CHC NEWS

For Community Health Councils

June 1981 No 67

HERE'S THE PICTURE!

by Gordon Tollefson, Secretary, Wakefield Eastern CHC

How best to tell people about community health councils? CHC secretaries in the Yorkshire region have decided that pictures speak louder than words, and have commissioned a twenty-minute 16mm colour film as a showcase for the work of their CHCs.

The film has been made at York University's audio-visual centre, where the centre director Harry Creaser is also chairman of York CHC and the regional association of CHCs. Yorkshire RHA put up £2500 towards production costs and the Yorkshire CHCs each contributed a further £100, bringing the total budget to £4200.

To get the message across to the ordinary viewer we recruited actor Bill Roache, who plays Ken Barlow in the TV series *Coronation Street*. In his role as the educated community worker who *Coronation Street* residents often turn to for advice and guidance he seemed the ideal presenter.

The film aims to awaken public interest in the NHS, a service which anyone may need to use and to which everyone contributes, to show people what CHCs are doing on their behalf and to encourage them to use their own CHC. Subjects touched on include the need to provide hearing aid batteries through local centres, misuse of the ambulance service, rural transport, accident and emergency departments and health education for children.

For more information contact Gordon Tollefson, Chairman, Yorkshire Regional Association of CHC Secretaries, c/o Wakefield Eastern CHC, Baghill House, Walkergate, Pontefract WF8 1QW.

We won't be muzzled, CHCs tell Jenkin

The Government can be in no doubt that CHCs want to be able to continue to comment on national issues in the health service and that they will resist any attempt to curb their work of helping patients with complaints. This is what emerges from an analysis of more than 100 English CHCs' replies to the DHSS' consultative paper on the role and membership of CHCs.

Ministers want CHCs to stick to local matters, and of the CHCs which sent copies of their views to the Association of CHCs, most agree that they have no role in the formation of national policies. But they also state firmly that as long as national decisions affect health services to local people, CHCs will consider themselves duty bound to speak up and seek to influence decision-making.

There are also strong reactions to the DHSS hint that handling patients' complaints is a diversion from CHCs' real job and so should be cut back. With almost one voice CHCs defend their track records in this field and their ability to provide a better service to patients with grievances than other helping agencies.

The councils stress that they should be consulted in good time about closures and changes of use in all health buildings (not just hospitals). Many would like to be consulted by regional health authorities (RHAs) on matters of regional significance and to be able to send an observer to RHA meetings. And the majority would like family practitioner committees to be compelled to admit CHC observers to their deliberations. Most CHCs endorse the hint that they might be allowed to visit private hospitals where patients are treated in NHS "contractual beds".

CHCs do not agree with Ministers' "firm view" that councils would be more effective if membership was cut to about 18 people. Many point out that members constitute the bulk of a CHC's workforce, "unlike a district health authority". But there is a split of roughly 3:2 in support of the plan to

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INSIDE ...

Your letters

CHC distribution of membership

BH Kingston, Member, South East Kent CHC

In your *Comment (CHC NEWS 64,* page 3) you ask what use is made of each type of member and this prompts further examination.

The "voluntary" member may be appointed by any one of hundreds of voluntary and charitable organisations in the district. Many are local branches of national bodies while others are of a purely local nature. Appointed representatives are naturally more likely to express the views and look after the specific interests of their own particular organisation, although they may have a personal interest in other aspects of health. Consequently, if the contribution of voluntary members is to cover *all* specialist interests in the community, then each CHC would need a membership of several hundred. Such is clearly unmanageable. Selective representation is therefore made, sometimes on a "first come first served" basis.

On the other hand, CHC members nominated by local authorities (whose work is also voluntary!) represent the interests of all the electorate in their locality. This is one of the reasons why greater numerical representation on the CHC is necessary. Also, from their knowledge of current local authority activities and procedures, they are able to make an effective contribution to CHC business. Furthermore, in the event of one or more council members being absent due to illness or other public service, at least someone will be available to represent the inhabitants of the district or county. It is the representation rather than the individual which is important. The claim made in the DHSS consultative paper on CHCs that there is a "higher level of turnover among members appointed by local authorities" is therefore meaningless if each district continues to have the same representation.

Reduction of the proportional number of local authority members will mean that, not only will those serving have a double commitment than hitherto, but the chances of ratepayers being without representation at some meetings is consequently increased.

Bringing up mixed race children

Jane Holiday, 2 Abberley Way, Highfield, Wigan WN3 6AU

I am writing a book about the experiences of parents of mixed race children in bringing up their children in Britain. I would like to hear from anyone willing to answer a questionnaire and/or to be interviewed (whether single, married, divorced, adopting, etc).

My interest in this subject arises from my experiences in bringing up my two daughters — now 17 and 18 — who are half Sierra Leonean.

CHC assistants get together

Sharon Perkins, Assistant, Scarborough CHC

In February 30 CHC assistants attended the three-day workshop for CHC assistants at the School for Advanced Urban Studies in Bristol. I think we all enjoyed it and found it worthwhile and I would like to thank Ruth Levitt and Chris Ham for organising the workshop. Demand for places was high and I believe a further course is planned. I was particularly glad to meet and talk to my hitherto unseen colleagues! We tend to work in isolation and the course prompted several ideas for future meetings.

The Yorkshire region secretaries have now arranged for their assistants to meet and discuss matters of common interest and I was pleased to read of a similar initiative in the West Midlands.

Sarah Organ, Assistant, Guy's CHC, Maggie Campbell, Assistant, King's CHC and Marianne Craig, Assistant, Brent CHC

Recently some CHC assistants in London met to discuss the possibility of coming together in some organised way with a number of clearly defined aims. We thought that by meeting regularly it would help reduce the isolation which some assistants might feel from the nature of their jobs. We also hope that such gatherings would provide a worthwhile opportunity to exchange news and experiences which would be of benefit to us in our everyday work and also perhaps be quite entertaining! Thirdly we felt that by becoming acquainted with our colleagues and how we work we would be able to clarify and improve the assistant's job and find out about training courses like the one some of us attended at Bristol.

Having agreed on our aims we felt that as most of us have more than enough papers to keep us busy in our jobs, it would be wise to keep our meetings as informal as possible. We should be most interested to hear from assistants throughout the country whether they have any form of organised ccontact, say within their region, and if they do, how they organise themselves. Any comments, advice or information would be more than welcomed.

Midwife shortage

Irene Watson, Secretary, Hull CHC

In view of the fact that the Yorkshire region was specifically mentioned in Beryl Sloan's letter (*CHC NEWS 65* page 2), I feel I must comment regarding a small maternity unit (seven beds) which we lost because of the shortage of midwives. The Hull health district now has centralised maternity services in one hospital and despite having a training school for pupil midwives we are still short.

Information for complainants

Graham Girvan, Secretary, Bexley CHC

After I read Jean Holden's letter (*CHC NEWS 60* page 2) on information about Nottinghamshire CHCs provided by the family practitioner committee to complainants, I contacted the Greenwich and Bexley FPC. The FPC felt it would be wrong to single out one organisation and now includes the names of all organisations to which complainants may turn for help, advice and guidance. As well as CHCs and citizens' advice bureaux, also mentioned are solicitors operating the legal aid and advice scheme, the voluntary legal aid scheme and a local law centre. I welcome this move by the FPC and hope this will mean more people will receive advice on complaints.

Lend us your ideas

Laurie Holmes, Secretary, Huddersfield CHC

In the Huddersfield health district there is a project to centralise all maternity services at the district general hospital. The CHC's special interest group is particularly keen to ensure that as many well tried and successful ideas, facilities and good practices as possible are incorporated into the planning of the new unit. My members would be interested to hear from other CHCs who have been involved in a similar project.

More on fluoridation

RJ Condon, 10 Helen Road, Hornchurch, Essex RM11 2EW

Since Professor Neil Jenkins (*CHC NEWS 64,* page 2) accuses me of making misleading or untrue statements about fluoridation, might I be permitted to expand on my previous letter (*CHC NEWS 60,* page 2)? He says the town of Kilmarnock ended fluoridation "not because it was ineffective but because of a misunderstanding over its cost". In fact it was stopped after the city treasurer told the council, "Before the age of seven, before fluoridation, the average child had seven bad teeth, whereas after five years of fluoridation, six bad teeth. Does any member here consider the achievement of fluoridation outstanding, convincing or worthwhile?"

I referred to Birmingham in an attempt to elucidate the claimed 62% reduction in tooth decay. How is such as precise figure

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CHC NEWS

JUNE 1981 **No 67**

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.

Comment

The Government's decision on lead in petrol is just not good enough. It seems almost ungrateful to say this about the 62% cut in lead content which the Government plans to introduce by 1985, but the issues of child health involved are much too important to let gratitude stand in the way.

High-quality scientific evidence linking lead pollution with reduced intelligence and disturbed behaviour in children has been available since 1978 (see *CHC NEWS 36* page eight), and when the DHSS set up the Lawther working party on lead in the environment changes seemed to be inevitable. But when Lawther's report *Lead and health* emerged last year it appeared to go out of its way to set the highest standards of technical perfection in an attempt to cast doubt on the new research. The stalemate over lead in petrol looked set to continue, so why has it broken down?

The answer seems to be that since Lawther reported two members of the working party have themselves completed research — not yet published but widely "leaked" — which confirms the harmful effects of lead. This seems finally to have tipped the balance of scientific opinion, and had the Government refused to change course it might have found few scientists willing to support it.

So now the lead content of petrol is to be reduced from 0.40 grams per litre to 0.15 by the end of 1985, or earlier in the unlikely event that the Government can persuade the oil companies to take action before they are compelled to. Probably nothing at all will happen until 1985, and there are no plans to introduce lead-free petrol at some later date. Cars will continue to churn out lead, adding to the large amounts already present in soil and in the dust of city streets. There is also the alarming possibility that when the new low-lead petrol is introduced the particles of lead emerging from car exhausts will on average become smaller — and so even more dangerous.

At present cars designed for use in Britain cannot run on petrol containing less than 0.15 grams per litre of lead, and much of the Government's case rests on the social and industrial upheaval a switch to lead-free petrol would create. It also argues that the cut to 0.15 will produce an instant reduction in pollution, whereas waiting for motorists to switch to lead-free would take much longer. The third main obstacle is a bizarre Common Market rule, which sets a minimum lead content of 0.15 as well as a maximum of 0.40.

These arguments won't wash. The USA and Japan have introduced lead-free petrol without wrecking their car industries, and Australia is planning to follow suit in 1985. British Leyland already produces cars for export which can run on lead-free petrol. A lower rate of tax on lead-free petrol could be used to encourage motorists to make the switch, and EEC directives can always be campaigned against and changed.

Many CHCs have backed the anti-lead campaign, and their support will continue to be needed. Once the oil industry has invested in new plant to produce petrol at 0.15 grams per litre a new sticking point will have been reached, and further progress will again become difficult. In the end nothing less than lead-free petrol will really do — would any of the world's great poisoners have been let off on a promise to reduce the dose by 62%?

Health News

Now patients can complain about "clinical judgment"

From 1st September, health service patients who complain about doctors' decisions and treatment by doctors will be able to have their grievances dealt with in a formal complaints procedure. But all hopes that the health Ombudsman might be granted power to investigate such complaints seem to have been dashed. Ministers have accepted lock, stock and barrel the BMA's own design for a "clinical judgment" complaints procedure and people who complain will have their cases looked into — by doctors.

The scheme outlined in DHSS circular HN(81)5 will operate on a trial basis for a while and will consist of three stages. The consultant in charge of the patient will first meet the complainant and discuss the grievance. Any other doctors concerned must also be consulted at all stages. If the patient is not satisfied after this the complaint can be renewed and the regional medical officer (RMO) must be informed. The RMO will then talk to the consultant and possibly also to the patient. If the consultant says there is no point in having another talk to the patient, the RMO has the power to move matters on to the third stage.

The RMO can now arrange for two consultants in a similar medical specialty to give "second opinions". At least one must come from another health region. They will read the medical records, meet the consultant, interview the patient, and then make a confidential report to the RMO.

If the assessors decide to back up the doctor, they must "endeavour to resolve the complainant's anxieties". If they think there were grounds for complaint, they may talk to the medical staff concerned, in the hope of ensuring that similar problems do not arise again. The final step will be a formal letter to the patient from the district administrator, written with the guidance of the RMO. At no point in the proceedings will the patient be allowed to be accompanied by a CHC representative. It is not clear whether the investigation will have to stop if the consultant refuses to cooperate with the second opinions.

The circular restates the procedure for dealing with other kinds of hospital complaints and does not replace previous guidance.

DHSS told clubs are not the answer

The Government's scheme to use long-stay hospital patients' money by setting up patients' clubs has not found favour. Age Concern, MIND and the Campaign for Mentally Handicapped People (CMH), as well as the Association of CHCs have all expressed concern that the most severely handicapped patients, who tend to have the most "surplus" money, would pay in the most to the clubs and would benefit the least.

A DHSS consultative document has suggested that the funds, which are often accumulations of mobility allowance, could be used in hospital clubs which would buy items and arrange activities "to improve the quality of life of their members" (see *CHC NEWS 64* page 1). Age Concern says that if the clubs do go ahead, there must be "legal safeguards to prevent over-large subscriptions and the exploitation of the very frail and mentally ill". MIND and CMH have totally rejected the clubs and want individual patients to each have a "friend" to help them use their benefits. ACHCEW supports this view and says clubs represent "a mass solution for people in mass institutions". All suggest that CHCs should play a part in monitoring hospitals' accounts of how patients' money has been spent and call for greater scope for patients to choose how to spend — better hospital shops, mail order shopping facilities, more flexible rules for spending the mobility allowance.

Cuts in consultation?

Recent trends in the DHSS consultation process have aroused strong criticism from the Association of CHCs. The Association (ACHCEW) has written to the Government expressing its "disappointment" with the length and scope of recent consultation.

ACHCEW stresses its concern about the short deadlines for some consultation papers — organisations were only given one month to respond to the highly controversial proposals for charging overseas visitors for NHS treatment. Such short periods risk making consultation "a pointless exercise" says ACHCEW, depriving ministers of "the best considered advice" and deterring some organisations

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from responding at all.

There is also disquiet about CHCs being sometimes omitted from consultation — the latest example was the circular about the cervical cytology recall scheme (HN(81)14) which was only sent to CHCs "for information" (See *Scanner*, page 15).

● The Health Service Commissioner has refused ACHCEW's request that a summary of each of his reports be sent to the appropriate CHC. The Ombudsman is worried that this might cause a breach of confidentiality, though he is "only too happy" to continue to notify CHCs about completed investigations when the CHC has had prior involvement with the complaint.

Whooping cough vaccine damage: risk is 1 in 110,000

The benefits of having your baby protected against whooping cough are greater than the risks of vaccine damage, says Health Minister Gerard Vaughan. The Government is passing on this advice from two heavy-weight bodies, the Committee on Safety of Medicines (CSM) and the Joint Committee on Vaccination and Immunisation (JCVI), which looked into the risks of neurological damage to children following whooping cough (pertussis) vaccination*.

Since 1974 when allegations that children had suffered brain damage from the vaccine came to light, the proportion of babies being brought for vaccination has plummeted from around 80% to around 30%. It is now officially accepted that there is a risk of damage to previously normal children — though proof is not absolute. The JCVI's estimate is that *roughly* 1 in 110,000 children who get the full course of three injections will suffer "persistent brain damage". Underlining the benefits of vaccination, the advisory reports draw attention to the 27 or 28 babies who died in England and Wales during the 1977-79 whooping cough epidemic.

A DHSS campaign to promote the triple vaccine (diptheria, tetanus, pertussis) will be launched in the autumn. Meanwhile the Government is acting on the JCVI's recommendations that doctors and nurses should be more alert to the factors which rule out vaccination or at least increase the potential risk of vaccine damage to an individual child. A DHSS letter is going out to GPs and others emphasising the need for care.

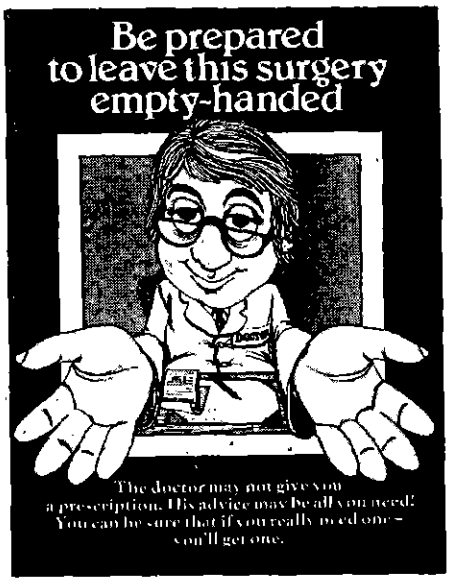
**Whooping cough: reports from the Committee on Safety of Medicines and the Joint Committee on Vaccination and Immunisation* HMSO £6.90.

Educating GPs to educate the public

GPs will be taking a more active role in health education if new initiatives from the Health Education Council are successful. In the next few months the council will be producing a variety of material for GPs to use in their surgeries and hand out to patients.

An anti-smoking "package" — of leaflets, posters and information for the GP and the receptionist — is being piloted now in Oxfordshire and should be available in the autumn. In a month or so a booklet on dealing with minor illnesses at home will be produced for GPs to give to their patients, and a series of leaflets on common problems such as back-ache, insomnia and cystitis is under way.

Dr Alan Maryon-Davies of the HEC says that there has been "a definite change of attitude to health education among GPs in the last 12 months". He hopes the new material will speed up this process — CHCs can encourage patients to find out if their GPs are participating.



DHSS amends fund-raising guidance

The DHSS circular (HC(80)11) on NHS fund-raising has been modified after fierce criticism from health charities (see *CHC NEWS 63*, page 1). Health authorities must now consult voluntary groups before employing professional fund-raising agencies for large public appeals and should keep local charities informed about all money-raising schemes. DHSS circular HC(80)11 Part II ends, "The Government has given an assurance that money donated will not be deducted from central funds to the NHS".

"Searching appraisal" needed in NHS health and safety

A searing attack on sloppy health and safety standards in the NHS has been made by the Health and Safety Executive.

In a report crammed full of the strongest possible official language (1), the HSE's Health Services National Industry Group warns of an "urgent need for a searching appraisal of the organisation for occupational health and safety" in the NHS. At present it says the NHS lacks both the expertise and the organisation to achieve satisfactory health and safety standards, and because of these deficiencies there is a "notable lack of internal self criticism".

The report points to a "serious lack of any system of internal monitoring of performance", and says that during the first round of health service inspections, which began in 1978, HSE inspectors found the NHS management system "singularly ill fitted for the achievement of rapid decisions and speedy remedy where there are defects in occupational health and safety".

Because Crown immunity protects health authorities against the HSE's legal powers it has had to "invent" a non-statutory procedure called the Crown Notice, so that in the worst cases it can threaten recalcitrant health authorities with unwelcome publicity (see *CHC NEWS 41* page three).

The DHSS is also asked to bear its share of responsibility for the lack of an effective health and safety organisation: "No effective guidance has been provided by DHSS to help health authorities formulate such an organisation, even though some central guidance is essential if efficient and economical systems are to evolve".

The list of specific problems found by HSE inspectors in the NHS is an alarming one, including: unsafe arrangements for the storage and use of medical gases and inflammable liquids, defective fencing around laundry equipment, unsatisfactory waste disposal procedures, and premises impossible to adapt to meet the requirements of the Howie Committee's code of practice on infection in laboratories and post-mortem rooms.

The report confronts the dilemma that improvements in health and safety may drain money away from the provision of patient services, and calls for "an allocation of resources for occupational health and safety divorced from those devoted to patient care".

1. *Manufacturing and service industries 1979*, HMSO £4.50, pages 34-36.

We won't be muzzled, CHCs tell Jenkin

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reverse the pattern of membership so that voluntary organisations appoint half the membership and local authorities one third. And opinion is evenly divided on the value of a reserved place for a trades council representative. However, most CHCs want tougher measures to deal with persistent non-attenders at CHC meetings.

On several counts, RHAs emerge in a good light. CHCs want them to continue to be responsible for CHCs, hiring staff and so on. They also oppose the DHSS notion that RHAs' power to appoint a few members to each CHC should pass to the district health authorities.

The Association of CHCs receives a big vote of confidence. Many CHCs pointedly respond to the Ministers' surprise suggestion that ACHCEW should fold up, by reminding the Government that if less than 55% of CHCs join ACHCEW each year it will automatically shut up shop. And that last year 95% of CHCs wanted to belong.

"I didn't know the disabled had rights"

*by Ursula Keeble**

Many local authorities are still not providing all the services they should do under the Chronically Sick and Disabled Persons Act. In October last year eight charities for the disabled got together to discuss ways of enforcing the Act — if necessary by taking test cases to the High Court. They agreed to jointly fund a worker (myself) for six months to give advice and assistance to individuals who are refused help under the Act.

Six months later 14 charities were involved in the project. By now 92 local authority social service departments had had their attention drawn to their failure to comply with their statutory duties. Of the 281 cases I handled personally 100 were about aids and adaptations, 48 concerned charges for home helps and reductions in the hours of home helps and there were 59 miscellaneous cases. The 281 does not include the numerous enquiries about social security benefits which were dealt with by Peter Mitchell, the Head of RADAR's Research and Intelligence Unit.

The most important point to emerge from this exercise was the number of people who still do not know their rights or even that they have rights in spite of our publicising the Act for ten years "I didn't know there was a law for the disabled until I saw the programme on TV" and "I didn't know the disabled had rights until I heard it on the radio" are typical comments.

The second point to emerge is that RADAR, with the help of sympathetic media, can continue to unearth cases of disabled people who are not receiving the services that they need. Many national newspapers covered the project and the main value of their reports was that they attracted hosts of provincial journalists who, at my request, were prepared to ask disabled readers with grievances to come forward. Specialist newspapers such as *Spastics News* and *Yours* produced a number of responses; and a number of community health councils became interested in the project as the result of a report in *CHC NEWS*. Local radio programmes also stimulated responses.

Another point to emerge was the national shortage of domiciliary occupational therapists. Two counties had only one OT for the whole county and one of these had 420 potential clients waiting for their first home visit. Where vacancies remained unfilled, or were frozen, services for the handicapped could be seen to be breaking down.

Adaptations to property were particularly subject to bureaucratic delay. In the private housing sector the dependence on improvement grants (still discretionary) and loans from local government often resulted in very heavy financial burdens for the disabled and their families. In the public housing sector the division of responsibility between social services departments and district housing departments, acting as their agents, has resulted in such appalling bureaucratic delays that there is clearly a need for much more joint planning and more effective communication. Again and again I was told by members of social service departments that delay in carrying out adaptations was because "the district council ran out of money" — sometimes six months before the end of the current financial year. Pressure in February and March towards the end of the financial year produced some extra money. And, in a number of cases where aids required installation, money saved as a result of the moratorium on improvement grants — which had never been meant to apply to the disabled anyway — was re-directed to the disabled.

Photo: Raissa Page

Co-operation between hospitals and social services departments also left much to be desired. District councils were slow to widen doors so that accident patients could return to their homes in wheelchairs. A double amputee had been waiting eight months for a ramp so that she could get out of her council flat. Small items like grab-rails took too long to install.

Of the 59 cases that were not strictly relevant to the project because they were not covered by the CSDP Act the majority concerned re-housing. Others concerned admission to residential homes, short-stay accommodation, problems about educating handicapped children and a shortage of places in training centres for handicapped adolescents. There were also a number of requests for chiropody. I particularly liked the letter which began "Please help me I have dangerous toe nails" which was very true as the client was diabetic and could have got gangrene if a toe nail had been allowed to grow in.

At the other end of the spectrum of need there was a diabetic who had lost both legs above the knee from gangrene and who was blind as well. Getting a shower installed for him into which he could be wheeled in a special wheelchair was one of the most rewarding cases I dealt with as until my intervention he had been waiting fifteen months, most of the time without any knowledge of what was happening. The importance of feedback both to social workers from social service committees and from social workers to clients needs to be stressed. Too many clients had been left in the dark for far too long.

As a result of this first six months the special project is to continue for at least another year although I could not stay on after the initial period. The project's success will depend on the continued co-operation of the public, and on publicity in magazines such as this one.

Mrs Keeble was taking up cases under Section 2 of the Chronically Sick and Disabled Persons Act 1970. This Act requires local authorities to ensure that they are adequately informed of the numbers and needs of handicapped people in their area so that they can develop satisfactory services for them.

Section 2 requires the local authority to assess the individual person's requirements and, where they are satisfied there is a need, to provide some or all of the following services:

- practical assistance in the home
- radio, television, library or similar recreational facilities in the home
- recreational facilities outside the home and assistance in taking advantage of educational facilities
- travelling facilities to enable the person to make use of these facilities
- assistance in carrying out adaptations in the home
- facilitating the taking of holidays
- meals at home or elsewhere
- a telephone and any special equipment necessary for its use.

Recently employed by a group of charities for the disabled to take up cases under Section 2 of the Chronically Sick and Disabled Persons Act. Author of Aids and adaptations *(Bedford Square Press, 1979).*

Getting the better of statistics

by Jean Robinson, Member, Oxfordshire CHC

Statistics and I are old enemies*. When I am faced with a page of figures, my mind dissolves into blank incomprehension. But no-one who is interested in the problem of the individual patient can run away from statistics for ever. My attempts to understand NHS statistics began 14 years ago when I became a member of a regional hospital board. Every time I asked a question about statistics we had been given I came up against a brick wall.

When I asked about waiting lists I was told they were meaningless. (A meaningful waiting list would not have provided an alibi for inactivity.) After seven years' hard questioning on the basis of available statistics my only achievements were to gain a marginal increase in the cost of food in hospitals for the mentally handicapped — without fundamentally changing the ratio between different types of hospital — and to gain a reputation as "that dreadful woman who keeps asking where the Emperor's clothes are".

When we decanted the occupants of our large psychiatric and mental handicap hospitals into "community care" (sleeping under railway arches) the statistics showed us the decline in occupied beds but not what happened to the patients. I recall one non-existent statistic was a violent schizophrenic who beat up his father who was dying of cancer while his frail, elderly mother tried to protect her husband. It is ironic that the introduction of the Hospital (now Health) Advisory Service, one of the few attempts to measure quality rather than quantity of care, was instrumental in getting the problem moved out of range of statistical visibility.

In response to a DHSS memorandum on waiting time in outpatient departments I asked for information on our region's hospitals. Here was a problem which was a major source of patient dissatisfaction, on which data could easily be collected and which could be remedied. I was simply told the matter was "continually under review".

I realised later that as a new board member I had been naive and slow to learn the unwritten rules of the game:

1 Officials are happiest when collecting and processing neutral information. This is seen as a useful and worthwhile activity.

2 No-one wants to seek information if they suspect they won't like it. If they don't think they will like the answers, they don't ask the questions.

3 If the routine collection of information does inconveniently bring to light unpalatable facts, collective loss of memory is the only solution.

An exaggeration perhaps, but with more than a grain of truth.

When we enter hospital as patients, we are asked questions which we sometimes find puzzling and occasionally find impertinent. "Why do they want to know how many husbands I have had in order to operate on my gall bladder?", asked one woman. Does the NHS have the right to collect such information, at the tax-payers' expense, if there is little pay-off in patient care or disease prevention?

On the other hand, I am puzzled by how often our information system functions badly at area and district level. When we visit hospitals we sometimes find staff in a state of despair because discussions with the district management team have revealed that plans are based on inaccurate information. "If they don't know how many medical staff are in post, what else have they got wrong?", asked one consultant.

Our CHC needed recently to get information on the social class of women having babies in two maternity hospitals, X and Y. Hospital Y apparently had the higher perinatal mortality rate, but after figures were obtained for low birthweight and congenital defects incompatible with life, the rates at the two hospitals were similar. Hospital Y has better facilities for dealing with high risk births, but is under a great deal of pressure. We would like data on the social class of patients, not only to assess the infant death rate, but also to make sure that, if the beds get short, the patients most in need get into hospital. Alas, the information is simply not available. Newcastle CHC and Central Birmingham CHC have come up against the same problem.

However unsatisfactory the statistics, we do at least have some measurement of workload in the hospital service. No-one is measuring the workload of families caring for sick relatives at home. This "community care" often means unpaid work by women, with no holidays or time off-duty. When in Oxfordshire CHC we are asked for help by families almost broken with the burden of caring for a disturbed elderly relative, we feel cynical about the response of the geriatricians that their statistics show they have no waiting list. We need not only good, up-to-date statistics on community needs, but the equivalent of the Health Advisory Service for community care.

Cartoon: Colin Wheeler *New Statesman*

After the frustrations of NHS statistics, I find date on mortality and morbidity (ill-health), published by the Office of Population Censuses and Surveys enthralling. Almost every figure is the beginning of a detective story. In 1960 W P D Logan's *Morbidity statistics from general practice* (1) raised intriguing questions such as why did retired male textile workers — not noted for living to a great age — have the highest consulting rate for senility? Who was that lovely Dr Logan, who under the dull title of Chief Medical Statistician, had, long before "women's lib", thought to provide us with patterns of morbidity for women working full and part-time, with and without family responsibility. As it was women working outside the home and looking after a family who had the highest consulting rate for disorders of menstruation and the menopause, did these women need artificial hormones or a jolly good rest?

The latest *Decennial Supplement* on occupational mortality (2) provides a fascinating and readable analysis of death, but only for half the population. Women appear almost as an afterthought in one short chapter *Women and children*.

It is particularly unfortunate that detailed occupational mortality and morbidity data has become less available at a time when interest in causes of illness is growing, especially in the way illness is related to hazards of occupation and environment. For now details of occupations are only available on microfiche, which makes them virtually inaccessible to the public.

Health statistics are no longer the property of epidemiologists, government officials or doctors. At last we have a growing number of ordinary people using them and questioning their origin. We have found that they lie less often than we thought but when we read them for ourselves, we find their interpretation has been wondrous strange. More important perhaps, the people who hold the tools of measurement, measure those things which are important to them and ignore the things which are important to us. I would like to see a change in the balance of power.

References

1 *Morbidity statistics from general practice* by W P D Logan, Vol II (Occupation), Studies on Medical and Population Subjects, No 14, HMSO, 1960.

2 *Occupational mortality — Registrar General's Decennial Supplement for England and Wales, 1970-1972*, Office of Population Censuses and Surveys, HMSO, 1978.

**This is an abridged version of a paper which Jean Robinson gave to the Statistics Users' Conference at the Royal Society last year.*

Book reviews

Open employment after mental illness

by Nancy Wansbrough and Philip Cooper, Tavistock, £8.95

With nearly three million people unemployed in Britain for the foreseeable future, is it reasonable to expect the problems of the mentally ill to be taken into account? The premise adopted in this book is that it is and that for those able to undertake it, full-time employment is the ideal solution for both the ex-patient and the community. Working for a living is one of a person's basic activities, and determines not only their income, but also their status, self-esteem, friendship patterns, and many other aspects of day-to-day life.

Nevertheless the problems of people seeking jobs after treatment as psychiatric in-patients are severe and insufficiently understood. The aim of this book is to increase the awareness of various groups who are concerned with the problem of the employment of the mentally ill, but none of whom is in a position to view the whole picture. Its succeeds! A detailed appraisal of the subject drawn from a study of over 1,200 ex-patients provides insight into both the medical and employment aspects of rehabilitation. Indeed this is the first study to deal with the employment experiences of the formerly mentally ill from the standpoint of the employer.

There is much in this book which will be of direct use to CHCs, in particular the chapter which reviews the provisions for rehabilitation and resettlement of the mentally ill, by state and voluntary organisations. This is the best summary I have ever seen. There is also a discussion of the quota system used under the Disabled Persons (Employment) Act 1944, which is under review at present.

Neil Collins
Islington CHC

Sparing time — the Observer guide to helping others

by Elizabeth Gundrey, Unwin paperbacks, £2.25.

Sparing time aims to tell potential volunteers about the scope of voluntary work, the characteristics of successful volunteers and the benefits which volunteers can confer on their clients and the satisfactions which they themselves gain. Almost every imaginable service is mentioned, from children's playgroups to prison visiting, from driving a minibus for elderly people to public speaking.

Unfortunately the author tries to combine a wide range of information with a chatty familiar style, which causes the book to become rather unbalanced and does indeed present a somewhat sentimental and over-optimistic view of some voluntary activities. The book has however one very valuable feature. There is a comprehensive list of the names, addresses and telephone numbers of voluntary organisations and other sources of help and information. From this point of view it could prove a useful reference book.

Olive Keywood
Worcester CHC

Home care for the stroke patient — living in a pattern

by Margaret Johnstone, Churchill Livingstone, £3.95

The purpose of this book is to bring a message of hope to people who have had a stroke and to those who care for them at home. Rehabilitation is a long slow process and it is essential that treatment must continue along correct lines. By comparing progress to that of the young child learning to sit, stand and walk, it shows how the patient has to be re-educated to regain balance and use the affected limbs.

This book outlines step by step the various exercises that need to be continued at home, first with the aid of a helper and then gradually by the patient unaided. Each step is illustrated by clear diagrams showing correct positioning and simple exercises. The importance of correct position to prevent pain in the affected limbs is repeatedly stressed throughout the book.

There is a rather technical chapter on speech therapy which the lay person may have difficulty in understanding, but it does outline the frustrations suffered by the patient when speech, even reading and writing, is affected. With the increase in the number of Stroke Clubs being formed and run by voluntary organisations, this textbook should give a valuable insight to the helpers on the complexities of the stroke patient.

Miss E M Bussby
Chichester CHC

Depression after childbirth: how to recognise and treat postnatal illness

by Katharina Dalton, OUP, £1.95

Readers who know of Dr Dalton's work on premenstrual tension (PMT) will not be surprised to learn that she believes that postnatal depression is hormonal in origin and that it too can be treated with the hormone progesterone. The symptoms, she says, are similar — tiredness, depression and irritability — and are caused by a drop in the body's progesterone level, which occurs after childbirth and also every menstrual cycle in the week before menstruation. In Dr Dalton's experience, postnatal depression often merges into PMT.

The book is very positive and at first glance quite convincing. The explanation of the hormonal changes of pregnancy, childbirth and the menstrual cycle is easy to follow. There are detailed descriptions, liberally laced with women's own accounts of their experiences of postnatal depression in its various forms, from maternity blues to puerperal psychosis. But there is a lot missing. For instance, Dr Dalton dismisses any possible non-hormonal cause of postnatal depression, such as the mother's experience in hospital, her isolation at home, or the baby's feeding, sleeping and crying habits. She gives no indication of the success-rate of hormonal treatment, and glosses over possible side-effects, long-term risks, and the fact that it may involve giving up breastfeeding. However, the treatment, and the book, may well bring comfort and relief to many women. And the call for better care and support for women after childbirth certainly needs heeding.

Vivian Sanders,
Former editor, CHC NEWS

Health shock: a guide to ineffective and hazardous medical treatment

by Martin Weitz, David and Charles, £7.95

This book describes some of the unnecessary, useless and harmful therapies and tests — both surgical and chemical — that have become part of modern medicine. This collection will shock those not already familiar with the lack of scientific rigour in orthodox medicine.

The form in which the material is presented makes it a compulsive book for "dipping into". It is easy to read, with bold headlines that capture the browser's attention — "Don't stay in bed during labour, your body won't breathe properly", "Why six-monthly dental checks are unnecessary".

Surgery, birth, dentistry, contraception, tests, prescribed drugs and over-the-counter remedies all get chapters to themselves. However while the chapter on contraception reviews *all* the main methods, and gives a quick guide to their relative risks, the chapter on surgery selects twenty procedures without specifying why these particular twenty.

The author sometimes relies on opinion to refute claims of efficacy, and does not tell the reader why one opinion is more "right" than another. Nonetheless this book is a valuable attempt to bring to popular attention the dangers inherent in intervention. A dip into it cannot help but increase our caution as users of medical services and strengthen our determination to ask for more information on possible outcomes.

The implicit message for CHCs is stronger: the failures in the present system point to the need for systematic monitoring and control of technology and techniques — and greater access for the consumer to sources of information and education.

Fedelma Winkler,
Secretary,
City and Hackney CHC

The health industry in the USA

*by Tom Richardson, Secretary, Oxfordshire CHC**

Advocates of private health care sometimes argue that the British NHS should be financed and managed more in the way that private companies run their hospitals for profit. There is always one factor absent from such discussions — the effects on individual patients and on the community in general. The evidence I collected on this during my two months in the United States of America last year* is far from encouraging.

Investor-owned hospitals in the USA tend to be in the richest areas of the richest states, have few out-patient facilities, cater mostly for those with short-term minor medical and surgical problems, play little or no part in the education and training of health care professionals, and do not attempt to provide a comprehensive health service for their communities.

A profit-making company, no matter how socially aware, is still in business to make a profit, which accounts for the almost complete lack of public involvement in the planning and running of such investor-owned services. The list of non-profitable services which the US private sector cannot provide on the scale required is a long one. It includes services for the elderly, services for the handicapped and chronically sick, accident and emergency services, out-patient and preventive services, and specialised services such as burns units and addiction centres.

Particularly in inner city and rural areas, the private sector has difficulty in providing services based on the home and local communities. Studies in New York, Massachusetts and Florida have found that up to 40% of the elderly people in nursing homes could live at home if appropriate domiciliary services were provided. Surveys have also shown that only 12% of elderly and disabled people who require help with household chores or personal care in the home are receiving such assistance.

Insurance cover

The 215 million population of the USA is covered, where it *is* covered, by a multiplicity of insurance schemes, supplemented to some extent by government funds. Insurers include straightforward commercial companies and "non-profit" organisations such as Blue Cross/Blue Shield, in which groups of hospitals run insurance schemes and provide services direct to subscribers. In 1978 insurance schemes funded over 67% of personal health care expenditure in the USA, mostly through "group employment" schemes in which employees are provided with health insurance as a fringe benefit.

Powerful as they are, insurers have failed to challenge the monopoly power of the US medical profession. Rather than demand the monitoring of medical services to achieve cost reductions, they have found it easier to react to increasing medical costs by simply putting up premiums. "Insurance companies are not generally leaders in the social field, and have not been aggressive in any approach to the medical profession", was one frank answer I received when I enquired about this.

Between 1950 and 1978, health care expenditure in the US rose from 4.5% of Gross National Product to 9.1%, in contrast with the UK where the proportion of GNP rose from 3.9% to 5.6% between 1949 and 1979. Major employers are now becoming restive about these escalating costs—in 1978, for example, Ford of Detroit spend about $175 on employees' health insurance for every car it produced. Blue Cross has decided, with some anguish, on a list of over thirty operations which must be justified in advance by the doctor concerned, and it is also restricting complex operations such as heart surgery to particular hospitals. The US government and major insurance companies are mounting major publicity campaigns urging people to stay healthy — and so avoid the need to use health services.

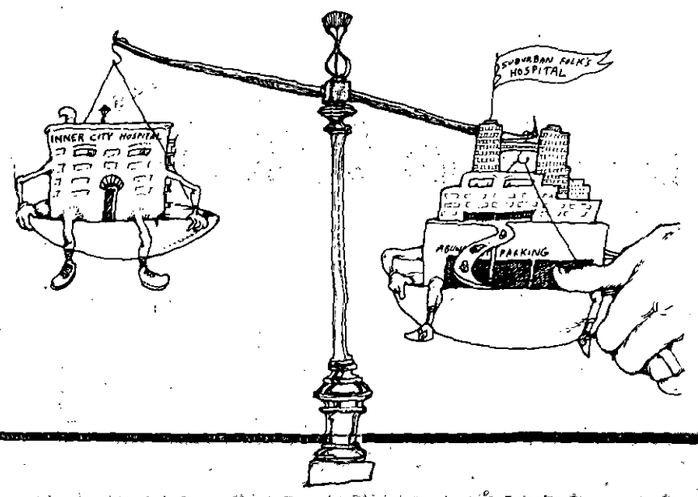
State provision

The widening gaps in this private system are increasingly having to be plugged by the Federal and State governments. The *Medicare* scheme, an attempt at some kind of national service, was introduced in 1966, and in states which choose to operate it now provides insurance cover for about 53 million people who are elderly, disabled or poor.

The cost of the scheme has grown rapidly, and it is now being cut back by the new US administration. In 1979 Medicare payments accounted for about 25% of all hospital expenditure in the USA, and between 1978 and 1979 its costs grew by 16%. Medicare does little more than buy services in the private sector — consumers have no voice within it, and its apparently uncontrollable cost has caused great concern. This bad publicity has in turn hindered the passage of more comprehensive national health insurance legislation through Congress and the State legislatures.

This combination of public and private insurance still leaves uncovered fifteen million out of the USA's 160 million whites, four million out of the 23 million blacks, and three million of the 12 million "Hispanics" (mostly people of Puerto Rican and Mexican extraction). The system fails to provide for those in the "poverty trap", those whose insurance cover is inadequate, unemployed and under-employed people who for some reason are ineligible for welfare payments, those who have lost public assistance because of government cuts, the chronically sick and handicapped, visitors and illegal immigrants. In all it has been estimated that forty million people in the USA have inadequate access to health care.

It seems that the "free market" has little to offer these people, for their only health care option is to attend their local public general hospital (PGH) — if there is one. The USA's 1900 PGHs provide about a third of all its hospital facilities. In large cities they are usually run by local government and many are in severe financial difficulties. The 45 university PGHs train two thirds of the USA's doctors and dentists, and half its other health service professionals. The 1400 rural PGHs are mainly small, and many have financial problems because of low bed-occupancy. In 1974 they were the only hospitals in one third of US rural counties.



The US philosophy of medicine appears to be lost in a cul-de-sac of bewildering proportions. In cases of serious illness even the very affluent can suffer — because paying for the very best that mainstream medicine now offers in the USA can be financially crippling. And the concept of the family GP has come close to vanishing in the USA, as wealth and increasing medical specialisation have made it possible for patients to get involved with several doctors without any of them necessarily knowing of the others' existence.

A consumer voice

The profit motive in US health care has tended to force out public and community involvement, but a major factor pushing in the opposite direction has been the work of the *Health systems agencies* (HSAs). These were set up in 1974 by the National Health Planning and Resources Development Act, which divided the USA into 204 "health service areas" with populations ranging from half a million to three million. HSAs were created in each area, each with a board of around thirty members and a professional staff.

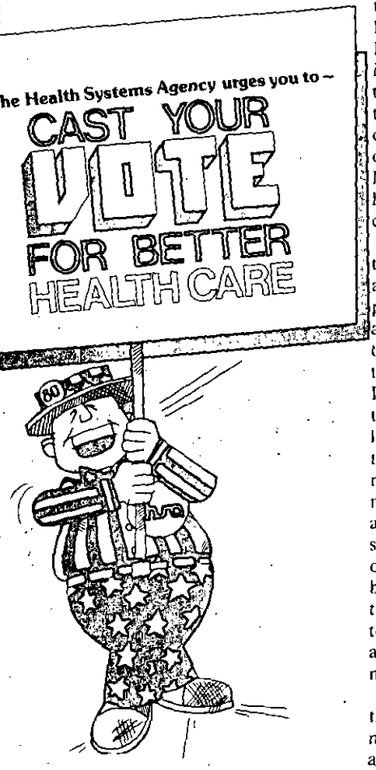
Board members work in a voluntary capacity, are appointed by the State rather than elected, and are mainly consumer representatives rather than health care professionals. The aim of the Act is to improve the accessibility, acceptability, continuity and quality of US health care, and the job of HSAs is to re-structure existing health care facilities with these objectives in mind. Like CHCs, HSAs were given few "teeth" — their main power being the right to veto new health developments and the introduction of high-technology medical equipment. They have to report to the State governments, and have tended to become just another pressure group lobbying in the state capital. Even so they have achieved a great deal, by creating an atmosphere for change and cooperation between the health care professions, institutions and the public.

But there has also been friction, particularly in the large cities, where it appears that political pressures have led to HSAs being set the task of reducing the grotesque surplus of hospital beds and other facilities in their communities. Private hospitals may still make an acceptable profit for their owners with a bed occupancy of less than 50%, and so will not readily agree to closures and mergers.

In the large conurbations such as New York, Detroit and San Francisco, HSAs have been locked in combat over this issue with doctors, the American Medical Association and the American Hospital Association. These HSAs are in difficulties with the public as well as the professions, as they are rarely able to ensure that resources saved through closures will go towards improving other services in under-served areas. In New York, for example, some closures have been at the expense of the poorest communities.

HSA members can sometimes take a terrible battering from the public, and also have to endure the full might of professional indignation. HSA staff are at least paid for their bruises, though their turnover appears to be high, but the members are often fearfully abused. It is difficult to imagine any but the toughest and most strongly motivated lay members being able to withstand these pressures. The high standard of membership which has been maintained is perhaps an indication of a general feeling amongst some sections of the US public that an overall planning agency is necessary to bring order out of chaos. Nevertheless, the statutory existence of HSAs is due to be reviewed shortly by the Reagan administration, so a question mark must hang over their future.

Providing a basis for people to live their lives in a state of physical and mental well-being is a worthy aim for any political system. This cannot be left to any single group or small collection of groups — be they health service professionals, bureaucrats or industrialists. The enlarging of public discussion on all these matters is essential, together with the involvement of the public in the planning and management of all health and social services.



Further reading

Health planning newsletter, a monthly magazine for members and staff of Health Systems Agencies, published by the US Department of Health and Human Services. To subscribe send cheque or money order for $11.25 to Superintendent of Documents, US Government Printing Office, Washington DC 20402.

Consumer health perspectives, published six times a year by the Consumer Commission on the Accreditation of Health Services Inc. an organisation campaigning for improved consumer representation and the setting up of a national health service in the USA. Send subscription of $10 (individuals) or $25 (organisations) to CCAHS, 377 Park Avenue South, New York, NY 10016.

Health/PAC bulletin, published six times a year by the Health Policy Advisory Center, a "public interest" centre which also produces educational materials and acts as a discussion network for health activists. Send subscription of $14 (individuals) or $28 (institutions) to Human Sciences Press, 72 Fifth Avenue, New York, NY 10011.

The Association of CHCs' secretary Mike Gerrard also made a fact-finding trip to the USA last summer, and his report *Visit to USA* is available free from ACHCEW, 362 Euston Road, London NW1.

* *Tom Richardson spent last July and August studying the provision of health care in the USA. This article, edited by CHC NEWS, consists of extracts from his report* The public and the health industry in the USA and Britain 1980. *Copies of the full report are available free from Oxfordshire CHC, 2 Market Street, Oxford, England.*

Photo: Dan Gushler/*Health Planning Newsletter*

Cartoon: Health Systems Agency of North Central CT

Cartoon: Health/PAC Bulletin

Healthline

Service committees and the NHS Tribunal

What is the difference between a service committee and the NHS Tribunal?

Service committees investigate complaints against family practitioners — GPs, dentists, chemists and opticians — about alleged failure to comply with their terms of service. There are separate service committees for each of the four professions — medical, dental, pharmaceutical and ophthalmic. Committee members are appointed by and from lay members of the relevant family practitioner committee and by the Local Committee of the profession involved.

After taking evidence about a complaint at a hearing the service committee sends a report to the FPC which can take various steps, including limiting the number of patients on a doctor's list or imposing a fine. If the FPC believes the continued inclusion of the "family practitioner" on the NHS list "would be prejudicial to the efficiency of the services in question" it can make representations about this to the NHS Tribunal.

The NHS Tribunal has the power to remove GPs, dentists, chemists and opticians from the lists of those authorised to carry out treatment under the NHS. The Tribunal's chairman is a practising lawyer, appointed by the Lord Chancellor. There are two other members who are both appointed by the Secretary of State: one to represent the FPCs and the other from a panel of members of the relevant profession.

Allergies

Are there any organisations for people with allergies?

Sufferers could join Action Against Allergy (AAA). This association is concerned about the number of disabling conditions which are turning out to result from allergies to everyday substances. It is pressing for more research into food and chemical allergies, and for more NHS allergy-testing clinics. It also provides information about allergies to its members and endeavours to foster local self-help groups. More information from AAA, 43 The Downs, London SW20.

The Residential Homes Act

I understand that there is a new law about residential homes. Can you tell me about it?

The Residential Homes Act 1980 applies to voluntary or private residential homes for the elderly, disabled and "mentally disordered". It does not cover hospitals, nursing homes, children's homes or state-managed premises which all come under other laws.

People running residential homes must now register with their local authority. If they do not they are liable to prosecution. The local authority may refuse to register the applicant if it is not satisfied that the people working in the home or the conditions in the home are "fit" for the proper running of the home — or if the services or facilities do not seem suitable. The authority may also cancel the registration if the home later falls below the standards set for approval, or if the person running the home is convicted of an offence under this Act.

The Secretary of State may issue regulations about residential homes — the type of facilities and services, and the permitted number of residents. And people authorised by the Secretary of State or the local authority have the right to enter and inspect residential homes "at all reasonable times".

CORRECTION

Elizabeth Ackroyd's article last month about *Patients' complaints* was incorrectly amended by us *(CHC NEWS 66* page 8). The time limit for complaints about a GP, chemist or optician is eight weeks. Complaints about dentists are allowed "within six months after completion of the treatment or within eight weeks after the matter which gave rise to the complaint came to the complainant's notice, whichever is the sooner" (Statutory Instrument 1974, No. 160).

Your letters

Continued from page two

arrived at? Even if true, Birmingham pays a heavy price in its greatly increased cancer death rate, a phenomenon observed elsewhere following fluoridation.

Paul Castle's letter (*CHC NEWS 64*, page 2) in justification of his opinion poll ignores a crucial ethical point. What right has Joe Public to demand that I be forcibly dosed with a dangerous poison? I happen to be one of the many victims of mouth and tongue damage resulting from the use of fluoridated toothpaste, hence what Mr Castle calls my "diehard" attitude. He quotes the USA Consumers' Union as claiming that, in 1978, there was no scientific controversy over the safety of fluoridation. That was the year of the Pittsburgh court case, when scientists defending fluoridation were totally unable to refute evidence linking the practices with increases in cancer.

Apart from Britain and Ireland, every country in Europe has now banned or dropped fluoridation. Are they all out of step except us?

Going loopy

John Hart, 36 Exeter House, Watermill Way Hanworth, Middlesex TW13 5NH

Hearing-impaired people have great difficulty in listening to the radio, and often give up because of the sound distortion produced by their hearing aids. One solution is to use an *induction loop system* — a loop of wire running around the room and connected at both ends to a radio or TV set.

The sound from the set can then be picked up by any hearing aid containing an *induction coil*, without the aid being directly connected to the set. When the loop is plugged in no sound need be emitted from the loudspeaker, so the volume can be as loud as required without disturbance to other people. Not all hearing aids have an induction coil — the ones that do can be recognised by the letter "T" on their controls.

What is not generally known is that it is possible to work an inductive loop from a transistor radio or tape cassette player, with the same clarity of sound as that produced by the conventional loop. *Large loops*, which are usually powerful enough to extend to more than one room, allow freedom of movement within the loop. *Personal loops* can be used in bed, and because they are easily portable can be taken out of doors to parks and gardens.

Parents of hearing-impaired children often regret the fact that although special equipment based on the inductive loop principle is used at school, it cannot help with their child's education. Cassette-player loops can now be used to overcome this difficulty. Mothers can record their own voices on tape, and can pick up and identify objects when the tape is replayed. The child can thus hear the mother's voice, and if she speaks at the same time can watch her lip movements. Pre-recorded tapes of children's stories can be played to help with speech development.

Some speech therapists have expressed an interest in experimenting with the transistor loop, which is remarkably cheap, effective and mobile.

Pushing for Portage

Ian Seavers, Secretary, Kingston, Richmond and Esher CHC

The Association of CHCs has circulated its members with details of the Portage system for involving the families of pre-school mentally handicapped children in their education. ACHCEW has commended Portage as a suitable subject for discussion with health authorities. Our Working Party for the Handicapped has asked me to draw readers' attention to the fact that the Health Care Evaluation Research Team has also carried out work on Portage, and no doubt could be approached for information. We are pleased that our own mental handicap services, based on Normansfield, are beginning to use this scheme, and we are watching developments with interest.

Ed: The Health Care Evaluation Research Team's address is Dawn House, Sleepers Hill, Winchester SO22 4NG.

BACKGROUND TO THE NHS

*by Sir George Godber**

The Report of the Royal Commission on the NHS (1) is a lucid but low-key document, which has had less attention than it deserves. The commission was appointed at a time of sharp conflict within the service. Some people, especially doctors, seem to have expected Sir Alec Merrison and his colleagues to produce proposals for radical changes which would somehow rescue the NHS from the effects of a chronic shortage of funds. Instead they reaffirmed the objectives of the service and expressed the view that the country receives a good return from its inadequate outlay, though this could be improved by various measures short of another major upheaval.

Posterity will probably look back on the work of this commission as a triumph for *understanding and* commonsense. It told us what we should have known — that during a period of national stringency the NHS has to concentrate on getting the best possible outcome for the most people out of inadequate resources. It showed clearly that past investment in the NHS has been far too small, and that an enlarged capital programme should be introduced as soon as possible. One of its published research studies, by Buxton and Klein (2), exposed fully for the first time the relative abundance of NHS funding in Scotland and Northern Ireland and the serious and long-standing shortfall in England and Wales.

Some of the short working papers produced by members and staff of the commission, or invited from individuals, have now been edited by Christine Farrell, a former member of the commission's staff, and Rosemary Davies, with financial support from the King Edward's Hospital Fund for London. These have been published as a series of Project Papers, designated RC1 to RC17, and CHC members will find them compact and *readable discussions of* different aspects of the NHS. Few will want to read them all, but each is likely to interest some members.

RC1, by Bramley and Bulman, is the best short assessment of the achievements and future needs of the dental services yet available. Dental services were sadly deficient before 1948 and the geographical imbalance between north and south is still more marked than in any other health field. But there has been progress, and there could be great gains from prevention.

Nursing presents quite different problems, some of which are well discussed by Jean McFarlane in the group of essays which makes up RC2, and in her contribution to RC12 on multi-disciplinary teams. The development of such teamwork is one of the *most important problems* in the NHS, both in and out of hospital, and Ivor Batchelor's part of RC12 is a particularly

good analysis of hospital work. One would have liked to see a matching analysis of teamwork in general practice, to which the commission clearly attached importance, as it did to the development of patients' *committees at group practices* and health centres. Jillian MacGuire's RC3, on the expanded role of the nurse, is more of a bibliography than a discussion of principles, but this leads the reader to other sources on a subject of major importance in both community and hospital services.

In RC11, Kay Richards discusses relationships with the social services, including housing, and the potential of joint care planning teams. The interface between the NHS and social welfare is an important concern of CHCs. Britain is fortunate in having public authorities covering the whole range of supports, from high-technology medicine at one extreme to home-help and housing at the other. Nevertheless these responsibilities are divided in our welfare state, and cooperation dependent on good communication locally between individuals is often less close than it should be. Communication failures will *not be eliminated by regulation* or by an inspectorate, but they could be minimised by better understanding at the district level — where the decisions that really affect the individual are made.

In RC8, Christine Farrell looks at health education and David Robinson writes on self-help — both subjects of concern to CHCs and areas requiring more systematic development throughout the NHS. Consumer involvement and the work of CHCs themselves are discussed in RC5.

Few people seem to realise *that in Britain we spend a* smaller part of our national resources on health care than do most of the other countries of the developed world, and Robert Maxwell's RC9 on this should end the myth that the British economy is overburdened by the NHS. The companion piece by Alan Williams, in RC10, discusses the objectives of the NHS and concludes that although these might be pursued "by means other than a tax-financed NHS"; other financing systems would "not readily encompass" the drive for greater equality of access to health services of a high standard.

Perhaps the most readable paper in the series is Rudolf Klein's RC4, *Ideology, class and the NHS*. He shows that the confrontation about pay-beds in 1974/75, an incident which did more harm to internal relationships in the NHS than anything else in the last 33 years, was unnecessary. We are still paying for that bi-lateral folly.

RC15 includes notes by three commission members — Jean McFarlane, Kay Richards and Chris Wells — discussing the relationship between hospital and community services from the social work, nursing and general practitioner points of view. These should be of particular interest to CHC members, because continuity of care and the balance between community-based care and the smaller but more professionally intensive hospital sector are the most important issues in the NHS.

Further reading

Project Paper No RC1- *Conflict and consensus- An analysis of the evidence submitted to the Royal Commission on the NHS.*
RC2: *Essays on nursing.*
RC3: *The expanded role of the nurse.*
RC4: *Ideology, class and the NHS.*
RC5: *Consumers, CHCs and the NHS.*
RC6: *NHS finance and resource management.*
RC7: *Deputising services, prescribing in general practice and dispensing in the community.*
RC8: *Health education and self help.*
RC9: *International comparisons of health needs and services.*
RC10: *Health service objectives.*
RC11: *The NHS and social services.*
RC12: *Multi-disciplinary clinical teams.*
RC13: *Aspects of dentistry.*
RC14: *The nation's health and the NHS.*
RC15: *Hospitals and the NHS.*
RC16: *Tracing decisions in the NHS.*
RC17: *Issues of manpower planning and management in the NHS.*
Project Papers are £1 plus 20p post each, from the King's Fund Centre, 126 Albert Street, London NW1 7NF. Complete set £20.00 including postage.

*Sir George Godber was Chief Medical Officer to the DHSS from 1960 to 1973.

1. *Report of the Royal Commission on the NHS*, 1979, HMSO £8. Also see *CHC NEWS 45*, August 1979.
2. *Allocating health resources*, Royal Commission on the NHS Research Paper No 3, HMSO 85p.

WAR PLANNING — *why we should refuse to co-operate*

by Diane Janes, Member, Coventry CHC

At its meeting on March 17th, Coventry CHC called on Coventry area health authority and the West Midlands regional health authority to take no action on DHSS Home Defence circular HDC(77)1. This is the Government's advice to RHAs and AHAs on preparations for nuclear war and was issued in 1977. Copies were sent to CHCs and family practitioner committees for information.

The resolution may, at first sight, seem peripheral to the work of CHCs, but, particularly now, it is of vital importance. The National Health Service Act 1977 states that it is the duty of a CHC "to represent the interests in the health service of the public in its district": By discussing HDC(77)1 and bringing it to the attention of the public and other CHCs, Coventry CHC was certainly representing the interests of the public in Coventry.

Although issued in 1977, the circular had not previously been discussed by the CHC — perhaps because the danger of war seemed far more remote then than it does now. Recently however, Coventry AHA appointed the area medical officer as "Area Health Director (designate)" in accordance with paragraph 40 of the circular, so steps are now being taken towards its implementation.

A DHSS spokesperson was quoted in the *Coventry Evening Telegraph* in September 1980 as saying "it is not our intention to alarm anyone but rather give them reassurance. We are trying to make sure that when the survivors emerge from a nuclear attack there will be a health service to cope with them". It is surely absurd to imagine that any form of health service will exist after a nuclear attack. Even more importantly, the publication and acceptance of the circular within the NHS are positively dangerous because they perpetuate the myth — which is becoming increasingly accepted — that a nuclear war is survivable in any civilised sense.

Scientists at the 30th Pugwash Conference in August 1980 came to the following conclusions. "Medical disaster planning for a nuclear war is futile. Effective civil defence is impossible. Bomb shelters under cities would be useless owing to blast, heat and radiation effects. Shelters as far as ten kilometres from the centre of even a one megaton surface explosion would become ovens for their occupants, the great surface fires would cook and asphyxiate them. At greater distance shelters would only provide very temporary protection against the high levels of fall-out. In a nuclear war one would emerge into a nightmare — water would be undrinkable, food contaminated and the economic, ecological and social fabric on which human life depends destroyed. For the survivors the risks of epidemic would be enormous, as a result of unburied human and animal corpses, multiplication of viruses, bacteria and fungi and insects which are highly resistant to radiation; and the high sensitivity of the human body to radiation".

The International Organisation of the Physicians for the Prevention of Nuclear War, a group which includes US and

Photo: Associated Press

SEVEN YEARS OF PERSEVERANCE

by Ken Jones, Secretary, Blackpool CHC

During a seven year exchange of correspondence between the Family Practitioner Committee (FPC), the Local Pharmaceutical Committee (LPC) and ourselves, Blackpool CHC has become older and wiser, and has finally disproved the tiresome accusation of "having no teeth".

Way back in November 1974, not long after the establishment of CHCs, dissatisfaction was expressed about a reduction in chemists' evening rota services within the Blackpool health district, which had taken place without prior consultation with the CHC. The CHC became aware of the problem when the CHC assistant attended a GP's evening surgery and was given a prescription for antibiotics. She left the surgery at 6.10pm, fruitlessly visited nine chemists and was unable to find out where it was possible to get the drugs dispensed.

The FPC's reaction to this was that if drugs are urgent the police can be contacted and for an additional fee to the health service, dispensing will be undertaken. The CHC believed that although prescriptions might not technically be considered urgent, patients might nevertheless be concerned to start treatment that evening, particularly if they are anxious about being absent from work.

More importantly, the FPC said that there were in fact some local chemists who did remain open late voluntarily. Gradually the argument centred on why, if certain chemists are open after GP surgeries close, the FPC could not inform the CHC of the names of these chemists — and why could not the CHC publicise their opening times as a service to the general public?

The CHC fought with two important assets — the ability to stay the course, and the power to generate adverse publicity. It has taken some 44 letters to persuade both the Lancashire Pharmaceutical Committee and the Pharmaceutical Society of Great Britain to approve the publicising by the CHC of the names and addresses of pharmacists giving after-hours service.

This may not seem to be the most significant victory of all time, particularly in those districts where publicising such information is a routine event. However the battle with the FPC, and the information which has been gleaned along the way, may prove of general interest.

The contractual services of GPs, dentists, pharmacists and opticians are administered by the FPC. What happens if there is disagreement between the CHC and the FPC, as in the case of the chemist rota service? Who arbitrates? We tried both the area health authority and the DHSS. Here are the relevant quotes:

"The Area Medical Officer stated that this (Chemists Rota Service) was a matter for the FPC and was not the responsibility of the AHA. Chemists were independent contractors. The CHC should direct their requests to either the Administrator of the FPC or the Secretary of the Local Pharmaceutical Committee." (Minutes of meeting of Lancashire AHA with Blackpool CHC, 16.1.78)

"In general however our view is that the subject of CHC/FPC relations is not a matter for hard and fast rules, but that the best results will be achieved through co-operation and the establishment of a good working relationship locally." (Letter from the DHSS, 26.5.76.)

In the event, results were achieved by the establishment of a *bad* relationship. After

Soviet scientists and doctors, came to similar conclusions in Geneva last year.

However, despite the overwhelming evidence that health planning for war is impossible, the Home Office is giving the DHSS £400,000 to distribute to RHAs for war planning purposes from 1 April this year. War planning officers are being appointed by the health service to draw up contingency plans. The North Western RHA for example advertised recently for a "war planning adviser" eligible for a salary between £12,000 and £20,000.

The DHSS is also asking each RHA and AHA to draw up its own war plan based on HDC (77)1 — possibly as a result of the glaring deficiencies shown up in Operation Square Leg (a major home defence exercise carried out last autumn, designed to simulate conditions in Britain after a nuclear attack). And a confidential draft document from Cambridgeshire AHA on war planning which was leaked to *The Guardian* only served to emphasise the impossibility of any viable war planning. It states, among other things, that medical supplies would be exhausted within hours of an attack and the public left to fend for themselves.

It seems that plans are afoot to revise the circular and it is essential for all CHCs to pressurise their AHAs and RHAs to refuse to act on Government advice for war planning. The only defence for our people is the absolute prevention of nuclear war. Any measures which encourage a "war mentality" and make nuclear war appear acceptable are against the interests of everyone. When the NHS is already in deep financial difficulty the expenditure of large sums of money on what has been shown to be futile planning only compounds the evil of circular HDC(77)1 and its apparently inevitable successor.

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adverse publicity resulting from CHC action the Lancashire Pharmaceutical Committee wrote to us "My Committee not only totally refutes, but also strongly objects to this accusation of using delaying tactics ...".

Final arbitration was achieved through the acceptance of the CHC's proposals by the British Pharmaceutical Society, and the pressure brought to bear by local chemists on the LPC as a result of the adverse publicity they were receiving.

The pharmacists in general proved amenable to constructive comment once the CHC's problem had become widely known and discussed as a result of our sustained efforts. The LPC had obviously been concerned that publicising out-of-hours pharmacy services should not give certain chemists an advantage in the sale of other items. The CHC stressed that its sole interest was to make known a needed public service, and that chemists with the initiative to provide it should not be penalised.

In the end the FPC did not provide the list of evening chemists — the CHC compiled it by contacting each chemist in the district. It is now being publicised on local radio and in the press, and has been distributed to GP surgeries and public offices. Since it was issued three more chemists have asked to be added to it.

DUSTBINS BUT NO DOCTORS

by H A Stoddart, Member, West Berkshire CHC

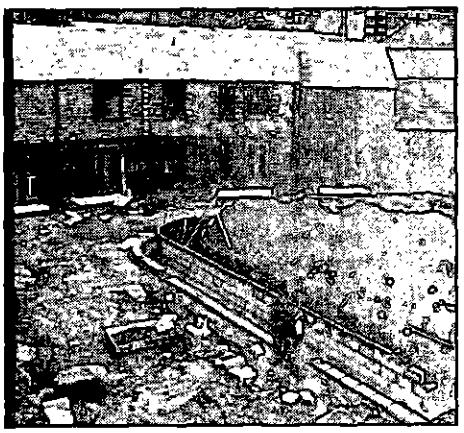
How do you hit a moving target with a projectile moving slower than the target? That appears to be the frustrating problem in attempting to provide primary care to an expanding population. This could well reach crisis proportions if "Heseltown", as it has been called, is built in central Berkshire. There are plans for an estimated 8000 additional homes and more than 20,000 people. This does not include the natural expansion of existing centres of population which in the last decade has also created difficulties.

Usually the county council in the capacity of strategic planning authority determines where building land may become available. As the development takes place ancillary requirements such as shops, schools, transport, refuse collection, roads are met. It is normal practice now to build most of the roads first in any housing development and depending on the project size shops are usually next. Services such as refuse collection are usually provided almost immediately a family moves into a new house. However other facilities which require a structural element such as schools tend to take longer. Such things as churches, community centres, doctors' surgeries and clinics come low on the list yet new development generally means young families needing ante-natal care and infant care. Why is it then that these facilities so often appear to be very late in the list of provisions for a new development area?

It is reasonable to assume that housing developments of limited size can be accommodated within the capacity of local general practitioners. Their ability to do this however depends on accommodation being available, the length of their patient list and where the new houses are located. In view of this, to achieve any success we must influence the process which makes suitable accommodation available and the conditions more attractive to general practitioners.

In our CHC's district there is an expanding area of development which includes a substantial housing estate owned by the local council. There was no accommodation available for a surgery and as the houses became occupied the provision of satisfactory primary care became more difficult. The local authority was eventually prevailed upon to allocate a council house on a temporary basis. This was done and it relieved the immediate presure. Soon a shopping precinct is to be extended and it will include provision for a surgery. The expansion of the shopping precinct means the temporary surgery in the council house has to be vacated but again the local council has come to the rescue by allowing temporary Portakabins to be erected and used as surgery premises until the new accommodation is ready in the shopping precinct.

Elsewhere we know of an expansion of about 1500 homes where the local medical practice did not have enough room to house the additional doctors needed. Land was sought and eventually one of about six sites was selected. This was owned by the local authority and was designated as land for housing. When negotiations took place it was impossible to reconcile the valuation at house-building land prices with the district valuer's price for building surgery premises. Eventually a piece of local authority land not designated for building purposes was used.



Pioneer Building

Lack of land, purchasing rules under the "cost" rent scheme, lack of suitable accommodation and the reluctance of doctors either to pioneer new areas or take minimal business risks all lead to difficulties in providing satisfactory primary care. We had hoped that the DHSS would consider legislation which would require planners to allow for surgeries in new developments. We wrote to the Health Minister Dr Vaughan, who is also a local MP; but his reply indicated that there was, in his opinion, no need for formal discussion at ministerial level. He felt that the problems outlined would be best sorted out locally.

With this in mind it should be obvious that the problem should be first dealt with at the strategic planning level and facilities such as surgeries be allowed for. The local family practitioner committee could then relate this need to a tactical plan in consultation with the local planning authority. This authority could then attempt to co-ordinate land usage through the planning process and with the developers' co-operation space or accommodation could be made available where necessary.

In addition to this, greater incentives are necessary to improve the conditions aimed at attracting practices into a somewhat pioneering situation.

Parliament

NHS reorganisation

The Government expects to have announced the pattern of the new district health authorities by the end of May. Names of DHA chairmen and members should be published by the end of September, and they will meet in the autumn as "shadow" authorities to appoint their future chief officers and begin to consider future management arrangements. Subject to approval of the necessary constitution and boundary orders, the new authorities will take over from the present area health authorities on 1 April 1982 (Dr Brian Mawhinney, Peterborough, 16 April).

Nurses in special hospitals

Secretary of State Patrick Jenkin is not prepared to introduce legislation to exempt nurses in special hospitals from prosecution over actions they take to restrain violent patients. He has "sympathy" with the nurses' anxieties but is "satisfied that it would not be right" to exempt them from the general provisions of criminal law. However, Section 141 of the Mental Health Act already makes provision for criminal proceedings arising from actions carried out in the discharge of functions conferred by the Act — including the control of detained patients — to be brought only with leave of the High Court. And the High Court should only give this permission when it is satisfied that there is substantial evidence that the person concerned acted in bad faith or without reasonable care (Joe Ashton, Bassetlaw, 3 April).

Invalid care allowance

From 1 June friends as well as relatives will be eligible to apply for *invalid care allowance* — the benefit paid to those who stay at home to look after severely disabled people. An estimated 2000 people should benefit, but children, students and married women remain ineligible for the allowance (John Hannam, Exeter, 6 May).

New but empty beds

Delays in bringing new facilities into use mean that a total of 1575 beds remain unopened in seven out of the 71 major new hospital developments completed since 1978 (Dr Roger Thomas, Carmarthen, 9 March).

Prescription season tickets

At the end of 1980 more than 5% of all the prescriptions dispensed went to holders of pre-payment certificates — "season tickets". A total of just over 600,000 certificates were bought in 1980 compared to nearly 400,000 in 1979. This is in addition to the 67% of all prescriptions which are dispensed free to those who are exempt from charges (Jack Aspinall, Kingswood, 13 April).

Travel to rehabilitation centres

If travel costs of attending hospitals or clinics providing specialist services (such as medical rehabilitation) would cause financial hardship to patients, health authorities "are required" to assist them with these expenses. Junior health minister Sir George Young has no evidence to suggest that patients are deterred from attending rehabilitation centres because they cannot get help with their fares (Lewis Carter-Jones, Eccles, 24 March).

Disposable needles

Disposable single-use needles will not be generally available to diabetic patients. Where such needles are essential on medical grounds they can already be supplied through hospitals (Gwilym Roberts, Cannock, 6 April).

Employing disabled people

Minister for the disabled, Hugh Rossi, says that the number of registered disabled people has declined so much that it is no longer possible for all eligible employers to meet the quota of 3% disabled employees in their workforce as laid down by the Disabled Persons (Employment) Act 1944. If all registered disabled people were employed they would account for no more than 1.9% of the working population. The quota system is being reviewed by the Manpower Services Commission which is expected to report back in a few months.

The Act does not cover Crown employees but on 1 June 1980 1.98% of DHSS staff were registered disabled (David Alton, Liverpool, Edge Hill, 15 April).

Waiting times for orthopaedic surgery

In March 1980, 40.4% of non-urgent cases for orthopaedic surgery had been waiting more than a year for treatment — compared to 30.6% of non-urgent cases in March 1977. Information on the number of *urgent* cases waiting more than six months or a year for orthopaedic surgery is not available, but in March 1980 82.8% of urgent cases had been waiting more than a month for treatment compared to 77% in 1977. Health minister Dr Vaughan is "not satisfied with the present position" and hopes that a recent report from Professor Duthie's working party about excessive waiting times in orthopaedics will "assist health authorities to take action within their resources to reduce the waiting times in this specialty" (John Heddle, Lichfield and Tamworth, 14 April).

What is Multiple Sclerosis?

by John Walford, General Secretary, Multiple Sclerosis Society

Multiple Sclerosis (MS) is the modern international term for what was once called disseminated sclerosis. Although we still do not know what causes it we do know that some powerful agent attacks and destroys the myelin sheath which protects the nerve fibres of the central nervous system just as insulation protects a telephone cable. As a result many of the millions of fibres that run through the spinal cord fail to carry their messages clearly and various parts of the body cease to function properly.

MS strikes suddenly without any apparent reason, it is not infectious or contagious and it is not a mental disease. In the main it is a disease of the temperate climates and is therefore more common in the higher northern and southern latitudes than in the tropics. It tends to attack younger people and the average age of onset is 32 years. It effects women more than men by a ratio of three to two.

The disease is characterised by a rhythm of attacks — which can be severe — and partial recoveries. Very often it is a slowly progressive disease although there are those cases where a patient is able to live with nothing more than a manageable disability.

It was against this background that the Multiple Sclerosis Society was formed in 1953. It has the dual aims of sponsoring and encouraging research into finding the cause and cure of MS and also providing a support and welfare service for those families one member of whom suffers with the disease. It is estimated that there are 50,000 sufferers in the United Kingdom.

The Society is structured on a network of over 300 branches and associations. All are autonomous and run by voluntary committees and now cover the whole of the country. A branch provides an understanding of the problem, advice based on experience, friendship, encouragement, a counselling service, assistance both direct and indirect, an opportunity for a social life and a sense of togetherness in the common fight against multiple sclerosis.

The Society grants money for medical research only on the advice of its medical research advisory committee which is made up of some of the most eminent clinicians and scientists in the UK. It is this medical advisory panel which considers in the first instance applications which have been made to the Society for medical research grants. To date the Society has authorised expenditure in excess of £3,000,000 for research and the level of funding in this area as with welfare is increasing each year.

The need for research is obvious, and at no time has MS been the subject of such intense investigation as at present. As a result the possibility of major advances in the search for its cause is probably greater at this moment than it has ever been.

The MS Society, 286 Munster Road, Fulham, London SW6 6AP Tel 01-381 4022/5.

Scanner

Towards standards

Is a ten-page discussion document by a Royal College of Nursing committee on standards of nursing care. In clear, easy-to-read language it sets out some concise principles for the complex task of nursing. "Nursing standards are how well an individual nurse meets an individual patient's nursing needs." The report condemns the concept of nursing as a mere collection of tasks and application of doctor-directed procedures. It identifies key factors for ensuring good standards of nursing. From Royal College of Nursing, Henrietta Place, London W1M OAB (70p inc post and packing).

Cervical cytology recall scheme: HN(81)14

The Government plans to wind up the national system for reminding women to have a cervical "smear" test. A DHSS committee on gynaecological cytology has condemned the present system, reckoning that less than one in five of the reminders sent from the Southport HQ get a response. The committee has called for the whole system to be computerised, but there is no money for this. The Government agrees with the committee's conclusion that the present scheme is ineffective and inefficient and proposes that after the end of this year no more reminders should be sent out. It is seeking views on whether to rely on GPs' individual arrangements or on local schemes run by health authorities or family practitioner committees. Comments, by 30 June, to DHSS, Room A412, Alexander Fleming House, London SE1.

Rights guide for the elderly

Age Concern has updated its excellent guide to welfare rights for the over-60s — covering pensions, rent and rate rebates, help with fuel bills, income tax and so on. *Your rights* 1981 edition, from Age Concern England, Bernard Sunley House, 60 Pitcairn Road, Mitcham, Surrey (50p).

Mental handicap

While everyone agrees that mentally handicapped people should be provided for in the community, it is not always easy to see what this means in practice. *Community services in action** offers a range of examples from different angles. There are several chapters on services for adolescents — work training, further education, sexual needs, leisure activities, as well as discussion about the needs of children.
*From the Association of Professions for the Mentally Handicapped, 126 Albert Street, London NW1 7NF (£2.50 plus 25p post).

NHS dental treatment

Is a DHSS leaflet about getting dental treatment on the NHS, what elements of it are free, who gets it all free anyway, and what to do if you can't afford the charges. The items which are free for everyone include check-ups, stopping bleeding, repairs to NHS dentures. Copies of leaflet NHS 4 from DHSS, PO Box 21, Stanmore, Middlesex HA7 1AY or from the Welsh Office.

Living with radiation

Thousands of people incur radiation risks at work — in hospitals, factories, power stations, colleges; others are exposed to radiation as patients. The National Radiological Protection Board's booklet sets out the basics of ionising radiation, the risks of harmful effects and the methods of protecting people against damage. There are sections on nuclear reactors and radioactive wastes. *Living with radiation HMSO (50p).*

Dangers of Windscale

Safety procedures need tightening at the nuclear fuel reprocessing plant at Windscale, Cumbria, according to a special Health and Safety Executive review.* The review team calls on British Nuclear Fuels Ltd to put more resources into reviewing and updating safety procedures, strengthening quality control, and implementing a safety audit.
* *Windscale: the management of safety* from Health and Safety Executive (IAS 5), Baynards House, 1 Chepstow Place, London W2 4TF (£2.50).

Household bleach, disinfectant, cough mixture, baby foods — with all these products and many more, it's vitally important to understand the instructions on the label. After two surveys conducted in adult literacy and language centres, the Adult Literacy Support Services Fund has written a report showing the difficulties some adults have in reading everyday labels. The report is supplemented by a workpack devised to teach basic knowledge about using over-the-counter medicines, household products and baby foods.
Understanding labels: problems for poor readers *from Adult Literacy Support Services Fund, 252 Western Avenue, London W3 6XJ (£2.25 inc post).*

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 5: South Bedfordshire CHC new tel: Luton 391666
Page 13: Walsall CHC Chairman: David W Bird
Page 15: Bolton CHC Chairman: Rev B Palmer-Smith, extra tel. Bolton 381179
Page 15: Rochdale CHC Secretary: Mrs Mary Turner
Page 17: Brecknock and Radnor CHC Chairman: W Pryce

Patients' rights handbook

When people are compulsorily detained in mental illness hospitals they lose many of the basic rights which other people take for granted. Larry Gostin, legal director of MIND, has written a guide to the provisions of the Mental Health Act 1959, setting out the legal safeguards which do exist. MIND's 50-page booklet covers all aspects of compulsory admission, both civil and criminal, mental health review tribunals, in-patients rights and complaints procedures. The explanations are straightforward and the booklet is aimed at patients, their relatives and friends, as well as welfare workers concerned with patients' rights. From MIND Bookshop, 155/157, Woodhouse Lane, Leeds LS2 3EF (£2.20 inc. post).

Reports in brief

All write now: Journalism for disabled people, by Pat Saunders (member of Portsmouth and SE Hants CHC), 70p inc post from RADAR, 25 Mortimer Street, London, W1N 8AB.
Guidelines on confidentiality in nursing, 75p inc post from Royal College of Nursing, Henrietta Place, London, W1.
National welfare benefits handbook: 10th edition, £1.50 inc post from Child Poverty Action Group, 1 Macklin Street, London, WC2.
Inner cities: Community services, by Chris Ham, David Towell and Jacky Underwood. £3.10 inc post from School for Advanced Urban Studies, University of Bristol, Rodney Lodge, Grange Road, Bristol.
Interim strategies and guidelines for the care of the terminally ill and those in chronic pain, free from South East Thames RHA, Randolph House, 46 Wellesley Road, Croydon.
The role of community medicine, by Professor Alwyn Smith, £2 inc post from Health Services Management Unit, University of Manchester, Booth Street West, Manchester M15 6PB.
Have you heard ....? (looks at how retired people can get involved with voluntary groups) 60p inc post from Help the Aged, Education Department, 218 Upper Street, London, N1.

News from CHCs

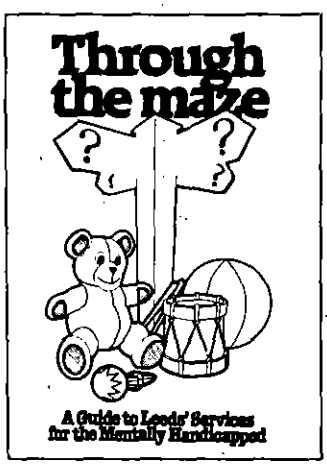
☐ **The Association of CHCs** has called for the withdrawal of DHSS circular HN(81)13, on the treatment of overseas visitors by the NHS (see *CHC NEWS 66* page three). ACHCEW says it has the strongest possible objection to the proposals, which "will place an unfair burden on employees of the NHS and on family practitioners; the necessity to make enquiries about patients will increase the stresses in hospital department and surgery alike, and the effect will be to deter residents in need of health care on account of the distasteful formalities they will have to undergo". The association's letter to the DHSS suggests that the Government should try to improve the availability of health care for UK residents overseas, as a practical alternative to "potentially discriminatory" controls.

☐ A working party formed jointly by **Haringey CHC** and the local Community Relations Council is pressing Enfield and Haringey AHA to take action on rickets in the borough's Asian population, and in other "at-risk" groups. The working party's report *Prevention of rickets and osteomalacia in Haringey* calls for an AHA campaign to increase the availability and uptake of vitamin D supplements. It argues that the emphasis on greater exposure to sunlight in the DHSS "stop rickets" campaign is misplaced, since it "might be seen as tantamount to asking people to change their cultural habits".

☐ **Hartlepool CHC** is investigating the reasons why people needing NHS treatment for mental illness are sometimes sent to prison instead. Within the last year two court cases of this kind, in which no hospital bed could be found for a violent patient, have occurred in the health district. The CHC is questioning the admission policy not only of local mental illness hospitals but also of the country's first NHS secure unit, in nearby Middlesbrough. CHC secretary Douglas Allan commented: "It bothers me greatly that people who require medical attention are sent to prison because hospitals will not admit them".

☐ **Islington** and **South Camden CHCs** helped organise a meeting at the House of Commons to discuss the effects of private hospitals on the NHS. Over a hundred people attended, and speakers included shadow health minister Gwyneth Dunwoody and **Central Birmingham CHC** secretary Steve Burkeman. A steering committee was formed to campaign against the growth of private medicine, and a full report of the meeting will be available from the two CHCs.

☐ **Walsall CHC** has called on the **Association of CHCs** to make sure that the next ACHCEW annual general meeting does not spend time discussing "wholly local issues". The decision followed a talk to the CHC by Rod Griffiths, the association's chairman, and Peter Moodie, one of the two West Midlands representatives on ACHCEW'S standing committee. Walsall is also asking the other **West Midlands CHCs** whether the defunct regional association of CHCs should be revived.



The two Leeds CHCs have published Through the maze, *a detailed guide to the city's services for mentally handicapped people. Based on information supplied by the AHA and the local authority, it contains sections on services for the various age groups, on where to go for help, on leisure activities and holidays, social security, housing, and on general financial and legal rights. Helpful explanations of services and rights make it far more than just a list of addresses, and cartoons and colour printing are used to good visual effect.*

☐ A valuable service on the point of collapsing has been discovered by **NE Essex CHC**, in a visit to a school attached to a local mental handicap hospital. The school's nursery is attended by developmentally retarded children aged three to nine, and as an experiment five teachers from the school have been paying weekly home visits to these children on a voluntary basis, supervised by the hospital's speech therapist. Parents are encouraged to join in the home teaching sessions, and also meet as a group at the hospital every fortnight. In some cases children's progress has been "phenomenal", and a video film has been produced showing how parent/teacher cooperation helped one child learn how to drink from a cup. The school's headmaster told the CHC that as things stood state funds could not be used to provide home visits of this kind, and that the scheme might fold up at the end of the year unless £10,000-£15,000 a year can be found. The CHC is helping the school in its search for charity funding.

☐ **Dudley CHC's** long-standing row with area over a local body-scanner appeal has flared up again, following publication of a scathing attack on the scanner plans in the CHC's annual report. The report points out that a scanner does not improve the outcome of cancer for most patients, it claims that the running costs will be double the official estimate of £40,000pa, and it alleges that local consultants want the scanner because they are reluctant to risk referring patients for treatment elsewhere on the basis of a diagnosis that might be wrong. A joint meeting with the AHA failed to produce any constructive discussion, and the CHC is continuing to insist that the scanner will run at the expense of Dudley's elderly and handicapped.

Reports

Other recent publications from CHCs include: *In sickness and in health*, a local guide to NHS services **(Huddersfield CHC)**, *City of Hereford: A guide for the disabled* **(Hereford CHC)**, *What can I do for my child in the early years?* a leaflet for parents *produced by* **Bexley CHC** with the help of the local Society for Mentally Handicapped Children. *The elderly in hospital*, a survey of opinions of patients, visitors and staff in three geriatric units **(East Cumbria CHC)**, *Good practices in mental health* **(Exeter CHC)** and *Health services for women* **(Central Birmingham CHC)**.

☐ Racism permeates every aspect of the NHS, according to **Brent CHC's** new report *Black people and the health service* (65p inc post from the CHC). It is not just a question of a few individuals with "nasty attitudes", but of an NHS "which in its policies and institutional practices continually makes assumptions about black people which serve to justify and perpetuate their continued exploitation". To back up its view that the NHS is not just a warm and caring arm of the state, the report looks in depth at racist attitudes amongst NHS professionals and the "new breed" of experts on ethnic minority cultures. Other sections deal with racial discrimination in NHS employment, with black people's working and living conditions, and with immigration policy and police "harassment".

Corrections

In last month's article on CHC surveys, on pages 10 and 11, we incorrectly attributed four surveys carried out by **South Tyneside CHC** to **NW Durham CHC**. They were isted under the headings *Health at work, Maternity care: Consumers' views of hospital care, Mentally handicapped people* and *Volunteers*. Under the *Chiropody* heading, "Surrey CHC" should have read *East* Surrey.