria.

Children's health services

General S W Surrey, Central Birmingham (mothers' views), S Lincolnshire (public attitudes).
Clinics Salford, Central Derbyshire, S Nottingham.
Health centres Salop (proposals for closure).

Children in hospital

General Cambridge, N Devon (ward in new hospital), Tunbridge Wells (children in adult wards).
Parents' views Enfield, S Gwent, S Sefton (on visiting) Stockport (on visiting).
Play Stockport, Hastings.

Chiropody

S Camden, S Nottingham, Islington (appointments), Mid-Essex (needs), Central Birmingham (waiting lists), Surrey (in old people's homes).

Community health councils

Public awareness of CHCs Northampton, NW Herts, Bury.
Publicity Plymouth
Involvement with joint care planning teams N Surrey

Convalescent homes

Enfield

D

Services for the deaf

SE Cumbria, W Somerset, Wycombe, Kensington-Chelsea-Westminster S, Stockport (elderly hearing impaired).

Dental services

(see also Fluoridation)
Waltham Forest, Newham, Wirral N, Central Birmingham, W Birmingham, W Cumbria, Central Manchester, Mid-Surrey, E Surrey, Worthing, King's, King's Lynn, Bury, S Camden, Wolverhampton (emergency services), Hastings (patients' views on surgery).

Services for the disabled

General Haringey, Central Birmingham, Aberconwy, Kettering, Wycombe, Bolton, N Warwickshire, N Surrey (family and handicap).
Access Hereford, E Birmingham, Wycombe, W Surrey and NE Hants, Central Derbyshire.
Community services SE Cumbria (for the young), W Somerset (for children), N Surrey (for the young), Doncaster (for drivers), Havering (exhibition of aids).
Hospital services Darlington, Walsall (units for younger disabled).

Discharge arrangements

***(see Elderly, Hospital discharge* arrangements)**

Drugs

Debendox S Sheffield
Depo-Provera Rhymney Valley
Eraldin N Gwent

E

ENT (ear, nose & throat) services

W Birmingham

The elderly

(see also Chiropody)
General needs N Tyneside, Enfield, Torbay, Isle of Wight, Sutton and W Merton, Central Derbyshire, N Hammersmith and Acton, Kings Lynn (incidence of elderly mentally infirm).
Community services N Tyneside, N Gwent, Central Manchester, N Bedfordshire, Grimsby, Huddersfield, SW Herts, Oxfordshire, W Essex and District, Islington (in own homes and in Part III homes), Havering (for those caring for elderly at home), Isle of Wight (voluntary services), Cambridge (problems of access), Hull (health checks for over-80s), S Bedfordshire (satisfaction with geriatric and psycho-geriatric services).
Long-stay hospital services Sefton N, E Cumbria (patient satisfaction), King's (patient satisfaction), Waltham Forest (inappropriate placements), E Birmingham (comparing patient and staff views), Kettering (communication problems), Wycombe (how relatives visit), Cambridge (elderly mentally ill), N Lincolnshire (blockage of acute beds by elderly), Beverley (day-hospital).
Discharge arrangements N Camden, City and Hackney, E Birmingham, Salop, Frenchay, Kensington-Chelsea-Westminster S.

F

Family planning

Havering, Central Manchester, Bury, Newcastle (clinic attenders), Salop (proposed clinic closure).

Fluoridation

Wolverhampton, Swansea/Lliw Valley, Central Derbyshire, E Leicestershire.

G

General practice

(see also Health centres and clinics)
General Islington, Worthing, W Birmingham, Harrow, W Essex and District, Durham (reaction to withdrawal of GP dispensing), City and Hackney (patient expectations, GPs' views), E Herts (effect of cuts), Kensington-Chelsea-Westminster S (patient satisfaction), Leeds W (patients' views).
Surgeries Newham, Durham (reaction to closure), Norwich (effect of closure), E Herts (need for new one), Chester (need for new one).
Appointment systems Islington.

H

Health centres

Carmarthen-Dinefwr, S Nottingham, Portsmouth and SE Hants, Rochdale (views on new one), Salford (comparison of attitudes of health centre/surgery patients),

Isles of Scilly (waiting times) Doncaster (public's views), Salop (closure of child health centre).

Health clinics

(see also Children's health services, Family planning, Maternity care, Women)
N Tyneside, Macclesfield, Guy's, King's, Walsall (cytology), Cental Manchester (VD).

Health education

Harrow (in schools), Kettering (in schools), S Camden (CHC knowledge about smoking).

Health services

(see also National Health Service)
Consumer satisfaction E Somerset, Walsall, Northampton, W Birmingham, Liverpool Central and Southern (patients'problems).
Consumers' views on priorities and needs Wirral N, Plymouth, Sheffield N, Doncaster, Sheffield S.
Surveys of local services, Kettering, Wakefield W, Newcastle, SW Herts (accessibility of services) Sheffield N (public knowledge of services).

Health visiting

City and Hackney (health visitors' views)

Health at work

NW Durham ("a study of the NHS as experienced by shop floor and management in industry on South Tyneside").

Hospital services — general

(see also Accident and emergency services, Children in hospital, Services for the disabled, Maternity care)
Inpatient satisfaction Croydon, Central Manchester, Wirral N, Weston, N Herts, S Lincolnshire, W Essex and District, N Tees, SW Cumbria, Wycombe, Harrow (and staff and visitors' views), Worthing (morale in a unit), Hastings (life in hospital).
Acute services S Bedfordshire.
"Hotel" services Wakefield W.
Mixed sex wards (see under M).
New hospitals Wirral N, Anglesey, Barnet and Finchley (redevelopment).
Hospital booklets Central Derbyshire, Southend.
Smoking in hospitals W Essex and District.

Hospital closures

Durham, Hull, Mid Surrey.

Hospital discharge arrangments

(see also The elderly)
Chichester, NW Surrey, N Bedfordshire, Beverley, Rochampton.

Hospital food

Hull, Beverley, S Nottingham, Portsmouth and SE Hants.

Hospital out-patient services

General Newcastle, Waltham Forest, Worcester, Cornwall, E Dorset, W Surrey and NE Hants, S Bedfordshire, Sefton N, Portsmouth and SE Hants.
Patient satisfaction Durham, Enfield, Salford, Leeds W, Dewsbury, Sandwell (and problems with transport to hospital).
Waiting times Dudley, Salford, Ogwr.

Hospital visiting

(see also Children in hospital, Transport)
Sandwell, Gloucester, Swindon, Wakefield E, Kensington-Chelsea-Westminster S, N Warwickshire, Wycombe.

Housing and health

Health care needs on estates Stockport, W Berkshire, Islington, Gateshead (health risks of high rise housing).
Health services for the single homeless City and Hackney, Liverpool Central and Southern, S Camden.
Housing transfers on medical grounds S Camden.

M

Maternity care

General Waltham Forest, Lancaster, Weston, Frenchay, Wycombe, W Surrey and NE Hants, Harrow, Huddersfield, SW Herts, Harrogate, S Lincolnshire (attitudes to closure of unit), Edgware and Hendon (post-natal survey), Stockport.
Consumers' views in general Newcastle, S Camden, Islington, Dudley, Winchester and Central Hants, NW Surrey, Bexley, Kensington-Chelsea-Westminster S, Cambridge, N Herts, Barnsley.
Consumers' views of hospital care E Cumbria, NW Durham, Cornwall, Tunbridge Wells, Leeds W.
Ante-natal care and clinics Dudley, Macclesfield, Central Manchester, Cornwall, Stockport, Wycombe, S Nottingham, S Tees (reasons for failure to attend for care).
Ante-natal care — consumers' views Rugby, E Cumbria, Wandsworth and E Merton, SW Herts (awareness of benefits of care), Canterbury and Thanet (views on proposed transfer of clinics).
Perinatal mortality York (take-up of ante-natal care and perinatal mortality), Oxford (comparison of perinatal mortality rates in two hospitals), N Tyneside.
Home confinements Preston, Bradford.
Midwives City and Hackney, S Camden, N Tyneside.
Induction Kings Lynn.

Mentally handicapped people

Services Newcastle, N Tyneside, W Birmingham, Wycombe, Northumberland, Oxfordshire, W Somerset (children), Cambridge (hospital care), Rotherham (register of all over 16).
Problems and needs of their families E Surrey, S Nottingham, Huddersfield, Greenwich, E Herts, NW Durham, Edgware and Hendon (planned for 1981), Bexley (views of parents on short-term care).

Mental health

Services Waltham Forest, Sheffield S, Peterborough.
Good practices Newcastle, Haringey, Worcester, W Somerset, Sheffield N, Sheffield S, Oxfordshire.

Mixed sex wards

Aylesbury and Milton Keynes, Winchester and Central Hants, E Leicestershire.

N

National Health Service

(see also Health services)
Northampton (efficiency of NHS), Central Derbyshire (NHS reorganisation), Beverley (survey re regional re-structuring proposals).

Nurses

Lancaster (survey of nurse staffing).

O

Ophthalmic services

W Birmingham, Frenchay, Bury.

P

Primary care

(see also General practice, Health centres and clinics)
Gloucester (access), Bolton (attitudes), N Tees (patients' responses), Greenwich (in relation to local special populations).

R

Rural areas — health services

(see also Transport)
Aylesbury and Milton Keynes, E Dorset, Winchester and Central Hants (three surveys), Kings Lynn (lack of GP surgeries), Northumberland (access), S Warwickshire (access to A and E services).

S

School health services

(see also Children's health services)
Kettering, Wycombe.

Stroke patients

N Hammersmith and Acton (discharge and after-care).

T

Terminal care

Tunbridge Wells.

Transport

(see also Ambulance services, Hospital visiting)
General W Birmingham, Frenchay. Kings Lynn (in rural areas), Liverpool Central and Southern (patients' travelling expenses).
To hospitals Sandwell, Waltham Forest, Hounslow, SE Cumbria, Darlington (isolated mental hospital), N Devon (in rural area), Tunbridge Wells (problems following proposals to close a maternity home), Northallerton (hospital car service users), Walsall (access when public transport cuts proposed), Wolverhampton (hospital bus service), Oxfordshire (outpatients).
To health centres Exeter and District, Harrow.

V

Venereal disease clinics

Central Manchester.

Volunteers

NW Durham (feasibility study of use of volunteers in the NHS).

W

Women

Well-women's clinics Mid Essex, Walsall, Havering, Central Manchester, Central Nottinghamshire, Cardiff and Vale of Glamorgan.
Women's preferences to be treated by women S Camden.

The right to die with dignity

by Vic Skelly, former member, East Herts CHC

Recent press reports about the proposed booklet advising people on suicide methods, and months of correspondence last year in *CHC NEWS* prompt me to put my own case in defence of the concept of voluntary euthanasia. I believe that the officers of *EXIT*, the Society for the Right to Die with Dignity, are being persecuted for their wish to get this booklet published. I also believe that CHCs have to debate publicly this question of euthanasia and take up the challenge of the concept of more humane treatment for those of us who wish to leave this life for what are, to us, good reasons.

It is true that CHCs alone cannot change the situation. They cannot make legal what at present is illegal — aiding a suicide. What they can do, as representatives of public opinion with a particular repsonsibility towards the health service, is to see that the issue is brought before the public at all levels so that informed discussion can take place. The fact that, if voluntary euthanasia were accepted, the NHS would benefit to a greater or lesser degree is neither here nor there. No-one is asking for people to be "put down" to save money. But some of us would not want to see scarce resources committed to keeping us alive when we want to die.

The word euthanasia has become corrupted to mean "mercy death". This implies that someone other than the patient makes the decision to end his or her life. The inclusion of the world "voluntary" restores the concept of a person being able to decide, whilst well and possibly whilst still young, that he or she does not wish life to continue beyond a certain predetermined point. This may be incurable disease with short life expectancy, reduction to a "vegetable" existence, extreme pain or mental anguish.

Of course this raises moral considerations and comes very close to the heart of everyone's personal philosophy. Why are we here? Your answer to that question may well determine your attitude to voluntary euthanasia. If you believe that your life was given to you by God and is in his hands, then you will possibly regard euthanasia — and suicide too — as an impertinent interference with the prerogative of your creator. But do you also agree with war? When speaking against the horrors of armed conflict we all seem to agree that reducing "man's inhumanity to man" is a worthy ideal. It is just as valid at the level of individual suffering, when all the evidence available says that it is unnecessary to prolong suffering and that the person should be allowed to die with dignity.

The legal considerations are of equal importance to the moral ones. It is a lot to ask of doctors and nurses that they should take positive action, or even cease positive action, so that a patient in suffering may die. To do so at present renders a person liable to prosecution. Suicide is no longer illegal — we do no longer bury suicides in unconsecrated ground, nor do we imprison those who attempt suicide and fail. In Scotland it is not illegal to *advise* someone how to commit suicide. But throughout the UK it is illegal to physically *assist* someone to die — this is manslaughter. This is understandable. Society is right to try to ensure that no-one is "assisted" to an unwanted death for financial or other reasons. Even the mentally anguished or the terminally ill have their rights.

And here is the nub. They should also have the right to be helped to put an end to their own suffering. Somehow a legal formula must be found that will protect people from being shuffled off by grasping or uncaring relatives whilst allowing individuals to take responsibility for their own time of dying if they so wish.

All that *EXIT* is asking is that help should be available for a person who has indicated, at an earlier stage, his or her wish not to be kept alive in certain circumstances, or to be given drugs in sufficient quantities and strength to kill pain even if this means shortening of life. Those of us who support *EXIT* do not want anyone to be pressured into making such a decision when their judgement is clouded. It is for each person to decide whilst fit and well.

If the law is to be changed it will only be as a result of changes in public opinion. More and more people are coming to share *EXIT*'s views but may feel reluctant to say so publicly. As a recently retired member of East Herts CHC I appeal to all CHC members to consider their responsibilities. If a society can be judged by the way it treats its weakest members, can it possibly claim the title "civilised" when it brushes under the carpet the treatment of the unwilling victims of modern medicine?

Publication of the EXIT booklet on "self-deliverance" was delayed by a constitutional wrangle last winter within the Society. Now members have voted to change the Society's rules and EXIT will seek the lifting of a High Court injunction which was served on its committee to prevent publication.
EXIT, 13 Prince of Wales Terrace, London W8. Tel: 01 937 7770.

STANDARDS IN SURGERIES

by Alan Hicks, Secretary, Barnsley CHC

Our interest in the standards of general practitioners' premises came about when we began examining the report of the Royal Commission on the NHS, in October 1979. This states quite clearly in paragraph 7.35 that "Family Practitioner Committees and health authorities have power to ensure that the provisions of GPs' contracts are complied with, and to inspect their premises. During our own visits to primary care services in different parts of the United Kingdom we saw some premises which were clearly unacceptable. We recommend that FPCs and health authorities should use their powers vigorously to ensure that patients are seen by their GPs in surgeries of an acceptable standard".

What was not so clear to us was what exactly these powers were which FPCs were supposed to use vigorously. So what better than to ask our local FPC administrator — which yielded the following most interesting results.

FPCs are involved in the question of surgery standards from three aspects:

1. In general the terms of service for a doctor require him to provide "proper and sufficient accommodation having regard to the circumstances of his practice" (Statutory Instrument 1974 No 160, schedule 1, paragraph 24). Unfortunately, however, there is no definition of the term "proper and sufficient", which means that every case has to be assessed on its individual merits. This obviously lays the system open to abuse, since each FPC could apply different standards, resulting in a "patchwork quilt" effect with some FPCs setting higher standards than others. Equally, there could be cases within the same FPC when differing standards could be applied, depending on which members happened to be sitting on the committee at the time—and if the premises under consideration happened to be those of one of the professional members of the FPC the suspicion of bias would always be lurking in the background. What is so obviously required is a precise definition of the term "proper and sufficient", so that FPCs have clear-cut criteria on which to assess cases.

2. The FPC approves eligibility for reimbursement of rent and rates to doctors for their surgery premises, under the rent and rates scheme in the Statement of Fees and Allowances (Paragraphs 51.2 to 51.11). To qualify for this reimbursement, the premises have to meet the criteria set out in the scheme. This means that the FPC is able to oblige a doctor to meet the standards of accommodation, even if only in a negative way, by refusing to reimburse him for the rent and rates of his premises. Whilst this sounds quite a useful power for the FPC to

WE PARTICIPATE.... but they decide

by Billy Powell and Ruth Stern, Members, Brent CHC

One of the many roles of CHC members is representing the community on bodies such as planning teams and working parties — with all the problems and contradictions that this involves. Brent CHC was recently allowed one member on a District Management Team (DMT) working party which has been established after a long and active campaign for a community hospital.

The campaign had met with such massive public support that the authorities felt the need to bury the issue — if possible with the CHC's complicity. Hence the working party.

Our alternative proposals to the DMT prior to the meetings of the new working party were rejected on the grounds that "many of the points that you (the CHC) have raised ... are covered by having a member of the CHC on the working party" (district administrator). In fact the working party only dealt with the feasibility of GP beds and ignored the other aspects of our proposal for a community hospital.

Despite our great misgivings about the terms of reference, composition and privacy of the working party, we felt it important to participate and then, if necessary, dissociate ourselves from it afterwards.

As it was difficult for our delegate to attend all the meetings, two of us attended them on separate occasions. We were warmly welcomed with cups of tea and made to feel that our role as the community representative was quite central. Throughout the discussions we were asked if the CHC would agree to differing proposals and we felt we were being uncooperative when we refused to presume to answer for the whole CHC, let alone for the community. We felt inadequate and

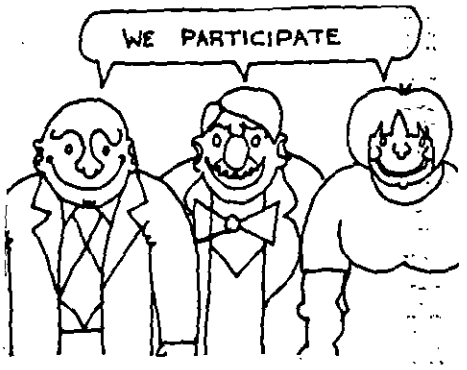
unreasonable, unable to counter the arguments of the professionals, especially as a minority of one on a committee of ten.

It seemed as though we were being manoeuvred into agreeing that GP beds were not practicable, although we knew that this was because of their terms of reference not ours. A particular anxiety was that in the end, when we did criticise the findings of the working party, it would be said that we had been there and had not adequately opposed them at the time.

All these frustrations were compounded by the ploy of confidentiality. This is used to protect the public from alarmist reporting but in fact it serves to conceal the facts upon which decisions are based, allowing the public little or no understanding of how conclusions are reached, and no possibility of challenging or changing them. We asked to have the working party meetings open to the public, recognising that the use of confidentiality is in complete opposition to our role as representative of the community, but this was refused.

The working party report was finally published and we dissociated ourselves from it. We issued an alternative report — so named because despite being a minority on the committee we knew we represented majority opinion.

The presence of a community representative can enable unpalatable decisions to slip through with less opposition from the public. We are aware that it may be in the interests of the authorities and not in ours to have a community representative, but our feeling is



that it is still worthwhile. It may be that at times the CHC representative can influence decisions or at least acquire useful information. If not, it may be that our resposibility to the community will lead us to expose undemocratic decisions, using the press or any other means at our disposal.

We feel it would be unrealistic to try and alter the structures set up by the authorities, as they make the rules. Instead, perhaps we can try to make some rules of our own. In Brent we have tried to structure our own meetings on our terms and our territory, with a reversed health authority/CHC ratio. For example, we have had the AHA chairman to meet us at the CHC (one AHA member to over 20 members of the community). We are inviting the DMT to meet the full CHC instead of the usual practice of sending a few members to joint meetings.

Hopefully in this way we will be able to avoid the feelings of being unsupported, and of being co-opted onto bodies on which we feel powerless. Many members of CHCs must have been involved in similar situations, and it would be interesting to hear their experiences

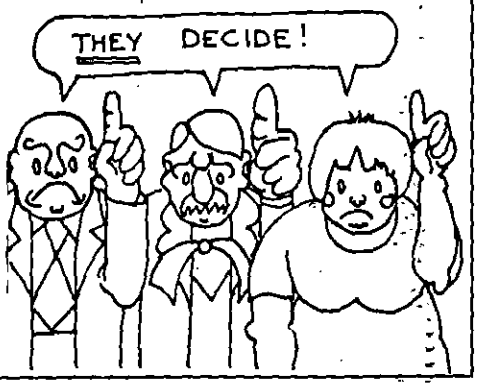


Illustration: Kensington-Chelsea-Westminster South CHC

have, it is severely limited by the fact that the standards in the rent and rates scheme can only be applied to new surgery premises being brought into operation, or to existing premises which are being extended or improved. All premises which were in use when the scheme started had perforce to be accepted by the Executive Council (as FPCs were then called) for payments under the scheme. What this means in practice is that many of the older surgery premises which might fail to match up to the standards set in the rent and rates scheme nevertheless qualify for rent and rates reimbursement, and the FPC is able to do nothing about it.

3. Where a doctor proposes to extend or improve his surgery premises he may be paid a third of the cost of eligible items of improvement by the FPC, but in this case the premises, after improvement, must conform to the standards laid down in schedule 1 to paragraph 56 of the Statement of Fees and Allowances. But once again things are not always what they seem, because the standards referred to relate primarily to adequacy of space and facilities and do not specify quality of maintenance and repair, which in the majority of older premises is precisely where the problems lie.

All in all, therefore, it was perhaps an understatement by our FPC administrator when, referring to the situation described above, he stated that "this limits the powers of FPCs in implementing recommendation 7.35 of the Royal Commission". This CHC feels that the time has come for the DHSS to take a lead in this matter, by giving detailed guidance to FPCs and laying down reasonable minimum standards of fitness for GP surgery premises, which would enable recommendation 7.35 to be implemented.

Parliament

Spending personally

In 1981-82 spending per person (*per capita*) in revenue and capital allocations will be as follows:

RHA	Rev. per capita £	Capital per capita £
Northern	139.20	11.50
Yorkshire	141.00	11.60
Trent	139.80	11.00
East Anglia	137.70	13.90
N W Thames	174.30	8.70
N E Thames	165.40	10.00
S E Thames	163.40	8.90
S W Thames	154.30	9.20
Wessex	139.50	13.10
Oxford	144.50	9.90
S Western	139.40	10.00
W Midlands	140.00	9.80
Mersey	147.10	11.00
N Western	138.70	14.60
England	147.70	10.90

The allocations are based on population figures (mid-1979 estimates for revenue, mid-1986 projections for capital) used in calculating regional target allocations. These allocations are weighted to reflect relative health care need. The revenue figures include Service Increment for Teaching (Joe Dean, Leeds West, 26 February).

Child-resistant containers

The Government and the pharmaceutical profession have reached agreement about dispensing all solid-dose medicines (tablets, capsules, etc) in packs which small children find hard to open. From 2 March retail pharmacists will get a higher container allowance for each prescription (up from 3.5p to 3.8p). They will dispense medicines in child-resistant packs, unless the patient requests a conventional container or would have difficulty opening the safety pack. (Mrs Renee Short, Wolverhampton North East, 5 March).

Patients who should not be in special hospitals

There are 133 patients in Rampton special hospital who are considered no longer to need conditions of special security. Some have been waiting for years to be transferred to other hospitals. The numbers of patients waiting in the other three special hospitals are as follows: Moss Side 45; Park Lane 7; Broadmoor 28 (Robert Kilroy-Silk, Ormskirk, 3 February).

British National Formulary

The information and advice about medicines, contained in the British National Formulary "should not be regarded as a 'consumer's guide'". The book is for the professional user and the DHSS has distributed it free to doctors, pharmacists and others in the NHS (Jack Ashley, Stoke-on-Trent South, 11 March).

The cost of smoking

It has been estimated that the annual cost to the NHS of in-patient care, outpatient and GP consultations resulting from the main smoking-related diseases is £115 million — at November 1979 prices (Dale Campbell-Savours, Workington, 3 March).

London's GPs

On 1 October 1980 there were 58 general medical practices in Inner London with less than 1,000 patients. The practices included 24 doctors over 70 years old (Lord Wells-Pestell, 9 February).

Diabetes

It is estimated by the British Diabetic Association that there are 20,000 people in Great Britain who are dependent on insulin (Peter Hordern, Horsham and Crawley, 25 February).

Joint finance

As the years go by a bigger slice of the joint finance allocations gets spent by area health authorities, and less is left to be carried over from one financial year to the next. At the end of the first year of joint funding (1977-78) 25% of the allocation (£7.3m) had been left unspent. At the end of 1980-81, it is estimated that health authorities will have to carry forward £9.4m, which represents 5.7% of the total cumulative joint finance allocation so far (Frank Field, Birkenhead, 23 February).

The cost of running the health service

From 1975-76 to 1980-81, gross annual revenue spending on the NHS in England has risen in real terms from £6932 million to £7576 million (at November 1979 prices). The yearly percentage increases over the previous year were:

1976-77 1.4%
1977-78 2.7%
1978-79 2.2%
1979-80 0.3%
1980-81* 2.3%
*provisional

(Ivan Lawrence, Burton, 18 February).

Drug addicts

In England there are 97 beds in special units for drug addicts and 145 more set aside for treating alcohol or drug dependency. There are no DHSS plans to increase this number (Mrs Renee Short, Wolverhampton North East, 3 February).

THE MASTECTOMY ASSOCIATION

by Betty Westgate, Chairman Mastectomy Association

Many thousands of women suffering from breast cancer have had a breast removed, and; for as far ahead as we can see, thousands more will have to undergo this operation — mastectomy. Without doubt, it is an operation which causes considerable anxiety and emotional distress.

The Mastectomy Association — a nationwide organisation — was set up in December 1973, largely in response to needs expressed by women who had had a mastectomy. The Association offers non-medical help and practical advice and support to women who have recently had, or been advised to have, a breast removed.

The association uses volunteer helpers. Each of these has had a mastectomy herself, and has come to terms with it and now wants to help other women who are faced with the same situation. A little help at such a time goes a long way towards overcoming fear of the unknown. It can be very healing to talk freely to someone who has been through the same experience and resumed her normal everyday life. An increasing number of hospitals invite their ex-patients back to talk to mastectomee patients while they are still in-patients. Volunteers offer supportive understanding rather than a "shoulder to cry on".

The association offers practical advice which is designed to complement medical and nursing care. It provides information about types of breast prostheses, styles of bras which hold a prosthesis, swimwear, and other useful aids. It also produces a number of booklets including *Living with the loss of a breast* and *A non-medical handbook for health professionals involved in caring for mastectomy patients.*

No one knows what causes breast cancers so prevention is not possible; but women can best help themselves by examining their breasts every month. This should be part of their regular routine health care — just like care of the skin, hair and teeth. If unusual signs in the breasts are identified at an early stage any necessary treatment can be offered while it may still be successful.

If a mastectomy does have to be performed it is important that the woman does not devalue herself in her own eyes. Fears about loss of femininity and complete womanhood are sometimes expressed. Husbands and families can help but about half of the women who have breast cancer are unmarried or living alone. And when it comes to "brass tacks", we all have to come to terms with the situation for ourselves, in our own way.

Mastectomy has been likened to a bereavement — there's a time to mourn for the breast, and then a time to accept the challenge of living to the full again. Many women have told me that at the time of their mastectomy they felt life — as they had enjoyed it — was over. But that later, they felt their lives had been enriched — no more procrastination, they were getting on and doing all the things there had "been no time for" previously.

When women are adequately prepared for their mastectomy, and the post-operative medical and non-medical care are equal in standard, they are eventually able to come to terms with the situation and resume their normal way of life far more easily.

For further information and leaflets write (enclosing a SAE) to The Mastectomy Association, 25 Brighton Road, South Croydon, Surrey CR2 6EA. Tel: 01-654 8643.

Scanner

NHS statistics cuts

Information about the NHS and the personal social services will be considerably reduced if the Government adopts a report on the statistical work of the DHSS*, from Mrs Thatcher's special adviser on waste Sir Derek Rayner.

The Mental Health Enquiry into mental illness and mental handicap hospitals should be scrapped, says the report, partly because "little active Departmental monitoring" of these hospitals has taken place for some time "and it seems unlikely that a strongly interventionist approach will be revived". Form SH3 — the main statistical return summarising the work of individual NHS hospitals — would also be abandoned.

The annual census of NHS non-medical staff would be abolished, and employment returns in the personal social services would also cease. Statistics on hospital pathology tests, community health facilities, antenatal classes, psychosurgery operations, the home help service and aids for the disabled would no longer be collected. The report claims that an annual saving of £1.5m at 1980 prices could be achieved if all its 99 recommendations are accepted.

Comments have been invited, and should go to C P Kendall, DHSS Statistics and Research Division, Room D212, Alexander Fleming House, Elephant and Castle, London, SE1 6BY.

* *Review of Government statistical services: Report of the DHSS Study Team*, £6 inc post from DHSS Information Division, Canons Park, Government Buildings, Honeypot Lane, Stanmore HA7 1AR.

Resisting rickets

The DHSS has launched a national campaign to combat the vitamin deficiency diseases rickets and osteomalacia in the Asian communities. For details of activities and health education materials available, contact the campaign's director Miss Veena Bahl, c/o Save the Children, 157 Clapham Road, London, SW9, Tel: 01-582 1414.

Recent reports on this subject include *Rickets and osteomalacia*, a report from the DHSS Committee on Medical Aspects of Food Policy (HMSO £3.90) and *Rickets in Britain*, a discussion document from the Manchester Community Health Group for Ethnic Minorities, available from Nick Harris at Central Manchester CHC.

Crossroads revisited

"Crossroads" schemes, which aim to ease the strain on the families of disabled people by providing support in the home, have been springing up around the country — sometimes with the help of CHCs — since the idea began in 1977. A detailed study of 14 such schemes has now been published, showing who they help and how. *Crossroads care attendant schemes* is £4.20 inc post from the Association of Crossroads Care Attendant Schemes Ltd, 11 Whitehall Road, Rugby, Warwickshire, CV21 3QX.

Selling IYDP

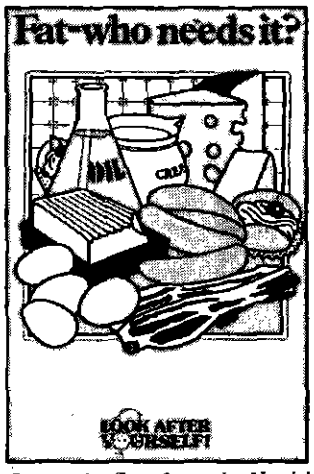
CHCs wishing to publicise International Year of Disabled People and also raise funds for specific IYDP projects might consider using a "promotional pack" being marketed by a commercial firm. Each pack contains an assortment of IYDP-branded items, including T-shirts, car stickers, badges and balloons, costs £311 and when completely sold produces a suggested net profit of £224. Contact T-Shirt Products, IYDP Dept, Unit 3, Worton Hall, Worton Road, Isleworth, Middx.

Deafness and work

Deaf people who believe that working in noisy jobs for several years has caused their disability can claim disablement benefit, DHSS leaflet N1207, *Occupational deafness*, explains.

Charges in homes

Age Concern has produced a useful fact sheet explaining how charges and fees are calculated for elderly people in homes and nursing homes. It includes advice on the vexed question of whether local authorities can force long-stay residents to sell their homes. Send SAE to Age Concern, 60 Pitcairn Road, Mitcham, Surrey.



Recent leaflets from the Health Education Council include Fat — Who needs it? *(above)*, Fibre in your food *and* Pregnant at work. *HEC, 78 New Oxford Street, London, WC1A 1AH.*

Charges up: HN(FP)(81)6

NHS dental and optical charges were increased last month. The maximum charge for most courses of dental treatment went up from £8 to £9, and the cheapest NHS denture now costs £19 (previously £17). Crowns now cost £20 per tooth (previously £18), and the overall maximum charge for any combination of treatments is now £60 (£54). Despite increases in the price of some lenses, a complete pair of NHS spectacles should still cost patients under £10. All full-time students under age 19 are now exempt from dental and optical charges.

Private patients: HC(81)4

Charges for private patients using NHS hospitals have been increased by 15½%. A single private room in an acute non-teaching hospital now costs £86.70 a day, and a private outpatient consultation now costs £4.10 (£5.90 in London). For Wales, see WHC(81)4.

Drugs guide: HN (FP)(81)3

Announces publication of the new British National Formulary, which now includes detailed notes on prescribing, compares the costs of alternative drugs and indicates which drugs are "not recommended". This replaces the 1976/78 edition, and from now on the BNF will be published twice a year. Every NHS doctor and pharmacist will receive a free copy, but the BNF is also available through booksellers, price £3.80 (published by the BMA and The Pharmaceutical Press).

Reports in brief

Alcohol: Reducing the harm, 60p inc post from the Office of Health Economics, 12 Whitehall, London SW1A 2DY.

Mental Illness, Mental handicap and *Why the confusion?* MIND Factsheets 1, 2 and 3, 15p each from MIND Bookshop, 155 Woodhouse Lane, Leeds LS2 3EF.

Health visiting in the 80s, 40p inc post from the Health Visitors' Association, 36 Eccleston Square, London, SW1.

Gardens and grounds for disabled and elderly people, a seminar report, 80p inc post from the Centre on Environment for the Handicapped, 126 Albert Street, London, NW1.

What's good about the NHS? 60p inc post from the NHS Consultants' Association, 51 Gerard Road, London, SW13 9QH.

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: South Nottingham CHC Chairman: Mrs Pat Howarth
Page 7: Mid-Essex CHC Chairman: E C Jameson
Page 9: Bromley CHC Chairman: Mrs Ann Foord
Page 12: Salop CHC Chairman: Dillwyn T David
Page 15: Stockport CHC Secretary: Keith Bradley
Page 17: North Gwent CHC Secretary Brian W Bates
Page 20: Stirling and Clackmannan LHC 62 Upper Craigs, Stirling. Tel: 0786 71550
Page 21: Caithness LHC 79 Upper Burnside Drive, Thurso KW14 7XB. Tel: unchanged

News from CHCs

☐ Several CHCs are concerned about their local health authorities making plans for health services in the aftermath of nuclear war. A circular about this (HDC(77)1) has been out since 1977, but recently the Home Office gave the DHSS £400,000 to distribute to RHAs so that they can appoint "war planning officers".

City and Hackney CHC says that "it would be more appropriate to use resources for the development of good health services now than prepare for the aftermath of a holocaust". NE Thames RHA has asked health districts to draw up contingency plans for nuclear war and the CHC is angry that there has been no discussion of this in public at AHA meetings. It has passed a resolution opposing such plans.

South Hammersmith CHC has been told that NW Thames RHA is advertising for a war planning officer. Members are worried about staff time and resources being diverted to war planning and they are considering sending a motion on this to the **Association of CHCs'** AGM.

Coventry CHC has passed a resolution calling on its AHA and RHA to ignore the circular about war preparations. It is also calling on other CHCs in the West Midlands to disclaim the circular and has sent them all a copy of its resolution.

☐ Two CHCs are currently campaigning for well woman clinics. In **Central Nottinghamshire** a women's health group was formed after a CHC meeting in 1979. This group now runs a counselling service for women from the CHC office and has its own member on the CHC. After making a thorough investigation of well woman clinics and carrying out a survey of the health needs of women in "deprived" areas of Mansfield, the group has drawn up proposals for a one-year pilot project for a well woman clinic in Mansfield. The project would be carefully evaluated to assess the need for a more extended project. So far the women's health group proposals (which are supported by the CHC) have received "a guarded response" from the district management team.

Swansea/Lliw Valley CHC first raised the possibility of a well woman clinic at last year's annual meeting with the AHA. It met with little enthusiasm from the AHA but the CHC went away and investigated existing services and came back with a detailed set of proposals — once again for a pilot project. This time the AHA was more encouraging and the CHC has had a meeting with the area medical and nursing officers who were "quite supportive". The CHC has found enormous public interest in the idea of well woman clinics. They have received several petitions — one with 2000 signatures — and numerous letters of support.

☐ **North Tyneside CHC** is providing £600 for a study into unemployment. The researcher, Malcolm Colledge, who is already involved in a long-term project on unemployment in Consett, will review the evidence about links between unemployment and health and will look at the implications for NHS planning.

☐ People needing dental care in and around Reigate can now find out from **East Surrey CP** which dentists will give treatment under the NHS. Some will do only limited work — eg they will fit crowns but not dentures. The CHC survey was carried out by phoning all the dental surgeries.

Photo: Oxford Mail and Times

☐ *Instead of holding public meetings* **Oxford CHC** *took this display caravan round seven local towns to publicise the AHA's consultative paper about care of the mentally handicapped, and find out what the public thought of the proposals. The CHC borrowed the caravan from the local health education unit and went out on five Saturdays, accompanied by AHA officers. The CHC publicised the venues in the local papers and on the radio and got a "very good response" from the public. The consultative paper was mainly of interest to those with mentally handicapped relatives but people also came to ask about local health services — and to find out about the CHC.*

☐ **The Northern Region Association of CHCs** recently held a conference titled "Unemployment kills?" on the effects of unemployment on health. Speakers included junior health minister Sir George Young, who said that provisional findings of DHSS research suggest "that periods of unemployment of less than a year do not damage health" and that only a minority of the unemployed suffer from depression. Other speakers called for "more benign attitudes" to the unemployed and measures to protect the most vulnerable — especially children.

☐ **East Berkshire CHC** has had "a quite overwhelming response" from other CHCs supporting its resolution on problem drinking, which it circulated to all CHCs before submitting it to the **Association of CHCs.** About 130 CHCs discussed the resolution said East Berkshire's secretary Juliet Mattinson. It was passed by 113, a few proposed more far-reaching amendments and "a handful" were against it. It calls for GPs and the general pu[illegible] to be better educated about problem drinking, and for a review of the level of finance for voluntary organisations involved with alcoholism. It also urges that services for problem drinkers be considered in joint planning programmes.

ACHCEW's standing committee has passed the resolution, and it has been sent to the DHSS together with East Berkshire CHC's suggestion that seminars about problem drinking be held at national, regional and local levels.

☐ To find out the availability of free chiropody a **Croydon CHC** member rang all the local chiropodists on behalf of a fictional elderly friend receiving a supplementary pension. She rang nine before she could find one who would offer an appointment. Several chiropodists said that they had used up their NHS allocation and could not consider new cases until the next financial year — April — four months later. The CHC circulated the results of the telephone survey to local chiropodists and ten responded. Some were dismayed with the CHC's method of getting its information, and several stressed the lack of NHS funds for chiropody. Suggestions for a meeting between the CHC and the local society of chiropodists are being followed up by the CHC.

☐ The secretary of **Bromsgrove and Redditch CHC,** Brian Thomas, is appealing against West Midlands RHA's decision to sack him from his job. The region has dismissed him because of the "breakdown in the working relationship between the CHC and its secretary". The CHC had voted 20-1 that Mr Thomas was not acceptable to them as secretary. This followed considerable press coverage of Mr Thomas's disclosures about alleged mistakes at the Bromsgrove General Hospital. The RHA says that the CHC felt that this was the culmination of many occasions when Mr Thomas had spoken out on the CHC's behalf before consulting the CHC itself. Mr Thomas says that his allegations "have been borne out by reports of the region about the hospital" and believes that "CHC members seem to be opting for a quiet life". His appeal will be heard before an RHA sub-committee at the beginning of this month.