CHC NEWS

For Community Health Councils

August/September 1981 No 69

Resources on the move

Government proposals for speeding up the transfer of long-stay patients from hospital to community care have been welcomed by major charities for the elderly, mentally ill and mentally handicapped — Age Concern, Mencap and Mind.

An estimated 15,000 mentally handicapped people (a third of the total) and a possible 5000 mentally ill patients could be discharged from hospital immediately if appropriate services in the community were available, according to the Government's figures. There are also considerable numbers of elderly people in hospital who do not need to be there.

The Government sees getting mentally handicapped people out of hospital as a top priority. At present there is no incentive for local authorities to provide care in the community for people now being cared for by the NHS. So the Government has brought out a consultation paper * setting out proposals for transferring NHS resources to local authority social service departments. The specific suggestions include:

- Extending joint finance arrangements — for example, 100% NHS funding for 10 years and then a "tapering off" to local authority funding over a further five years.
- Health authorities to pay a lump sum or annual payments for each patient discharged into a local authority's care.
- "Leaseback" — the sale of a large hospital to a private owner before it is closed. The new owner leases it back to the health authority which uses the proceeds of the sale to fund the development of alternative services outside the hospital.
- Closer cooperation between the NHS and the personal social services — funds available for particular client groups might be pooled and services planned jointly.
- Central transfer of funds from the NHS budget to local government — with some kind of guarantee that they would be "earmarked" for the development of community care.
- A pool of NHS funds at central or regional level for use by local authorities for particular projects.
- Giving one of the authorities — health or local — all responsibility for providing services for a client group, eg mentally handicapped people.

Photo: Mencap

Junior Health Minister Sir George Young has made it clear that whatever is decided *no* extra resources will be available. However he is equally adamant that this is not a cost-cutting exercise — good community care is often no cheaper than hospital provision.

The document is being widely distributed. The Government says it has sought to reassure unions that although the kind of skills needed may eventually change, people will still be employed to care for the mentally handicapped and elderly if they are living in the community. The goodwill of local authorities is also crucial. They usually see "earmarking" of funds for particular services as unwelcome interference in their affairs — although the Association of Metropolitan Authorities has already agreed its members would accept it in this case.

Comments have to be in by 30 November. Depending on the response, and on ministers' final decisions, it should be possible to bring in any necessary legislation, orders or regulations quite quickly as the Government does not anticipate opposition to them in Parliament. This document applies to England but a similar one is being issued for Wales.

**Care in the community: A consultative document on moving resources for care in England. DHSS July 1981 (free).*

October issue

Publication date for the next issue of *CHC NEWS* is 2 October.

Rules are made to be broken

In spite of the *Patients first* ruling that there should be no more than one CHC for each DHA, two exceptions have already been allowed by the DHSS. Announcing the new district health authorities for the South Western Region, Health Minister Dr Gerard Vaughan said. "Exceptionally, we have also decided that, contrary to the normal pattern of one CHC per DHA, the Isles of Scilly should retain a suitably-sized community health council. We are also minded to retain the Weston-Super-Mare CHC".

● See *Reorganisation round-up*, page 14.

Your letters

The challenge of the Advocacy Alliance

Robert Sang, Co-ordinator, Advocacy Alliance, 16 Chenies Street, London WC1

The central challenge posed by the Advocacy Alliance project (*CHC NEWS 68* page three) is that, in a society which does not normally expect to provide full representation for residents of closed institutions, we propose to introduce independent lay advocates into long-stay mental handicap hospitals to work with patients on a one-to-one basis. This runs contrary to most traditional views of hospital care, and exposes us to the charge of well-intentioned interference.

Nothing could be further from the truth. A divisional nursing officer at one of the hospitals involved in the project put it very well when he told me that he saw our relationship as a *partnership*. We shall be working together to develop good communications and cooperation at all levels and in all spheres of activity, especially training. But the most important feature of this partnership lies in the nature of *resident advocacy* as we envisage it.

An advocate is an ordinary member of the community who befriends a mentally handicapped person. The advocate will learn to express the mentally handicapped person's wishes, so that he or she can obtain a better quality of life. Thus advocacy becomes more than friendship, for it allows mentally handicapped people a measure of self-determination they can rarely hope to achieve alone. Although some of our proposals are new to this country, we hope that they will come to be seen for what they are: humane and positive, and offering hope to the most isolated residents in long-stay hospitals.

We have already received some very helpful advice from CHCs, and would welcome further comments.

CHC NEWS

AUGUST/SEPTEMBER 1981 No 69

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

CHC NEWS and Information Service Staff:
DAVE BRADNEY (EDITOR)
JANET HADLEY, JENNY KEATING

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.

1982 and after

Jack Hallas, Nuffield Centre for Health Service Studies, The University of Leeds, Clarendon Road, Leeds LS2 9PL. Tel: 0532 459034.

For some years now the Nuffield Centre has run seminars for mixed groups of CHC secretaries and members. Two more such events will be held during 1981/82, on 24-26 November and 9-11 February, around the theme of "CHCs — 1982 and after".

The DHSS funds tuition and residential charges, and the only cost to CHCs is that of travel. Because there are only 18 places on each seminar, only one representative from each CHC can be accepted. Interested individuals should contact me at the above address as soon as possible.

Building Regulations and access for the disabled

Clifford Vardy, Secretary, Kidderminster CHC

It is to be regretted that the recent Department of the Environment consultation paper *The future of building control in England and Wales* (Cmnd 8179, HMSO £2.10) makes no mention of the special needs of disabled people. Architects and planners have been criticised in the past for showing a lack of understanding and/or consideration of the access and mobility needs of the disabled, especially with respect to public buildings. In view of this criticism, the basic technical requirements for the disabled should be written into the proposed new Building Regulations before they are presented to Parliament as a White Paper.

Season ticket refunds

J W Murray, Secretary, Renfrew District Local Health Council

The prescription prepayment certificate clearly states that "This sum is not refundable in any circumstances". That might have been reasonable in 1968, when it was introduced, but now that annual certificates cost £15 there should be some leeway allowed.

On 25 June the Association of Scottish LHCs passed my council's motion "that a scheme be instituted whereby refund, or pro rata refund, of fees paid for prepayment certificates, be made if the certificate is surrendered on the death of the holder". The Scottish Minister for Health, Russell Fairgrieve, has now said that he will "consider the point with English colleagues", so CHC members should be aware that refunds, either total or pro rata, are now a distinct possibility. Patrick Jenkin has to be persuaded by our Minister to alter the rules. Perhaps some CHCs will take up this matter?

Correction: Going loopy

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

Unfortunately my letter "Going loopy" (*CHC NEWS 67* page ten) contained two errors introduced during sub-editing. My letter related only to transistor radios and radio-cassette players, and it could be very dangerous for readers to try to connect loops to a TV set — as well as disastrous for the set.

The sentence "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" should have ended with the additional words "at home". The school loop already helps very much in the education of children, and my point here was that parents want a simple and inexpensive means of helping with their child's education at home too.

Hospital information booklets for children

Priscilla Alderson, Chairman, National Association for the Welfare of Children in Hospital, Exton House, 7 Exton Street, London SE1

Southend District CHC's survey of hospital information booklets (see *CHC NEWS 63*, page 12) should prove very useful to CHCs and others planning hospital booklets.

However, at least one quarter of the patients for whom the standard booklets are intended is likely to find them inappropriate and misleading. Information for *child* patients should be quite different from that given for adults on eg visiting hours, possessions to bring into hospital and overnight accommodation for relatives.

CHCs could do much to help local children by checking that children's needs are remembered, either in the standard hospital booklet or in a supplementary children's leaflet — such as the one that can be provided by NAWCH.

This association is making a survey of hospital information booklets sent to children, and we would be very grateful to any CHC which sends us a copy of exactly what is given to their child patients.

Wanted

We often publish letters from readers asking other readers for help of one kind or another. In future such requests will be published in shortened form, as shown below, in this special "Wanted" section of the Letters page.

Information on the effectiveness of "immediate care" or "flying doctor" schemes, particularly in rural areas. How many GPs are involved, and what are their relationships with the AHA, ambulance department, police etc?
– *Salop CHC*

Do any CHCs know of local plans to set up centres for assessing industrial deafness?
– *Kidderminster CHC*

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

Comment

"An amazingly inventive list" was one verdict on the Government's new proposals for transferring resources from long-stay hospital services to community care (see page one). This is probably the first time health service proposals from this Government have received such a positive welcome from the voluntary organisations and pressure groups. However, after the congratulations a few doubts creep in — can the admirable intentions of the document be implemented?

If funds are going to be diverted to local authorities for the care of particular groups the authorities will have to accept that these funds are "earmarked" and cannot be used for any other purpose. At a time when rate support grant is being cut the temptation will be to sink the extra funds into the general pool of council spending. Government action to prevent this will have to be diplomatic if it is not to alienate the authorities, whose goodwill is so necessary.

Within the NHS itself there may also be doubts, despite the enthusiasm for any proposals which would bring patients back into the community. Because the cold reality is that NHS jobs will be lost and NHS funds will be cut. It will be a gradual process, and the Government assures us that although the type of skills needed may change, the overall number of jobs will probably not alter. And it insists that this is not a money-saving exercise, merely a transfer. However, unions and administrators may have doubts about a policy that in the short-term will mean yet more cuts, perhaps without equivalent savings, especially during the interim period when large hospitals are still being kept open. The National Association of Health Authorities (NAHA) survey on joint finance (see Health News, below) shows that half the responding AHAs did not favour the transfer of resources to local authorities

No more money will be available — the Government is quite clear about that. This is worrying some people too, because underfinanced community care could be disastrous. As well as caring staff and well-equipped premises, good community care requires an intricate web of back-up services — all of which have already been hit hard by cuts in local authority spending.

Also we must not forget those who are left behind. For the foreseeable future, some patients will remain in long-stay institutions, and what resources will be available for them?

The Government's proposal to extend joint finance arrangements also raises several unanswered questions. As Tim Booth reminds us on page 11, joint finance was itself intended to help safeguard the strategy of switching resources from long-stay hospital services into community care during a period of severe restraints on council spending. But 60% of the responding AHAs in NAHA's survey have found that councils are limiting their involvement in joint finance because of the resource implications. A number of them are refusing to participate in any new revenue-incurring joint finance projects at all.

We have stressed some of the difficulties that may lie in wait for the Government's proposals. But if the will is there — and the funding — they can become a reality. This is a chance for CHCs to make sure that these proposals are not allowed to gather dust quietly in filing cabinets all round the country.

Health News

Abolish the quota?

The quota scheme for employing disabled people will be ended if the Government accepts the recommendations of the Manpower Services Commission (MSC).*

The MSC has carried out a review of the quota scheme and suggests that it should be replaced by a statutory "general duty" on employers to give disabled people "full and fair" consideration for vacancies, and opportunities for career development. An accompanying code of practice would elaborate on this duty. The legislation would apply to those employing more than 20 people, like the present quota under which 3% of employees should be registered disabled.

In making the case for abolishing the quota, the MSC discusses the decline in the number of those registering as disabled, the difficulties in enforcing the quota and the ease with which firms gain exemption. It looks at alternatives to the quota and admits that many organisations for the disabled wanted "more comprehensive and strictly enforced provisions". And certainly voluntary groups have not reacted favourably to the MSC's review. The Disability Alliance calls it "a totally inadequate response to the serious and growing problem of unemployment among disabled people" and criticises the vagueness of the proposed new duty on employers.

The Government is giving interested organisations and individuals until the end of the year to comment on the MSC's proposals. It says that it will not come to any decision until then.

**Review of the quota scheme for the employment of disabled people — a report* available from Mr M Houghton, Room W10/23b, MSC, Moorfoot, Sheffield S1 4PQ.

Joint finance surveyed

Joint finance has received a vote of confidence from area health authorities in a recent survey carried out by the National Association of Health Authorities (NAHA). Of the responding AHAs in England, 98% (two thirds of all AHAs) wanted joint finance to continue.

However, only 35% of the AHAs wanted to see an increase in the available funds for joint finance. NAHA suggests that this may reflect the problems some AHAs are encountering with local authorities who place restrictions on joint finance schemes. 60% of the responding AHAs reported that resource constraints were limiting local authority participation in one way or another — councils were either refusing to participate in future revenue-incurring schemes, introducing reduced limits on levels of revenue costs, abandoning existing schemes or renegotiating previously agreed tapering arrangements.

The idea of local and health authorities sharing long-term costs for certain schemes met with approval from 70% of responding AHAs. Likely projects would be on the border between health and social service responsibility such as "very sheltered housing" for the frail elderly and community services for the mentally handicapped. Such schemes already existed or were being planned in 37% of the areas.

In view of the new Government proposals (see page one) it is interesting to note that half the AHAs in the survey were not in favour of the transfer of resources from the NHS to local authorities. And many of the 38% who favoured this idea qualified their approval with demands for contractual agreements and arrangements for monitoring the use of transferred resources.

Several AHAs mentioned their fears that joint finance would be seriously affected by restructuring — loss of coterminosity and small budgets might lead to "a multiplicity of relatively small and unrelated schemes".

Copies of the survey report are available from Sarah Head, NAHA, Park House, 40 Edgbaston Park Road, Birmingham B15 2RT. Tel: 021-454 2669.

Regions "must be more positive" about health service supplies

A wider role in planning and monitoring NHS supplies arrangements has been given to regional health authorities in the first circular from the Health Service Supply Council. "Unless a more positive role is played by RHAs, the supply function, in which there is need for so much improvement, will not improve but will deteriorate", the council warns. On the other hand a "much stronger commitment" to efficiency and economy

Continued on next page

Health News

Continued from previous page

could cut the £100m NHS supplies bill and release resources for direct patient care, says the circular.

The supply council was set up as a special health authority in June 1980 (see circular HC (80) 1 for details), and its circular *Future organisation of the supply function in the NHS in England.* SCC (81) 2, can be obtained from 14 Russell Square, London WC1B 5EP.

CHCs' help with drug reports rejected

The Committee on Safety of Medicines is adamant in its refusal to take account of reports of patients' adverse reactions to drugs, sent in by anyone other than the patients' own doctors. The CSM monitors the safety of drugs, by relying on doctors to report untoward side-effects.

When the Association of CHCs first suggested that CHCs could help the CSM in its monitoring task, the CSM replied that no-one but a doctor had the knowledge to judge whether a patient's condition was caused by drugs or not. ACHCEW persisted, trying to persuade the CSM that what it dismissed as "anecdotal" reports from CHCs might just be valuable, "as one piece of such information may corroborate another". But the CSM insists that nothing can be fed into its system unless it has first been checked out by doctors and such scrutiny of CHCs' reports would be disproportionately costly.

ACHCEW has had better luck with another aspect of drug policy — double prescription charges. The British Medical Association has weighed in with the Association against the DHSS ruling that patients should pay two prescription charges for "duo-pack" medicines (see *CHC NEWS 64,* page six).

Another voice for NHS staff

A new NHS "trade union" — representing most of the professions supplementary to medicine — has been formed. Called the Federation of Professional Organisations, it will hold 14 out of the 22 staff side seats on the relevant NHS negotiating body, the PT'A' Whitley Council.

The FPO's member organisations represent clinical biochemists, occupational therapists, dieticians, orthoptists, physiotherapists, hospital physicists, chiropodists, radiographers and remedial gymnasts — some 50,000 people in all, mainly working in the NHS. The FPO will provide a common voice for its member organisations, and a forum for consultation with Government and other bodies. The federation's secretary is Peter Bennett, c/o the British Association of Occuptional Therapists, 20 Rede Place, London W2 4TU.

Citizens need more advice than ever

Citizens' Advice Bureaux are busier than ever before. Last year enquiries increased by 12% — the bureaux handled four million new queries. Requests for advice about social security were up by almost a third, and there was a 9.5% increase in enquiries about health.

Two new health bodies .....

Health Minister Dr Gerard Vaughan has set up a new health service quango, the Maternity Services Advisory Committee, to "advise on matters relating to the maternity and neonatal services". The new body will represent medical and nursing interests, along the lines of a recommendation of the Short report on perinatal and neonatal mortality.

The major mental health charities have launched the Independent Council for Mentally Handicapped People, to agitate for faster progress in improving mental handicap services. Its chairman is Brian Rix, the secretary-general of Mencap.

..... and a third bows out

The last report from the Advisory Committee on Services for Hearing Impaired People (ACSHIP), axed by the Government last autumn, has now been published (1).

Photo: Liz Heron

ACSHIP's Children's Sub-Committee recommends that all children should be screened for hearing at least three times — by health visitors at eight months and three years, and through the school health service at five or six. A further screen at eight or nine would be justified where a child had missed earlier screening, in children receiving special education, or in "high-risk" groups such as children in inner-city areas or with retarded language development.

The report recommends that the DHSS should make enquiries wherever the proportion of one-year-olds screened falls below 90%. It also lends strong support to the DHSS campaign to encourage women of child-bearing age to accept vaccination against rubella, which is the cause of 20-24% of all congenital deafness.

Screening personnel should have their *own* hearing tested at least once every two years, and because of the monotony of screening children for hearing impairment health authorities should not employ staff solely for this purpose.

In large cities the audiological service for children should be organised on a multi-district basis, but elsewhere a single-district service is recommended, provided there is a catchment population around 250,000.

1. *Final report of the sub-committee appointed to consider services for hearing impaired children,* DHSS June 1981, £1.35.

London's post-grad teaching hospitals to remain aloof

The future of the 12 specialist post-graduate London teaching hospitals is sealed. And the Government has taken most of the advice proffered by the London Advisory Group (see *CHC NEWS 66,* page three). Six boards of governors will become six Special Health Authorities. Two hospitals will be taken over by regular health authorities and four more will later come under DHA management, when London University has resolved the future of their associated institutes. There will be three year's protection for the funds of the hospitals which enter the NHS structure.

Hammersmith Hospital, with its associated Royal Post-graduate Medical School has not previously had a board of governors, but is now to become a seventh Special Health Authority (see *Reorganisation round-up,* page 14).

Maternity statistics

CHCs want more detailed statistics collected on antenatal care, acceleration of labour and who performs deliveries than is intitially recommended by the official body looking into health service information systems.

Earlier in the year the National Perinatal Epidemiology Unit (NPEU) sent all CHCs the draft list from the official body, the Korner Committee, of items of information needed to be gathered around maternity. It asked CHCs what they thought of this list.

So far 60 CHCs have replied to the NPEU — 48 of them say that maternity care is a major interest of the CHC.

Many CHCs would like to see extra items collected about antenatal care, and say that knowing the date of the first antenatal assessment is particularly important. The NPEU says this shows that "CHCs share the widespread concern" about the lack of information about antenatal care.

Another major area of interest was around labour itself. More information was required about acceleration of labour, drugs given during labour, analgesia and epidurals. Some wanted to know what choice mothers were offered about the place of delivery.

The NPEU has sent a summary of the CHCs' views to the Korner Committee, which is publishing a final report on maternity statistics in the autumn. And an analysis of the CHC responses is being written for CHCs by the NPEU.

Time to belt up

At last seat-belt use is to be made compulsory for car drivers and front-seat passengers. The measure should come into force in mid 1982 after the Department of Transport has consulted with relevant organisations and drawn up regulations about exemptions and enforcement.

Compulsory seat-belt wearing was approved by a majority of 77 in the House of Commons in a free vote on a House of Lords' amendement to the Transport Bill. It will be brought in for a trial period of three years.

The birth of a community plan

by Naomi Honigsbaum, Chairman, North West Kensington, Chelsea and Westminster CHC

Over the past two years our district has appeared near the top of the "league table" in all adverse reports about inner London's health care problems, from poor primary care through to double the national average for mental illness admissions. But now an exciting new social experiment may begin in a small way to tackle some of these long-term historical problems.

The experiment is the result of an initiative taken by the CHC in April 1979, following a lengthy consultation exercise on the district's long-term needs for hospital provision. This was carried out in response to an AHA plan to rebuild St Mary's Hospital, Praed Street (the teaching hospital), to close St Mary's Hospital, Harrow Road (in the centre of the district), and to upgrade St Charles' Hospital (in the north of the district). Following consultations with the public the CHC rejected the plan and then obtained a three-month delay in order to formulate an "alternative" strategy.

This gave the CHC time to carry out a random survey of 1000 people, selected from the electoral register across all the wards in the district. We also interviewed patients in outpatient departments of the three hospitals, clinics and GP surgeries, as well as members of local community groups and voluntary organisations. In a questionnaire we asked people to consider four alternative plans and to say which they preferred. These plans were based on earlier discussions with the public during the first stage of the consultation.

The vote was overwhelmingly for the plan which suggested the retaining of St Charles' (including its children's ward), the rebuilding of St Mary's, Praed Street, and the replacing of the general hospital at St Mary's, Harrow Road, with a community hospital on the same site. A community hospital was defined as a hospital where GPs could admit their own patients, and where there might also be facilities for pre-convalescents, geriatrics and mentally handicapped adults, a health centre, provision for the young chronically sick, and a minor casualty centre.

This plan was presented to the AHA as the preferred alternative proposal of the community. We urged the AHA to shift resources away from the acute hospital services, towards providing low-technology hospital services which would more appropriately bridge the gap in provision between hospital and community care.The AHA was impressed with the evidence, and agreed in principle to adopt this plan and to explore with us how it might be implemented. But although the AHA welcomed the *concept* of a community hospital, and saw it as an extension of primary care,it had doubts about the support that would be forthcoming from local GPs.

The CHC then adopted a two-fold strategy: to canvass GPs' opinions and encourage their support, for without their enthusiasm and commitment the plan would founder, and to seek a broad band of support from the relevant local agencies, including voluntary organisations and the statutory social services.

Between April and September 1979 the CHC was involved in delicate negotiations with the District Management Team, during which it established the terms of reference of a joint working party, its membership, and the time-scale for discussions. The working party consisted of myself and two other CHC members, the CHC secretary, three DMT members, one RHA officer, two local GPs, two social workers, two members from voluntary organisations and one staff representative. It began meeting in the autumn of 1979 and presented its final report to the AHA in October 1980. It met 16 times, made visits to other community hospitals, invited experts with particular knowledge to its meetings, and read much of the official literature on community hospitals. It considered every aspect of a community hospital, eg the payment of GPs, methods of funding the hospital, the level of nursing and ancillary staffing, the range of services and the catchment area for patients.

Meanwhile the CHC held two large meetings with GPs. At the first, hosted by the DMT, a doctor from the Wallingford Community Hospital described its operation, and this was very influential in persuading GPs to join in further discussions. A second meeting with local doctors was held at the CHC office, and this also included GPs from St Thomas' and Brent districts, who were also trying to establish community hospitals. These two meetings proved crucial in gaining GP support — 25 local GPs were identified who wished to participate in establishing a community hospital. These GPs formed their own working group, and fed their ideas and suggestions into the working party through their GP representatives. Similarly the CHC held meetings with a range of local voluntary organisations, and encouraged them to make suggestions about the likely needs for services alongside the community hospital.

Early meetings of the working party were rather tense and cautious. The CHC and DMT both needed time to establish confidence and trust in each other. The GPs were guarded too, suspecting that the hospital might be just a device to exploit them by discharging patients earlier to their care. What interested them was the concept of an extended and improved primary care service to their patients. But over a period of time the atmosphere of caution and hesitancy gave way to enthusiasm and growing trust. The CHC and DMT worked hard between meetings keeping all interested parties informed and in touch.

As the original ideas were explored more throughly, compromises inevitably had to be reached. The doctors decided that they could only admit their own patients to the hospital, so the CHC's plans for a "walking wounded" minor casualty service had to be abandoned. The GPs had done a survey which identified an immediate need for a 25-bedded unit, so they asked for a two-year "trial run" prior to the opening of a larger community hospital on the Harrow Road site in 1986. The CHC proposals for a health centre, outpatient clinics. a unit for the mentally handicapped, rehabilitation services, day-care provision for psychiatric patients, and day-care services for elderly patients were all endorsed by the working party.

In the end the working party agreed on a two-year "trial run" GP hospital of 25 beds at Chepstow Lodge, a small unit used for pre-convalescent patients, about half a mile from the Harrow Road site. If this trial is successful the DMT will be committed to using some of the buildings remaining at Harrow Road to provide the nucleus of a larger community hospital, with day-care facilities to be developed alongside. The CHC could not agree to the closing of the children's ward at St Charles', and this issue is awaiting further discussion.

The AHA accepted the working party's recommendations in October 1980. The DMT has now set up an operational working party, with the CHC, GPs and the DMT all represented, to establish the "trial run" community hospital. A separate monitoring group, with a CHC representative, has been set up to evaluate the trial, which should begin this autumn.

The CHC has been surprised by the enthusiasm with which its ideas have been taken up. The original plans have already undergone changes and some watering down, but many of them may well be achieved. The working party certainly introduced a new era of cooperation and communication for all the groups involved, and it remains to be seen what fruit this will bear in terms of greater involvement in the future planning of community services.

Book reviews

More than sympathy

by Richard Lansdown, Tavistock Publications £3.50.

The content of this book is summed up in its subtitle *The everyday needs of sick and handicapped children and their families.* It is a practical guide to the emotional and practical problems faced by chronically sick and handicapped children — and their parents, brothers and sisters. The author discusses family tensions, behavioural difficulties, problems facing children in hospital and sex education. He gives a full list of organisations which can help families with handicapped children in all kinds of ways — with counselling, practical aids and information, legal advice etc. He also includes detailed descriptions of the various conditions that children may suffer from — from autism to cerebral palsy to leukaemia.

This book might be useful for some parents with handicapped or sick children but many would find that it covers too wide an area to be helpful in their particular situation. It would be of much greater value to those who come into contact with handicapped children and their families and want to understand their problems better and learn how they can offer more effective help.

Images of ourselves — women with disabilities talking,

edited by Jo Campling, Routledge and Kegan Paul, £3.95

The twenty five women who contributed to this book paint a vivid picture of living with a serious disability. As their ages range from adolescence to old age all facets of disability are touched upon and real insight is gained into personal relationships, education and employment.

Common themes that emerge are the desire to live as independently as possible and the desire to be able to make the most of one's abilities. As one contributor says "There is a very firm belief by those in authority that a disabled person should at all costs have a 'secure' although boring and dull job, and once this has been secured then that is one's niche for life."

Readers will, I'm sure, quickly gain the impression that this negative, protective attitude is quite widespread and extends across all aspects of life, even — or perhaps particularly — into personal relationships.

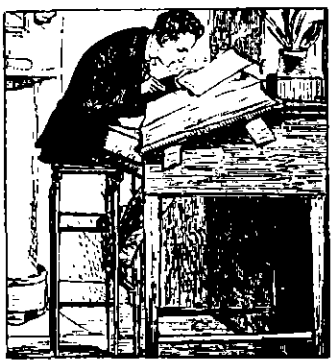
Everyone has the right to make their own decisions and mistakes and there is a great deal in this book which will help CHC members when they are discussing the needs of people with disabilities with the wide cross-section of people with whom they come in touch.

Joan McGlennon, Secretary, North Surrey CHC

The office workers' survival handbook

by Marianne Craig, British Society for Social Responsibility in Science, £2.35.

For the last 18 months I've been working every day under two fluorescent strip-lights in a



window-less office — and during this period my eyesight has sharply deteriorated. Is there a link? Probably not. But in this book Marianne Craig (who herself works at Brent CHC's office) describes in admirable detail the damage caused by the familiar equipment of the average office — and that includes fluorescent lighting, photocopiers, chairs and correcting fluid.

She makes it extremely clear that work hazards aren't just found in factories and on building sites. Office-workers suffer considerable physical and mental stress — even illness — from their work conditions. And in a separate chapter on the new technology Ms Craig looks at the new and disturbing problems caused by its use — in particular the introduction of word-processors and VDUs (visual display units).

Most office workers are women — except in the higher echelons of the average organisation. This book emphasises the particular problems facing female office workers — conflicting demands from management and children, lack of creche facilities — even sexual harassment.

However don't think this is a negative book. It has a lot to say about how to improve conditions — by working through unions, enforcing legal requirements and taking direct action. Despite the need sometimes to go into quite technical detail the book is easy to read and gives plenty of useful real-life examples of both problems and solutions. Anyone who works in less than perfect office conditions would probably find it interesting.

Jenny Keating, CHC News

In and against the state

by the London Edinburgh Weekend Return Group, Pluto Press £2.95

Most CHC people will probably not get on too well with this book, which is written from an explicitly marxist point of view by a group of eight authors, including Jeannette Mitchell of Brent CHC. It looks at the plight of socialists doing "professional" work for agencies of the state, such as teachers and social workers.

Their predicament, the book explains, is that although they would prefer to have socialism the services they provide help to smooth over some of the worst deficiencies of capitalism and to side-track people who might otherwise be persuaded of the need for drastic changes in society.

Interestingly, the book includes five pages of interview with "Joan and Kate", two CHC workers who "know that their job for the state is to channel protest into manageable forms", but also feel that they can "use their position to support the struggle for better health". Other allusions to and examples drawn from CHC work crop up regularly throughout the text.

The book does suffer from that irritating sense of infallibility which seems to pervade marxist writing, but even CHC readers not sympathetic to its politics will find that it strikes plenty of familiar chords in relation to their own everyday problems within the NHS.

Dave Bradney, CHC News

Our elders

by Muir Gray and Gordon Wilcock, OUP £4.50

The book is succinctly but aptly titled, as it examines every aspect of the physical, emotional, social and legal needs of "our elders". The authors are seeking to awaken a deeper understanding and awareness of possible new ways of helping this growing population and in this they succeed, although as usual the problem is implementation.

Chapters on the pattern of services for the elderly will be of particular interest to new CHC members — these highlight some of the continuing service shortages. eg chiropody. Medicines for the elderly and their regular review is also a topic to which CHCs might usefully pay attention.

The authors consider social attitudes towards old age and old people and the effect on their status in society due to their lower income, immobility and political impotence. There are informative chapters on the history of pensions and allowances with prospects for the future. Housing problems, the traumas of retirements, bereavement, dying and isolation are sensitively discussed as is the stress on families caring for aged relatives.

The people of this generation who will be our elders in the 21st century — having been brought up to expect much — will certainly demand more from social services, housing and health authorities. They will already be better housed and nourished than their predecessors and, having more organising power, they will undoubtedly have more political "clout". It follows, therefore that the more powerful the elderly become the stronger will their voice by heard for improvements.

I found this an interesting book although, due to its scope, there is a wealth of information to digest and each topic could be the subject of a book on its own.

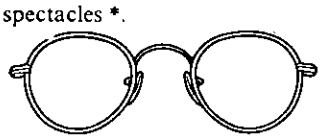
Wenonah M Hornby Assistant, Hull CHC

An eyeful of trouble

"When the time came to choose the glasses, the optician pointed to a show-case of flatteringly-lit frames. I had to insist that I wanted to see the NHS glasses. With obvious resentment, she opened a drawer of frames, all higgledy-piggledy. I felt like a pariah, but really, it's a racket, isn't it?"

It certainly seems like a racket to a worrying proportion of the people who buy new glasses. Every year in England about eight million people have their eyes tested and over six million buy new spectacles. This article explores the reasons why glasses cost so much, the range of conflicting interests and why the public is so confused about what opticians have on offer.

At the start of the NHS, glasses were free — private specs were regarded as a luxury. The Opticians Act in 1958 set up the General Optical Council to regulate opticians' work and to establish their status as independent professionals. It also made it illegal for anyone except an optician or an eye doctor to sell spectacles *.



The range of NHS spectacle frames for adults and children has hardly changed since 1948. The DHSS admission that it is not a "wide fashion choice" is an understatement. NHS glasses are no longer free, the lenses are slightly subsidised and patients have to pay almost the full cost of the frames (from £1.84 to £9.27).

Although 78% of children have NHS frames (free to those under 19 and still in full-time education), adults are often lured to the more flattering private frames, which today cost anything between £40 and £100. Frightened by friends' tales of exorbitant prices, people delay going for an eye-test, even though there is no charge for this. A survey by West Birmingham CHC found that many spectacle-wearers did not know whether they had received a private or NHS service and many who intended to obtain NHS glasses ended up with private frames for the NHS lenses. About half of all spectacles sold are now private.

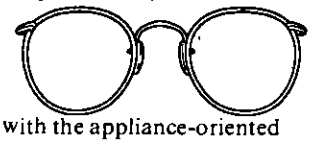
The opticians' monopoly on sales was investigated in 1976 and 1978 by the Price Commission. The 1976 report found people paying £18 for spectacles which cost less than £4 to make and both reports noted the lack of competition in the sale of private spectacles, said that dispensing them was very profitable, and vainly recommended changes.

If dispensing spectacles is such a good deal for opticians, why do we not see them all riding around in Rolls-Royces? The professionals bristle at the suggestion that they actually "sell" spectacles ("we supply them", *CHC NEWS* was told), yet all acknowledge that it is impossible to make a living out of NHS practice alone, because the eye test and dispensing fees from the NHS are so low.

The NHS pays an optician £4.50 for conducting an eye examination. This is supposed to cover practice overheads and includes £1.82 professional fees for a procedure which takes 20-40 minutes. The current dispensing fee for NHS lenses and frames is £4.45 and this drops to £2.65 if the patient chooses private frames for the NHS lenses. About 25% of patients tested do not require a prescription for spectacles. It is easy to see why opticians have been setting high fees for private dispensing and why in some practices the NHS specs are kept under the counter.

The opticians' justification for their monopoly is that before every purchase it is essential to check that there is no damaging eye-disease — such as glaucoma. At present it is an offence to sell glasses without an examination by a qualified person. The monopoly has been defended by the Government in the face of repeated pressure for a review. A Government spokesman told the House of Lords recently, "The restrictions on the testing of sight and the supply of spectacles which the Opticians Act lays down ensure ... that patients' sight is tested by practitioners who are qualified to recognise signs of eye or other disease and refer patients for early medical advice and treatment."

The system for supplying spectacles has come under increasingly widespread attack, particularly in recent months. The Jekyll and Hyde combination of the caring professional, offering a diagnosis and prescription,



with the appliance-oriented commercial operator is becoming increasingly unstable. The commercial element threatens to swamp the "patient" relationship. Now there is news that Tesco and Woolworths are considering setting up concessions within their stores, where an optician would test eyes and sell glasses. Already about half the high street opticians are corporately owned — Dollond and Aitchison, the biggest chain, belongs to the tobacco firm, Gallaghers. Several drug companies also have a financial stake in the business.

There are worries that the NHS will slip from just being subsidised by the private interests to being completely overwhelmed by them and that excessive pricing is already a temptation to excessive prescribing.

The solution which will satisfy all parties is far from easy to find. There is provision for help with the "basic NHS charges" for people on supplementary benefit and other low incomes. DHSS leaflet *Your sight and the NHS* explains that basic charges are for glass lenses and NHS frames. Plastic NHS lenses are generally only available for bifocal glasses and if you need very thick specs the NHS "choice" is non-existent. Children under 19 and still in full-time education can get NHS children's glasses free.

Several CHCs have been advising local consumers to "shop around" for their private spectacles. You may take a prescription from the optician who has examined you and go elsewhere for the glasses. But as North West Leicestershire CHC warns in its leaflet *Setting your sights*, "Please note that the cost of the NHS frame alone will not be the cost of your spectacles".

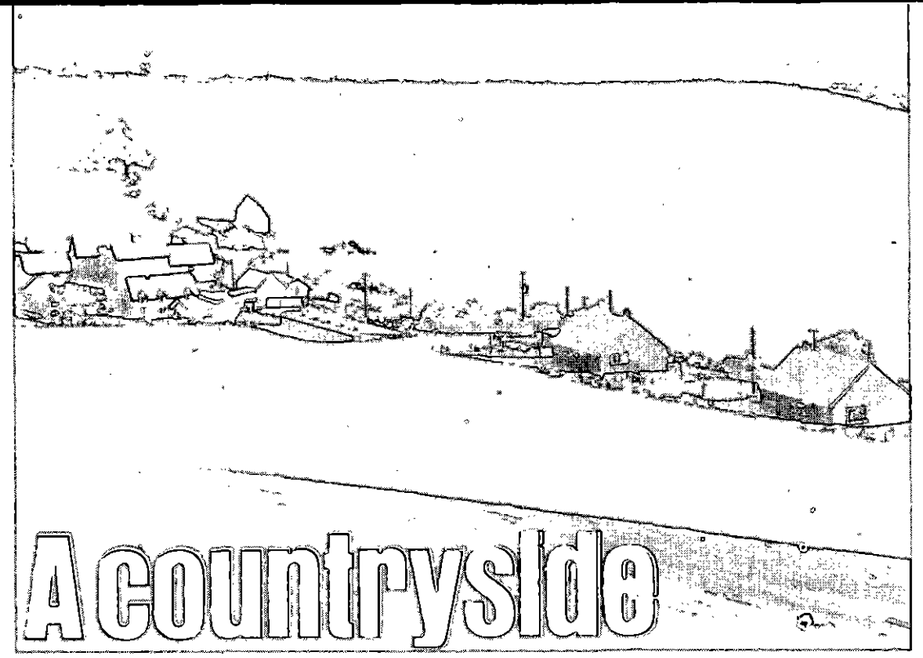
Last year the General Optical Council narrowly voted to lift its ban on displaying the price of frames, following veiled threats by the Office of Fair Trading to refer the whole optical industry to the Monopolies' Commission. Few opticians have taken up the option to show price tags. The Price Commission reports urged this move and so did the Royal Commission on the NHS.

CHCs which have looked closely at the ophthalmic services seem agreed that a system must be found which encourages a professional relationship between patient and optician and does not require subsidising by private dispensing. Consumers and opticians alike agree that the place to start is a decent NHS fee for sight tests — £10-£15 is a figure now being bandied about.

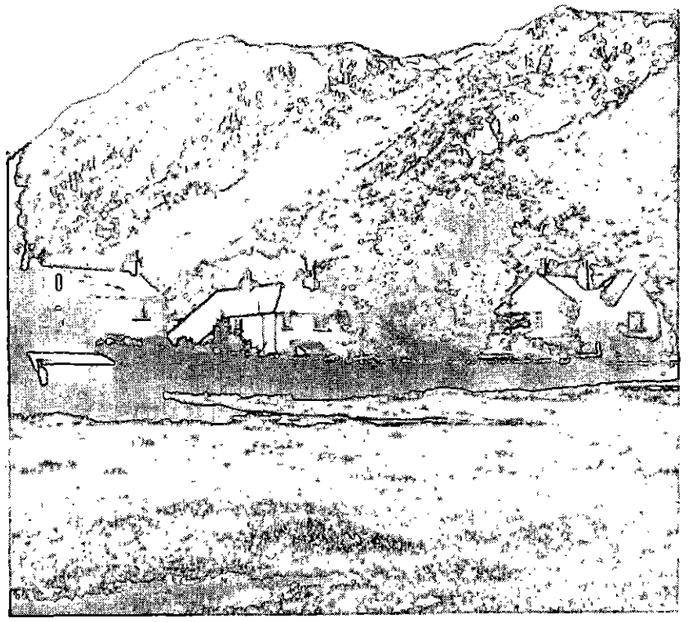
"There is scope for improvement in the range of NHS frames", as the DHSS drily admits and the Department is discussing this with the manufacturers and the profession. Whether contact lenses are also on the agenda is not known.

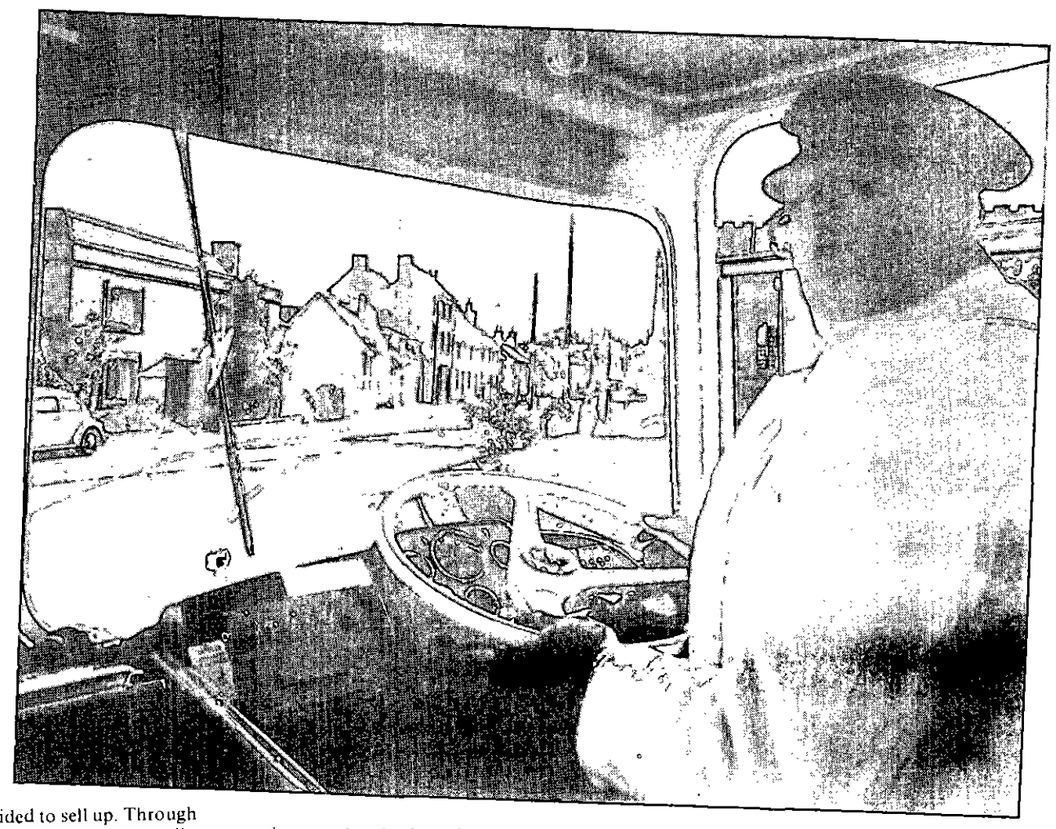
But both these improvements would cost a great deal of money. Increasing patient charges would be very unpopular and increased Government spending is highly unlikely. In many ways the encroaching of the big conglomerates into the retail end of the optical industry may actually suit Governments, or at any rate their Exchequers, and it becomes more and more expensive to halt this trend. The choice for the patient seems to be "cheap and nasty" or "nice but pricey".

* The term opticians is used here to cover what are strictly three different types of ophthalmic practitioners, in the General Ophthalmic Service — *ophthalmic opticians, ophthalmic medical practitioners,* and *dispensing opticians.* For details of what each does, see *CHC NEWS 55,* page six.



A countryside survival kit





*by Stephen Woollett**

Over the past few years, we have grown used to headlines such as "Rural services declining", "Our villages are dying", in the local and national press. Frequently rather exaggerated stories paint a pessimistic picture. But it is not so surprising if we look at some of the figures.

In Suffolk 33% of villages with a school in 1961 had lost it by 1978 and over the same period 25% of villages had lost their only shop. There is no chemist's shop in 96% of Wiltshire villages; in Nottinghamshire 85% of villages do not have a surgery; and in Gloucestershire(with a relatively high level of provision) 68% of the villages do not have a surgery. Combined with dwindling public transport the pattern is one of increasing isolation for many rural dwellers.

The higher level of car-ownership is partly a response to this decline and partly a cause of it. It is those least able to afford or to use a car who are most dependent on local services — the elderly and disabled as well as young people and those households where the husband takes the car to work leaving his wife and children trapped and isolated. Clearly the problems of mobilitiy and accessibility are especially serious when it comes to health facilities simply because those most in need are those least able to drive, or wait a long time for public transport or for a surgery to open.

There are two main reasons for the decline in services. First the providers of services have wanted to reduce costs by operating services most centrally — by closing village schools, pubs, garages and doctors' surgeries. Secondly, improved personal mobility, changes in behaviour such as shopping patterns, and changes in the social and age structure of the rural population have all led to a decline in the use of local facilities.

There are also more specific forces at work. For example rural pharmacies have been closing because of competition for the profitable sideline products from supermarkets and larger town-based chemists. The growth of group practices in health centres has forced the centralisation of dispensary facilities.

The centralisation of GP services in health centres where the cost of expensive equipment can be shared has dramatically reduced the number of small practices. In addition many doctors believe that there is insufficient financial support for the single-handed rural doctor and that the Rural Practices Fund (1) which aims to help such doctors is simply inadequate.

The decline of services in the countryside has been going on long enough to show that there is a limit to how far traditional forms of service delivery can cope with the changing demands of rural communities, and with large-scale social and economic trends. We have to turn to unconventional ways of organising services and facilities in rural areas. The task need not be so difficult for these alternatives already exist and information on them is becoming increasingly available(2).

Doctors' surgeries

For a village without its own surgery the most practical proposition is for the community itself to try to establish a part-time or branch surgery. The most common way is for the surgery to be linked with the village hall. The surgery can be a self-contained annexe to the hall or it could be, as for example in Appleton, North Yorkshire, a separate room within the hall which has been adapted for use as a surgery.

In Elham, Kent, villagers formed a community trust, gave their labour and raised money to build a doctors' surgery. In Orford, Suffolk, the village managed to keep the surgery by buying the property when the owner decided to sell up. Through voluntary contributions the parish council raised £11,000 required to purchase and renovate the property and have since established a charitable trust which now leases the surgery to a GP.

These examples reflect the importance of community *ownership*. It is clear that a community which owns a facility, through the parish council or village hall committee for example, has considerable control over how it is used. This encourages local people to have some commitment to using the place and ensuring it is improved and adapted.

Parish council involvement is another key issue. For example in Burgess Hill, West Sussex, the parish council has used its power to levy a local rate to help a GP get started in the village. Elsewhere a parish council has contributed to the running of a mobile physiotherapy unit and paid for the installation of a doctor's car radio.

Pharmacies

Few villages are able to support a full-time pharmacy. Current estimates suggest that a population of 7000 to 8000 is required before a pharmacy becomes viable. Those communities lucky enough to have a chemist's shop ought to support it as much as they can. There may be scope for an existing business, such as a general store or sub post office, to be combined with a pharmacy but this depends on willing proprietors and suitable premises. It may be possible to establish a part-time pharmacy operating a limited number of days or hours per week by a pharmacist from a nearby town or village.

For villages in remote areas dispensing by GPs is the only practical alternative. Current NHS arrangements enable patients living in a rural area and more than one mile from a pharmacy to ask their doctor to dispense medicines. In addition patients who can satisfy the FPC that they would have "serious difficulty" in obtaining medicines may ask their doctor to dispense(3).

Another solution may be a prescription collection and delivery service. Normally a collecting point such as a shop, post office or pub is agreed on and prescriptions are taken to the pharmacy and the medicines returned to the village to be picked up. Alternatively prescriptions can be collected and medicines delivered direct to individual residents.

Transport

In many villages the only means of improving access to medical facilities will be through improving transport. In the Waveney Valley, Suffolk, and in Cuckmere, in Sussex, volunteers drive the community bus and are responsible for day-to-day management and organisation of services and routes. In Shropshire and Cumbria there are "social schemes" where car owners prepared to use their own cars for regular or occasional journeys are linked with people requiring transport. Such schemes appear to be particularly suitable where a small number of people require fairly infrequent transport to a specific point, such as a surgery or hospital, and the 1980 Transport Act has lifted many of the licensing, insurance and advertising restrictions.

Others alternatives include the use of shared taxis and hire cars and hired village buses. In all cases local people are actively involved in arranging,running and perhaps financing the service. They can ensure that a bus service co-ordinates with surgery opening-hours and that local people, by having a stake in the service are more likely to use it.

Villages fight back

Community initiative in the countryside is not confined to the health and transport field. Some villages which have lost their only shop have established a community shop run by volunteers on a simple no-profit basis — in many ways a logical development of the bulk-buy clubs common in urban areas.

Village halls are increasingly being used to house part-time services such as community shops, sub post offices, clinics, playgroups and surgeries. As village schools come under threat of closure more and more communities fighting to save this essential facility are suggesting the local people directly put finance, voluntary labour and expertise into the school.

Action by CHCs

CHCs can take an active part in making communities aware of these pioneering initiatives and helping them to take action. In 1978 Aylesbury and Milton Keynes CHC undertook a survey of rural health facilities in 148 villages. Among its recommendations were the establishment of a mobile

Continued on next page

* *Stephen Woollett works in the Rural Department of the National Council for Voluntary Organisations.*

Photos: British Tourist Authority

Healthline

On the starting line

How do I find out where my local CHC is?
Look in the phone book. In 1977 the Association of CHCs arranged with the Post Office for every alphabetical telephone directory to include details of all CHCs in its area, under the heading, "Community Health Councils". Some CHCs have also arranged entries under their names, so if you know the council's name, you can look there. You could also try Yellow Pages. CHCs are entitled to a free Yellow Pages entry, under "Consumer Consultative Organisations", but not all have contacted their local telephone area office to claim this, so the listing is not complete.

No beds for elderly mentally ill

Most of the psychogeriatric patients admitted to our local mental illness hospital are only accepted on a four- or six-week "contract". Obtaining a long-term bed is almost impossible. Is such a contract legally binding and what advice can we give to relatives who clearly cannot care for the patient any more?
The legal department of MIND has advised that the contract is not legally binding but nor is the NHS acting illegally in seeking such agreements before admitting a patient. There may be a medical policy or a need to share out scarce resources amongst a great many people. Only if refusal to continue hospital treatment amounted to negligence would the patient have a legal case to bring. If relatives are adamant that they do not wish the patient to return home, then they cannot be forced. However,the patient may wish to return and may have a legal right to the accommodation. On the whole this sort of dilemma is not solved by recourse to the courts. It is better for the family to try to persuade the GP, social worker and the hospital that a local authority place should be provided.

Dentists, pharmacists, opticians

Do dentists, pharmacists and opticians have codes of professional practice?
Dentists have *Ethical and legal obligations of dental practitioners*, from British Dental Association, 64 Wimpole Street, London W1. Pharmacists refer to *"Statement upon matters of professional conduct* from Pharmaceutical Society of Great Britain, 1 Lambeth High Street, London SE1. Opticians' code of practice is still being reviewed following a merger of various professional bodies to form the British College of Ophthalmic Opticians. Contact the BCOO at 10 Knaresborough Place, London SW5. For information about the terms of service of these members of the family practitioner services, look at *CHC NEWS 54*, page 11 (dentists) and *CHC NEWS 55*, page six (opticians and pharmacists). GPs were in *CHC NEWS 53*, page six.

Home confinement

My GP has refused to have anything to do with my wish to have my baby born at home. He is on the list of doctors providing obstetric services. Is he allowed to refuse to look after me?
Yes, GPs often refuse to give medical cover to women wanting home births. The Society to Support Home Confinement's advice is don't waste time looking for a more sympathetic GP, but write straight away to the Area Nursing Officer who has responsibility for organising midwives in the area. Ask the ANO to make the necessary arrangements and state, "I accept full responsibility for my decision to give birth at home". For more information contact Society to Support Home Confinements, 17 Laburnum Avenue, Durham.

Nucleus hospitals

Where are these kinds of hospitals being built?
One has been opened, at Pinderfields General Hospital, Wakefield, Yorkshire. Seven other projects are under way at Newham, Maidstone, West Cheshire, Macclesfield, Redhill, Croydon and Ipswich.

Holistic medicine?

What do people mean by holistic medicine?
This is an umbrella term, covering all those types of "natural" medicine whose philosophy is based on treating the whole person, rather than concentrating on the symptoms as Western conventional medicine does.

A countryside survival kit

Continued from previous page

pharmacist (currently illegal), the development of a new practice for a group of villages, the setting up of prescription collection services and arrangements for a part-time surgery in one village. Many CHCs have been involved in trying to improve and maintain transport facilities. Among these are Southend CHC which has run a publicity campaign to encourage people to use and thus safeguard a bus service run from outlying villages to a hospital and Worksop and Retford CHC which has been involved in setting up a community bus scheme in North Nottinghamshire.

Burnley, Pendle and Rossendale CHC managed to get the district council to reverse a decision to refuse planning permission for a vital new surgery in Crawshawbooth. Durham CHC challenged an FPC decision not to advertise a vacancy for a rural practice, South East Cumbria CHC helped (though unsuccessfully) a local campaign to start a surgery in the Lake District village of Grasmere.

Making their services accessible to and known by the rural dweller is a problem which many CHCs must experience. In Oxfordshire the CHC has an "agency" arrangement with information centres and similar organisations for these "agents" to supply information to help the CHC fulfil its monitoring role. The CHC is provided with statistics on health queries and the agents supply information from the CHC about health services. The CHC makes a contribution towards the agents' postage and telephone costs.

It is encouraging to see that there is such innovation and imagination by people in rural communities to seek solutions to problems which they have identified. Central government, local authorities, health authorities, CHCs, and voluntary organisations need to recognise that with their support (not necessarily financial), advice, information, and a flexible attitude communities can not only fill gaps left by services which have been lost, but more importantly can improve the quality and accessibility of health care in rural areas.

Notes

1 The Rural Practices Fund compensates GPs for the extra costs involved in running a rural practice. The money is distributed by FPCs on a DHSS scale, according to the proportion of patients living beyond a certain distance from the surgery. Last year about 20% of GPs in England and Wales claimed the payments and received an average of £1400 each.

2 *Alternative rural services: a community initiatives manual* by Stephen Woollett, Bedford Square Press £3.50 or £3.95 by post from Macdonald and Evans, Estover Road, Plymouth PL6 7PZ.

3 See Statutory Instrument 1974 No 160 (Part VIII, reg 30).

Correction

In Ann Shearer's article "Institutions don't have to be this bad", published last month, the third sentence on page ten should have read: "Without such support the abuses and the dehumanisation can creep in again, unbidden".

JOINT £INANCE there for the taking

by Tim Booth, Lecturer in Social Policy University of Sheffield

Joint financing began in England in 1976/77, in Wales in 1978/79, and in Scotland in 1980. Through the scheme, limited NHS funds are available for spending on local authority personal social services where this can be expected to yield a better return to the community than if the money was spent directly on health services.

The scheme builds on the interdependence and overlap between the health and social services especially in fields such as the care of the elderly, or mentally handicapped or mentally ill people. It acknowledges that improvements in health care, and better use of health resources, may depend crucially on the level and quality of the social services provision.

Joint finance may be used to support either capital development or revenue spending (running expenses). Health and local authorities normally share the costs of capital projects, with 60% being regarded as a reasonable contribution by the AHA, though occasionally a higher proportion or even the whole cost may be met from NHS funds. In the case of revenue schemes, the AHA contribution is calculated on a tapering scale with the local authority gradually paying a greater share until, generally after five years, it assumes full financial responsibility for the project. This period of support may be extended up to seven years by agreement between the two authorities or even longer with the approval of the Secretary of State.

It was intended that joint finance should mainly be used to help local authorities fund new developments likely to benefit the health services, expand those services given high national priority, and maintain services at risk because of expenditure cuts. However, it may also be used to finance projects proposed by voluntary organisations, or for primary or community health care purposes where agreed by both the health and local authority.

How much money?

The money available for joint financing is determined nationally and AHAs are informed each year of their allocation. It is calculated according to a formula based on population and weighted to take account of the numbers of mentally ill and mentally handicapped and the proportion of elderly aged 75 and over. In 1980/81 £54m of NHS money was set aside for joint financing in England, a sum increasing to £56m in 1981/82 and £58m in 1982/83.

Set against the total budget for health and personal social services, currently about £9,600 million, the joint finance programme is clearly very small. Yet it represents a key source of uncommitted money in council budgets otherwise starved of growth. Indeed, for many local authorities it is now a vital source of finance for new construction and building work, given the squeeze that successive rounds of spending cuts have exerted on their capital programmes.

The aims of joint finance

Joint finance was intended to help safeguard the national strategy of switching resources from the long-stay hospital services into community care at a time of severe constraints on local council spending. It enables the DHSS to earmark extra resources for the social services without upsetting the local authority associations who are opposed to specific grants.

It can also be seen as providing a stimulus to joint planning by offering a financial incentive to local authorities to collaborate with AHAs in the development of their services and by easing some of the difficulties in funding joint planning proposals.

Joint finance is supposed to help to smooth over some of the long-standing conflicts between the health and social services, which erupt where their responsibilities clearly overlap — for example, in the care of old people.

Finally, it is intended to promote innovation and experiment in service delivery. Because joint finance is not tied to traditional spending categories within social service budgets it can be used to support novel ideas which are normally difficult to finance under conventional accounting practices.

Achievements

Joint finance certainly has helped joint consultative committees (JCCs) to find a role for themselves. JCCs, usually made up of local councillors and AHA members whose responsibilities cover the same area, were set up to promote collaboration, joint planning and joint delivery of services of common concern (see *CHC NEWS 50*, page five). Without joint finance many would have little to do, and in some places joint planning consists entirely of deciding how to spend the earmarked allocation.

Undoubtedly it has also helped to improve understanding and communication between health authorities and local government. And it has cushioned the social services against the full impact of cuts in local government expenditure, and even brought about an improvement in services for "priority" groups such as the elderly and the mentally handicapped.

Shortcomings

The scheme has been used by some local authorities as a pretext for curbing social services spending, in the expectation that the shortfall would be restored by the NHS. This has led to resentment by some AHAs who see themselves as subsidising the rates, and has damaged relations on JCCs.

Joint finance arguably has given health authorities a direct influence over social services policies and priorities by enabling them to reduce the costs to local councils of providing certain services. At the same time, it may divert NHS expenditure away from sectors which would have been favoured if the money had been available for spending directly on the health services. The danger is that both sides end up supporting projects that neither really wants.

Finally, joint finance has encouraged a preoccupation with short-term decisions, on how to spend the allocation for the year ahead. It has deflected joint planners from taking a longer-term view of objectives and priorities. In this way, joint financing has tended to squeeze out precisely those strategic issues with which joint planning was supposed to be concerned; though it is doubtful whether joint planning would have survived at all without the bait of joint finance.

The next step

On balance, joint finance must be judged a success. But the programme is not expanding fast enough to sustain the momentum of earlier years, and as commitments build up the flexibility of the scheme will diminish. Indeed, the Government's plan to find additional ways of transferring NHS resources to the personal social services undoubtedly anticipates the impending reorganisation of the NHS, which will fracture existing links between the health and social services and severely impede joint financing. There are widespread doubts about whether the system can survive the loss of the area tier, doubts which it seems the Government also shares.

Next month Tim Booth will discuss the problems of joint finance collaboration between authorities.

LISTENING TO COUNSELLING

by Joan Burn, Secretary, Trafford CHC

Last September Trafford CHC held a study day to consider the provision of care for the young mentally handicapped in the community. It was attended by parents, members of voluntary organisations, CHC members and a representative from the area health authority.

The group was small but vocal, and the day was organised through informal small group discussions to enable participants to express and share their ideas. Several main issues emerged from the day: communication, information, and the relationship between parents and the professionals who provide the services.

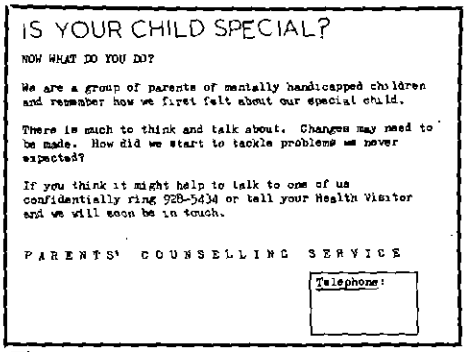
Arising from the report of this study day, the CHC was asked to host a follow-up meeting of parents and professionals to discuss several of the recommendations — particularly the one relating to the setting up of a *volunteer parent counselling scheme.*

Two main problem areas for parents were identified: information and support. Various ideas were discussed for providing a counselling and support service which might "bridge the gap" between parents and the professional services already in existence, and so meet these unfulfilled needs.

After considerable debate it was generally agreed that parents themselves would be able to provide this service, since they had the day-to-day experience of caring and could identify with both parents' and children's needs.

The scheme was defined as a service which could be provided *by* parents *for* parents, *additional to* and *linking with* the professional agencies for mental handicap services. It was felt that much information is gleaned through hard-won experience, and only parents have access to this information.

The idea was subsequently discussed in greater detail, and advice on the role and function of a volunteer counsellor — as distinct from the professional carer — was sought from professionals concerned with the care of the mentally handicapped. A steering committee was appointed to consider the functions of the parent counsellor, and to establish criteria for selecting and training volunteers for the scheme.


IS YOUR CHILD SPECIAL?

NOW WHAT DO YOU DO?

We are a group of parents of mentally handicapped children and remember how we first felt about our special child.

There is much to think and talk about. Changes may need to be made. How did we start to tackle problems we never expected?

If you think it might help to talk to one of us confidentially ring 928-5434 or tell your Health Visitor and we will soon be in touch.

PARENTS' COUNSELLING SERVICE

Telephone:

This card will be enclosed in a revised handbook for parents of mentally handicapped children, now being prepared by Trafford Social Services Department. Parents involved in the counselling scheme feel that an up-to-date handbook about services is a vital communications link.

The main functions of a parent counsellor were defined as:

- Providing a link with the professional agencies,
- Assisting parents to tap existing sources of knowledge and information , and
- Answering the basic questions: What do I do? Who do I go to? and How do I go about it?

One of the senior clinical psychologists in our area advised the steering committee at each stage, and was responsible for the training programme.

One crucial question emerged from the discussions on the launching of the scheme — how should it be introduced to parents? It was obvious to all who were involved that this must be done with sensitivity, and as part of the total service. Confidentiality is another very important factor.

We were all very fortunate at this stage to have the cooperation of one of the senior nursing officers, who agreed to include a card giving details of the scheme (shown above) in a handbook specifically prepared for parents of mentally handicapped children by the AHA and social services. The first point of contact with the scheme for parents will be the health visitor.

Our involvement with this scheme has brought the consumer face-to-face in an informal setting with the providers of the service, giving parents a new understanding of the role of the "professional". It has demonstrated that cooperation is the keynote for a more comprehensive service, and it has shown that extra resources in hard cash are not always needed to "plug a gap" where there are untapped resources within the community. Finally it has highlighted the role of the CHC in acting as an "honest broker", by bringing together various groups.

Further reading

Report on study day: Caring for the young handicapped in the community, Trafford CHC.

PENALISING

by Marie Dukelow, Secretary, Sutton and West Merton CHC.

It is a common belief that the NHS offers free hospital treatment to all who need it, regardless of means, and indeed when it was set up it was intended to be "free at the point of delivery".

Yet there is one group in the population — the elderly — whose members are required to pay should they occupy a hospital bed for more than eight weeks. Their DHSS pensions are reduced regardless of any commitments to the maintenance of their homes, and no account if taken of the fact that rent, rates and household bills still have to be met.

The elderly owner-occupier needing a long-term NHS bed is particularly disadvantaged. One of the first questions asked after — and sometimes before — admission of an elderly patient to hospital or long-term Part III accommodation provided by social services is whether the patient is an owner-occupier. Should this be the case, it is suggested, sometimes not very kindly, that the house be sold and the proceeds used to pay nursing home fees.

But for those who live in rented accommodation, whether council or private, local authorities and the NHS have a duty to provide appropriate facilities.

For elderly owner-occupiers there are no geriatric long-stay beds. They are people who have been ruggedly independent throughout their lives, nurturing the hope that there would be something to pass on to their children when they die. Had they depended on the local authority for housing or spent their income on pleasures many take for granted — such as holidays — the state and the NHS would have taken care of them in their declining years. Most have borne the burden of a mortgage and its related expenses and now their thrift is penalised. They are faced with the cost of a bed in a nursing home of at least £100 a week — and for an indefinite period.

This latter aspect is even more disturbing for how long will the money last? The interest on capital is unlikely to cover the fees, and capital itself has to be used. Even at £100 a week this represents £5000 pa and many elderly people can live for years in nursing homes.

In Sutton and Merton, with 21% of the 279,000 population over 65, there are several patients in private nursing homes whose capital will become exhausted during the next few months. The DHSS claims that this is not their responsibility, and Social Services has no funds to bridge the gap between pensions and nursing home fees. One hesitates to envisage the attitude of nursing home owners (who are

PARENTS PLANNING

by David Mumford, Convener, Mental Health Sub-Committee, Darlington CHC

Darlington CHC's first open meeting about mental handicap services was held in March 1980. Around sixty people attended, the majority being parents, but with people also coming from health, education, social services, the CHC and voluntary organisations.

We had decided to call the meeting as a result of some members attending a conference in Northumberland in late 1979, which opened our eyes to what other authorities were doing in the field of mental handicap. The CHC had been visiting Aycliffe Hospital, the local mental handicap hospital, and had assisted individuals, but we also wanted to establish a "shopping list" of further proposals as a basis for further discussions with the statutory authorities, and to gain some idea about "consumer" priorities.

At the March 1980 meeting the need for adequate counselling and support for the parents of mentally handicapped children was stressed, as was the need to produce a booklet which would give details of all the services available locally, and to appoint a "key worker" to coordinate services for families. It was also felt that a district planning team should be established for mental handicap services.

Problems of full involvement of parents in the assessment of their children were mentioned, and the need to inform parents in writing of the results of such assessment was underlined. The need for short-term "respite" care, to give parents a break, was expressed very strongly by some of the parents. The local adult training centre had too few places, and concern was expressed at the shortage of further education opportunities. These and other points provided clear guidelines for the CHC as to the areas where we should be pressing for action.

During the summer of 1980 we found that we were pushing against a health authority door that was already more than half open. Aycliffe Hospital produced a forward planning document which included the establishment of a community unit in Darlington, with short-stay beds as part of the unit. A district planning team, with a CHC representative, was set up in spring 1981, and a working party to produce a booklet on local services is now in being.

Photo: Raissa Page

The second meeting was held in October 1980, and this coincided with a visit from the Development Team for the Mentally Handicapped. Having had the first meeting, we were able to present to the team a clear picture of needs in the district, and we are currently awaiting its report.

By spring 1981, when the third meeting was held, the meetings had become an established and invaluable aspect of the CHC's work and we agreed to continue to convene them every six months. By this stage the CHC had also established a mental health sub-committee, and the mental handicap work of this committee was greatly strengthened by these meetings. At our last meeting discussion ranged from the need to attract funds to develop a horticulture section at the adult training centre, to educating ourselves by hearing about ways in which mentally handicapped children can live in small groups in ordinary housing, instead of hospital.

Although some of our aims have been achieved or are being worked towards, others are being held back because the statutory authorities are not persuaded of their value. Recently the CHC expressed its disquiet at the very disappointing result of a working party between the AHA and the count council, on the possibility of appointing a "key worker". The working party had taken three years to report, yet was still unable to recommend that this post be created.

The CHC now has a clear strategic idea about how mental handicap services should develop in the district, based on the direct experience of users of the service. Some parents are unwilling to criticise shortcomings for fear that their criticisms would be personalised, and that in some indefinable way their children might suffer if they spoke out. Yet the CHC can pursue these problems without any such fears, provided it has good communications with users of the service.

THE THRIFTY?

invariably not philanthropists) when told that there are no more funds. There are waiting lists for nursing homes and no shortage of patients; there are limits to the generosity of charities; the patients' home has been sold; the NHS and local authorities have waiting lists for their places — so what will happen to these patients who have contributed to the NHS throughout their lives?

While most GPs can find a bed somewhere if immediate treatment is required for an elderly patient, this is usually in a medical or surgical ward, and a few days later the patients are reminded that they are "blocking beds". Pressure on them to return home or to a nursing home continues even if the house is shared by a spouse or son or daughter. It may be suggested that the latter can live elsewhere and sell the property — but why should they? It is their home as well!

Another problem is the shortage of short-term care for the elderly in Sutton and West Merton. This means that if one period of short-term care has been provided during the year, an application for a second short period of care made as a result of a family emergency (such as the carer being admitted to hospital) might be refused on the grounds that the patient has already had that year's "ration" of geriatric care.

The marked deterioration in meeting geriatric needs in recent months has attracted the attention of the media and I accepted the BBC's invitation to speak on *You and Yours* about the discrimination against the elderly. I pointed out that there were no other groups in the population subjected to such pressures — for example the young chronic sick. Those in Part III accommodation pay according to their means (for which any house they may own is taken into account). Should they refuse to sell it a charge is made against the estate after their death for the cost of their care. An elderly owner-occupier needing NHS care is not even offered this option — there is only a private nursing home.

I was then invited to appear on *Nationwide*. As a result of these appearances the BBC and ACHCEW received many letters confirming this situation all over the country, and I was inundated with telephone calls and approaches from people in the street asking how this discrimination against the elderly owner-occupier could be halted.

As far as the elderly are concerned it seems that the private sector is welcomed by the NHS — effectively relieving it of some of its statutory responsibilities. Doubtless, while elderly patients are in private nursing homes they are "out of sight, out of mind".

REORGANISATION
-the story so far

As the dust settles, the shape of the new district health authorities is more or less clear. At the time of writing the Secretary of State has yet to announce the chairmen's names, and at all levels of the NHS mighty confusion still reigns — about liaison with FPCs, local government, what has to be done before 1st April 1982 and what can be left till after. The fate of CHCs seems low on the list of decisions to be made, and the regions are mostly waiting for the DHSS to pronounce on role and membership issues.

There is only room to give a round-up of the picture for CHCs, whatever the merits of the mergers and boundary changes. The ministers' ruling has been one CHC to each new district health authority (DHA). So far the only exceptions to this have been made in the South West — Isles of Scilly CHC and Weston CHC are to stay, giving two CHCs in their respective DHAs. East and West Somerset will follow the rule and merge. Since 1974 in the Northern region there have been two CHCs in one Cumbria district — SE and SW Cumbria CHCs. These two are fighting plans to merge them.

Extra CHCs will be needed to monitor new DHAs in Oxford, East Anglia and North Western regions. Aylesbury and Milton Keynes will split, Huntingdon DHA will emerge from part of Cambridge district and Preston will divide to form a new Chorley and South Ribble DHA.

In Mersey some boundary juggling means that South Sefton CHC will be renamed Walton and Fazakerly CHC. The districts of North and South Wirral have already merged, leaving an "extra" CHC — a CHC merger will tidy things up. In all, Mersey will lose one CHC.

In Wessex, West Midlands, and Yorkshire the CHCs will remain undisturbed. The same goes for Wales, though the Welsh reorganisation is a special case. But there is turmoil in parts of Trent and in London. Five CHCs are under the axe in Trent. Central Derbyshire is paired with South Derbyshire, North and South Nottingham are to form one DHA, as are North and South Sheffield. A monster DHA (pop 840,000) is in store for Leicestershire — a three-district merger.

Away from London, the four Thames regions look much as before. But in and around London, the old sores of inner city deprivation and the teaching hospital have been strangely treated. The DHSS decision overrules its own enjoinder to RHAs not to tamper with regional boundaries. Two CHCs' patches are to cross regional boundaries. London will see few stunning gains for the principle of co-terminosity.

Kensington-Chelsea-Westminster NE CHC (NW Thames RHA) will pair up with South Camden CHC (NE Thames RHA). North Surrey CHC, reprieved from a merger with North West Surrey, leaves SW Thames and will merge with Hounslow CHC to shadow a new Hounslow and Spelthorne DHA (NW Thames RHA). In SE Thames the merger of Guy's with Lewisham gets the green light and the region loses one CHC. NE Thames also loses one, as Barking and Havering merge.

North Hammersmith CHC's fate after 1 April is in the balance, due to the creation of a temporary Special Health Authority for Hammersmith Hospital. This post-graduate teaching hospital will be run by a board of governors, which will also run the former North Hammersmith district's services until a permanent solution is agreed. Potential for chaos here seems unlimited, and the monitoring and patient's friend role of the CHC is unclear. But the CHC thinks the decision is a progressive one, in the interests of eventual co-terminosity. Also in NW Thames, Barnet/Finchley CHC is to merge with Edgware/Hendon. Edgware is pleased, Barnet is dismayed. Views also differ about the virtues of mergers in Sheffield and Nottingham. On the other hand the three Leicestershire CHCs are putting up a solid fight against the idea of just one CHC for the whole county.

CHCs have clearly paid a key part in influencing the outcome of reorganisation. Weston and North Hammersmith lobbied successfully, and Redbridge and Roehampton also got more or less what they wanted, in the teeth of RHA opposition. Where the DHSS has overruled RHA proposals local (Tory) MPs' pressure is sometimes detectable.

Where there are to be mergers, CHCs are worried about the increased workload which they are likely to have to face with a reduced membership. Where boundaries have shrunk, CHCs are all anxious about the dangers of losing resources in the annual hand-outs.

If no more Weston-type exceptions are made by the DHSS, there may be as many as 12 fewer CHCs at the end of the day. Major change will hit around 25 CHCs.

Parliament

Delay for overseas charges plan

The Government's plan to introduce regulations for charging overseas visitors for medical care has met a setback. Instead of implementing proposals in October the DHSS has set up a working party to advise on "how best to operate a scheme combining simplicity and fairness while minimising abuse" (Dr Brian Mawhinney, Peterborough, 30 June).

Pensioners on the poverty line

In 1980, 21.4% of retirement pensioners in Britain were receiving supplementary benefits, including supplementary pensions (Tony Speller, North Devon, 29 June).

Cash from prescription charges

In 1980/81 financial year, an estimated 7% of the cost of NHS pharmaceutical services was recovered through charges for prescriptions. In 1979/80 4.9% was recouped this way (Dr M S Miller, East Kilbride, 9 June).

Homoeopathic hospital to stay

The Government has renewed its commitment to retaining the Royal London Homoeopathic Hospital as a "general homoeopathic hospital". If the operating theatre has to close for safety reasons, surgical facilities will be available at a nearby hospital (Baroness Jeger, 1 July).

Half a loaf for the disabled

The Disabled Persons (No 2) Bill has completed all its stages in Parliament, but in a very different form from the way it began. Its sponsor, Dafydd Wigley MP, originally sought to make enforceable the sections of the 1970 Chronically Sick and Disabled Persons Act which require plans for public buildings to incorporate access. The Bill also sought to make Section 1 of the 1970 Act legally binding, requiring local authorities to keep a register of disabled people.

But the Bill no longer contains such provisions — Mr Wigley withdrew the clauses under heavy Government pressure. The legislation now makes it an offence to misuse the disabled drivers' orange badge (maximum fine £200) and increases the fine for wrongfully parking in a disabled drivers' space. New public halls must be wired with induction loops to help deaf people.

Finally, if developers provide no access for the disabled in plans for public buildings, the burden of proof is to be on them to show that such access would be unreasonable or impracticable. The Government is to appoint a body to decide on such cases, but there will be no sanctions for flouting the law.

Death grant

A 500% increase in the death grant would be needed to restore its value to the 1949 level. The present grant would have to rise to £180, costing £85m a year more than at present. (David Young, Bolton East, 16 June).

Generic prescribing

The proportion of NHS prescriptions written in generic form (approved name rather than trade name) is:

1976	19.9%
1977	19.7%
1978	19.6%
1979	19.6%
1980*	20.1%

* *Ten months only*

(Lewis Carter-Jones, Eccles, 8 June).

Scanner

After IYDP — what ?

An excellent summary of the facts and figures of disability in Britain makes a gloomy forecast about what the 1980s have in store for disabled people. The Office of Health Economics predicts that economic recession and social service cutbacks may reverse the limited gains which disabled people have enjoyed in the last ten years. It is sceptical about the hopes that charities will be able to stop the gaps. The report stresses the plight of the elderly who become disabled, but are regarded "merely" as elderly. *Disability in Britain: the processes of transition* 30p from OHE, 12 Whitehall, London SW1.

Help for children in hospital

"To a toddler three days in hospital seems much the same as three months", says the National Association for the Welfare of Children in Hospital. This handbook could help ensure that a child remains confident and co-operative while in hospital and is a guide to the rights of parents and children. *Your child in hospital: a parent's handbook* (40p + 20p post) from NAWCH, 7 Exton Street, London SE1 8UE.

Mental handicap books

The Campaign for Mentally Handicapped People has published a reading list, divided into sections which trace the course of a mentally handicapped person's life. The list summarises each book and says why CMH thinks it worth including. From CMH (40p inc post), 16 Fitzroy Square, London W1P 5HQ.

Meeting mentally handicapped people

There are so many enquiries from school students for information about mental handicap that CMH has published an excellent straightforward leaflet which deals with the most frequent sorts of queries. It also explains how you might go about getting to know a person with a mental handicap. For a single copy, send a stamped addressed envelope to CMH (address above).

Mental health blockbuster

MIND has published a 600-page reference book, combining directory information — health services, social services, voluntary organisations — with statistics, reading lists, summaries of the law, articles about mental illness and services for the mentally ill and mentally handicapped. The book will be updated each year. *Mental health year book 1981/82* £12.95 (inc. post), MIND Bookshop, 155/157, Woodhouse Lane, Leeds LS2 3EF.

Always say goodbye

"Remember to say 'goodbye' when you leave a blind person so he is not left talking to himself." This is one of points made in two leaflets which aim to bring home to the able-bodied during IYDP some of the problems facing deaf and blind people — and some of the simple ways in which life can be made easier for them, such as facing the light when talking to a deaf person to facilitate lip-reading. Available from IYDP, 26 Bedford Square, WC1B 3HU Tel: 01-636 3464.

Hot off the press

Community newspapers come and go, but with the help of this book, your publication could come to stay. This is a guide to editing, printing, funding and running a community newspaper, but is

full of tips for anyone planning a bulletin, newsletter, etc. *Community newspapers* by John Rety, £1.15 (inc. post) from Inter-Action Inprint, 15 Wilkin Street, London NW5.

Affairs of the heart

Coronary heart disease is the most frequent cause of death in middle age (and beyond) in the United Kingdom. Numerous reports from Government and the medical profession have pointed to the need for changes in our diet, smoking and lifestyle, which could reduce the deaths. Now the Coronary Prevention Group has been formed to campaign for action on prevention. Its leaflet gives more detail. Coronary Prevention Group, Central Middlesex Hospital, London NW10 7NS.

The Ombudsman's year

Complaints to the Health Service Commissioner, Mr Cecil Clothier, went up by 15% last year, though the proportion which he had to reject as outside his jurisdiction fell. The 1980-81 annual report records the first formal enquiry by a Health Ombudsman, with the parties legally represented and evidence taken on oath. Highlighting individual cases of particular interest, Mr Clothier notes the importance of giving parents full and clear explanations of what is happening to their children. He also urges health authorities to check that they are following the DHSS guidelines on handling patients' money. *Health Service Ombudsman Annual Report 1980-81*, HMSO £2.90.

Congenital hypothyroidism screening: HN(81)20

Asks health authorities to adopt a screening policy for this condition in babies. It can be treated and the screening is simple. A national screening programme could prevent about 50 cases of mental subnormality each year.

Who's holding the baby now?

Is the title of the Spastics Society's highly critical report on the Government's maternity services policies. It attacks the DHSS for not increasing spending as was recommended last year by the Short Report on perinatal and neonatal mortality. Taking issue with the Government's reply to the Short Report, eleven baby care specialists assert that "the arguments for an immediate allocation of special funds are overwhelming and irrefutable". The report covers the neonatal intensive care service, midwifery, and prevention of handicap. From the Spastics Society, 12 Park Crescent, London W1N 4EQ (75p + 20p 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 2: Northumberland CHC Chairman: Coun. Mrs E Tully. Secretary (from 1 October): Patrick Conway.
Page 3: South Tyneside CHC Chairman: Mrs B Bolam. Secretary: Mrs Carol A Knock.
Page 3: Beverley CHC Chairman: Mrs P M Byass.
Page 7: Mid-Essex CHC Chairman: G Bowden
Page 8: Enfield CHC Chairman: John Billings
Page 11: Exeter and District CHC 94 Sidwell Street, Exeter EX4 6PH. Tel: unchanged.
Page 14: Halton CHC Chairman: Father Oliver Simon.
Page 16: Clwyd North CHC Chairman: Mrs Barbara Howell.
Page 16: Pembrokeshire CHC Chairman: W R Stocker.
Page 16: Rhymney Valley CHC Chairman: Mrs C A Norman.
Page 17: North Gwent CHC Chairman: Coun. D W Puddle.
Page 19: West Midlands Association of CHC Secretaries c/o Walsall CHC, Third Floor, Permanent House, 1 Leicester Street, Walsall WS1 1PT. Tel: Walsall 33970. Secretary: Miss June Smith.
Page 22: Dundee LHC Chairman: Mr J Martin.
Page 24: The Association of Welsh CHCs Chairman: Desmond Perkins.
Page 24: Scottish Association of LHC Secretaries renamed The Society of LHC Secretaries. c/o Stirling and Clackmannan LHC, 62 Upper Craigs, Stirling. Tel: 0786 71550. Secretary: Mrs S W Eunson.

News from CHCs

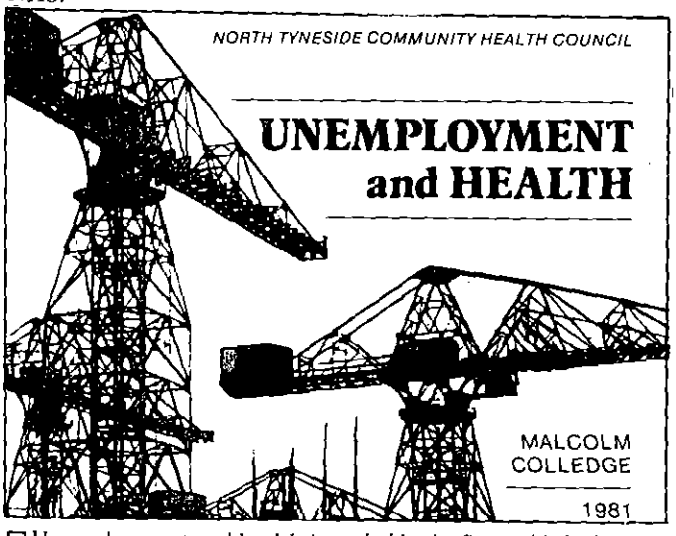
☐Did the enforced move from St Benedict's Hospital in South London last September increase the death rate among its elderly ex-patients? The AHA commissioned a study about these patients which shows that after the evacuation the death rate was "significantly higher than usual" but says that "it is not statistically proveable that this pattern was determined by tthe closure".

Wandsworth and East Merton CHC was so concerned about the AHA's dismissal of the increased death rate that it commissioned an independent commentary on the AHA's report from a medical sociologist, Geoff Rayner. He made severe criticisms of the methodology and analysis in the report and said that it "confirmed the view" that the move led to an increase in mortality, although it was "presented in a way liable to obscure this basic fact". The CHC sent Mr Rayner's comments to the RHA, which it says has virtually ignored them. The CHC is now worried that the AHA's report on St Benedict's will be used to justify other enforced evacuations of geriatric patients.

☐Despite the short consultation period many CHCs sent comments to the Government on its proposals for charging overseas visitors for NHS treatment. Opinions varied — some thought the measures would be divisive and impracticable, others generally accepted them. **North** and **South Camden** and **Islington** CHCs are so worried about the regulations that they are sponsoring a public conference on 12 September to discuss ways of opposing them. **Dudley CHC** on the other hand agrees with the Government's "basic premise" and has strongly criticised the **Association of CHCs** for making adverse comments about the measures without finding out what the majority of its members thought.

☐**Swansea and Lliw Valley CHC** has discovered that an implied threat to CHCs from the Government was really just a "misunderstanding". The CHC took exception to the proposal in the English and Welsh consultative documents on CHCs that CHCs should not "extend their role formally to providing an individual service to complainants". As secretary Brian Maunder pointed out in *CHC NEWS 65* page 12, there is no question of CHCs *extending* their role to assist complainants — this is already part of their role. The CHC complained directly to the Government and to a local MP who has now had a letter from Welsh Under Secretary Wyn Roberts admitting that the Welsh document "might have been worded differently to avoid misunderstanding" and was intended to state that it was not proposed to extend CHC's role along the "patient advocate" lines discussed by the Royal Commission on the NHS.

☐**Cambridge CHC** had strong criticism for the geriatric wards at local Fulbourn Hospital. After several visits members said "Few of us would be happy to contemplate admission or to see one of our relatives cared for there". Staff were "gentle and courteous" but "bad ward environment", washing and toiletting facilities that are sometimes "little short of being disgraceful", lack of nursing aids and an acute shortage of staff "make their already difficult task even more demanding and unenviable". There has been considerable press and public interest in the CHC's report and the AHA will be discussing it in the autumn.



☐Unemployment and health *is probably the first published review of the research into the links between the two – and it has been produced by* **North Tyneside CHC.** *The CHC commissioned medical sociologist Malcolm Colledge to carry out the survey. He looked in general at the current literature on unemployment, and in particular at health and social problems in North Tyneside. Unemployment is seen as one of the factors involved in deprivation – though Colledge says that "it is almost impossible to determine single cause-and-effect relations". He concludes that "the clear message of all the studies is the need for positive action in certain specific geographical areas of multi-factor deprivation" such as North Tyneside.*

☐When **Bromley CHC** contacted other CHCs who have been active in promoting well-woman clinics it found that despite all the publicity the clinics have received they do not appear to have taken root as part of standard NHS provision except in Islington. In other districts they seem to be barely more than cytology clinics — counselling sessions are only provided outside the NHS, for a fee. Bromley found this "a most disappointing result" and notes that "earlier impressions that such clinics were a fairly normal feature must be wrong".

☐Expectant mothers who are working should be given a hospital leaflet to give to their employers, drawing attention to the legal rights to paid time-off for antenatal care. This is the priority recommendation by **Macclesfield CHC**, which asked 126 maternity in-patients for their views on antenatal care. The CHC's survey also brought to light delays for patients between visiting the GP and first clinic visit. Of 28 patients who were not seen at the clinic until after 20 weeks of pregnancy, 22 had visited the GP before 12 weeks. The survey *Antenatal care in pregnancy* was done with the cooperation of the hospital and staff handed out the questionnaires.

☐For a long time **South Gwent CHC** pressed its area health authority to publish a strategic plan of services for the mentally ill and mentally handicapped. Last year there emerged what CHC secretary Emrys Roberts describes as a "flimsy document, full of good intentions, but in no sense a plan". The AHA called this an area policy. The CHC has now obtained the help of a student from Brunel University, who is preparing a set of suggestions which the CHC will ask the AHA to consider for a strategic plan. The CHC will be looking at referrals, assessment, treatment and rehabilitation.

☐In Scotland the **Orkney Local Health Council** has been pressing for a replacement for the resident doctor on the tiny island of Papa Westray (pop. 98). LHC secretary Mrs H D Moore commented "If I lived on the island with children, I'd want a resident doctor. Last winter there were 46 days when the weather was too bad to cross over to the main island by boat and fog often prevents aircraft flying". The islands have been promised a resident nurse.

Publications

☐**Oxfordshire CHC** has produced a *Guide to NHS dental treatment in Oxfordshire* which explains about how to get NHS treatment and who has to pay for it. From **North Devon CHC** comes a *Directory of facilities for the health and welfare of children in North Devon.* This is a comprehensive guide which covers educational and social service provision as well as health services, and provides a separate section on services for handicapped children. **Haringey CHC** has produced a leaflet called *Community health clinics* explaining the different services they provide and where they are.

Disabled people living or holidaying in Weston can now get a very thorough guide to all the town's facilities. It lists door widths, number of steps, parking facilities and accessible toilets at all the shops, pubs, cinemas and hotels. **Weston CHC** has co-published *Weston made easy* with the local district council. It costs 50p.