CHC NEWS

For Community Health Councils

January/February 1982 No 73

Funding row grows

Government funds for *CHC NEWS* are to be cut off from the end of March. The Department of Health has taken this shock decision without consulting community health councils, and Social Services Secretary Norman Fowler now faces a heated CHC campaign to get the decision reversed.

Doubts about the future funding of *CHC NEWS* first emerged during the Association of CHC's annual general meeting in September, when the Department said it wanted talks about the future of the magazine, "including the possibility of putting it onto a subscription basis". This caused consternation at the AGM, and a motion calling for the work of *CHC NEWS* to be "continued and where possible expanded under the present arrangements" was carried unanimously.

But by 10 December, when representatives of ACHCEW and the DHSS met to open talks, the Departmental attitude had hardened. "It's a decision of Ministers that the *NEWS* should no longer be funded by central grant", was the announcement from the DHSS team.

Ministers had no strong views on whether the magazine should continue in the 1982/83 financial year, the ACHCEW representatives were told. Since CHCs seemed to like the magazine they could pay for it on a subscription basis, out of their existing budgets. If this did not produce sufficient income, costs could be cut "by reducing the scale of activities of the Information Service".

ACHCEW chairman D M Thomas has written to Norman Fowler protesting that the decision was taken "without the opportunity for us to marshall any counter-arguments". Taking away the grant "will place a new and unprecedented strain on the small budgets of CHCs in paying for a service which successive Secretaries of State since 1975 have considered a reasonable one for the Department to cover".

The letter continues: "I understand that your reasoning relates to effecting a small saving in the DHSS budget. It does not take account of the benefits conferred by *CHC NEWS* to its readers, nor has consideration apparently been given to the fact that the present grant is undoubtedly the least complicated and costly procedure for getting information to CHC members"

ACHCEW is already taking steps to publicise the decision. CHC chairmen have been alerted, and reminded that subscriptions to *CHC NEWS* would have to be paid for "out of budgets which are bound to be under pressure as a result of the Government's decision to cut back 10% on administrative costs in the NHS, including the costs of CHCs".

MPs, professional bodies and voluntary organisations are also being contacted. A detailed case for saving the magazine is being prepared, for presentation to Mr Fowler, and it is hoped that CHCs will use this case to raise the issue with their MPs and the local media.

●See Comment on page three.

Norman Fowler: asked to reconsider

INSIDE ....

Gill Kent

Gill Kent has joined *CHC NEWS* as assistant editor. Gill is 26, and has worked with the Spastics Society, with the Birth Control Trust, and as a freelance writer on health issues. She is also an executive committee member of the Maternity Alliance.

The new rules of the game

Yet another review of the value of CHCs can be expected soon — that is the depressing message of circular HC(18)15, the new DHSS document on the role and membership of CHCs. A tough line has also been taken on exceptions to the "one-CHC-per-district" rule.

Announcing the new arrangements to the House of Commons on 23 December, Social Services Secretary Norman Fowler said: "As we announced last year CHCs are to be retained for a period. The longer-term case for their retention will be reconsidered in the light of the experience of the operation of the more locally based district health authorities".

Mr Fowler has also decided that "there should be separate CHCs for the Isles of Scilly and for Weston, and also for each of the two sectors of the Liverpool DHA, but that no further exceptions will be considered until the new structure of the NHS has had time to settle down, and then only where exceptionally strong arguments are advanced by the local communities concerned".

The detailed provisions of HC(81)15 contain little that is unexpected. CHCs post-reorganisation should normally have

Continued on page four

See also Comment on page three, and reactions to the circular on pages 12 and 13.

Your letters

Year of decision for children's health

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

It seems that the 1982 reorganisation will make or break child health services. For years the government has been recommending that all children in hospital should be in children's units, that care should be provided by qualified children's staff, that there should be more day units and home-nursing schemes, and that local, comprehensive child health services should be developed, with better primary and preventative care to help keep children out of hospital.

Yet in practice:

- One third of child in-patients stay in adult wards,
- Many never see a paediatrician or Registered Sick Children's Nurse,
- There is a serious shortage of RSCNs, *who cannot train in districts where children are scattered around adult wards*,
- Thousands of children who could use day units stay as in-patients for days or weeks,
- Very few districts have paediatric home-nursing schemes,
- More children are staying overnight in hospital because they use casualty instead of GP services, and
- Surveillance and preventive care are inadequate and underfunded.

Progress will rarely be possible when scarce resources are shared among conflicting interests, when there is no clear policy or advocate for children, and when even the Specialist in Community Medicine (Child Health) and Area Nurse (Child Health) are being removed. In 1982 DHAs will either have to break child health services up still further among different units of management, or make the children's service one unit with its own budget, managers, specialist advisers, recorded policy and flexible response to need. Where DHAs decide against the unit for children, we hope that CHCs will at least persuade them to appoint the expert adviser and agree on a recorded policy.

The missing amendment

W S Whitson, Chairman, East Cumbria CHC

As the mover of the motion on the drug Debendox at the last ACHCEW AGM, I support the constitutional point made by David Johnson in his *CHC NEWS 71* letter.

This CHC decided in May 1981 to submit the motion presented at the AGM. In July new information published in the *British Medical Journal* was discussed, and it was decided to withdraw the motion. In September, during the two days before the AGM, a number of other CHCs urged us to allow the motion to go forward. It was therefore decided to submit the motion for debate. At no time was this CHC aware that any amendments had been submitted to ACHCEW.

At the AGM we supported the motion being referred to the Standing Committee, since it was apparent during the debate that some other CHCs had additional information which was not at the time available to all. If the motion had been referred back, it and the amendments, together with any other information, could have been collated and considered.

It would have been of help to this CHC if members had been aware that amendments had been submitted, and if the wording of the amendments had been known. May I suggest that in future ACHCEW should pass on the wording of amendments to the mover CHC, thus giving it the opportunity to change its motion prior to consideration by the ACHCEW resolutions committee.

The fluoridation debate

R J Condon, 10 Helen Road, Hornchurch, Essex RM11 2EW

I could take issue with Professor Jenkins on practically every point in his *CHC NEWS 71* article on fluoridation. For example, he is quite wrong to imply that Dr Waldbott did not carry out double-blind tests with water fluoridated at one part per million. Such an experiment is recorded in the book *Fluoridation: The great dilemma*. Adverse symptoms were produced in each patient.

Prof. Jenkins claims that Drs Yiamouyiannis and Burk compared Birmingham's cancer death rate only with that of Manchester, and that other non-fluoridated cities had even higher rates of increase than Birmingham. In fact when Birmingham is compared with seven non-fluoridated British cities, including Bristol and Liverpool, all show lower rates of increase of cancer deaths than fluoridated Birmingham.

A research paper by the statisticians Oldham and Newell is cited as evidence that the US studies showing a link between fluoridation and increased cancer deaths were incorrectly calculated. But under cross-examination in the Edinburgh Court of Sessions on 11 June, Prof. Newell admitted that there were errors in his paper. So the US studies remain unrefuted.

Nobody wants to withhold anything which might prevent disease — those who want fluoride for themselves or their children can get it. But it is medically unethical for a drug to be forced upon a whole population, many of whom neither need nor want it, and who may be suffering from conditions which would make fluoride medically undesirable. If the DHSS gets away with this, what will they put in our water next?

How maternity statistics are used by CHCs

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

Earlier this year we sent a questionnaire to CHCs about their use of maternity statistics. A report based on the replies received was sent to the Korner Committee on NHS information systems. We are sending copies of the report to those CHCs which replied to our survey. If any CHC which did not reply would like a copy, we should be glad to send one on request.

Rural transport

Margaret Campbell, Co-opted Member, Oxfordshire CHC

Further to your article "A countryside survival kit" (*CHC NEWS 69* pages 8-10), a car service linking villages to the south of Oxford with the health centre at Berinsfield has been running successfully for several years. It is organised by the Womens' Institutes and uses a village post office as its base.

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.

Any information or research findings on lumbar supports or corsets — particularly on how to make them more comfortable to wear.

—North East Essex CHC

How is advice given to people issued with low-vision aids, and what follow-up service is given to enable the recipients to use them successfully?

— Clwyd South CHC

Information on the foot-care problems of adults, including disabled adults. Details of solutions to foot-care problems and ways of maintaining mobility in the elderly (for a book aimed at NHS professionals).

– Mrs Janet Hughes, Disabled Living Foundation, 346 Kensington High Street, London W14 8NS.

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

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Comment

Circular HC(81)15 was not much of a Christmas present. The Secretary of State's brief statement to the House of Commons, and the introduction to the circular itself, both went out of their way to emphasise that in two years of intensive campaigning for survival all CHCs have won *for certain* is a short reprieve.

Of course we have known since July 1980, when the DHSS announced the outcome of the *Patients first* consultation, that the need for CHCs would be reviewed again "later on". By February 1981, in the consultative paper on role and membership, the line had hardened into "CHCs will be retained for the time being", and the latest formulation "CHCs are to be retained for a period" has a distinctly more hostile and definite ring to it.

So now, in the phrase beloved of sports commentators, CHCs "have it all to do again". This time they will have fewer members, and some of their most experienced campaigners will have been siphoned off to the new district health authorities. If the Department's 10% cutback in administrative costs turns out to be applicable to CHCs they may also have smaller budgets. And this time the review will be carried out in the confused aftermath of a sketchily-planned reorganisation of the service, amidst all the strains and antagonisms created by repeated cost-saving exercises.

Every one of these factors will make it tougher for CHCs to repeat their persuasive performance of 1980/81. Plus there is the little matter of *CHC NEWS*....

On this page in October we explained some of the complexities inherent in putting the magazine onto a subscription funding basis. What has become brutally clear since then is that CHCs would have to find the subscription out of their existing budgets — no extra money will be made available through the regions.

At first sight it might appear that the existing *CHC NEWS* service could be maintained fairly painlessly if all CHCs agreed to pool about 2% of their total budgets, but this kind of calculation grossly underestimates the impact that subscription funding would have. The bulk of a CHC's annual budget has to be spent on fixed costs, such as salaries, rent and rates, leaving just a few thousand pounds for "creative" spending — for example on publicity, survey research, special publications and visits to NHS premises.

CHC NEWS enjoys widespread support from CHCs, but even so the prospect of losing £400 or so from this precious part of the budget is bound to force some CHCs to the reluctant conclusion that the money would be better spent on local activities. Their withdrawal would mean a smaller income for *CHC NEWS*, which in turn would necessitate a reduction in the quality and/or quantity of the service. A poorer service would mean more CHC withdrawals, and thus a vicious spiral of decline would set in.

We feel sure that the DHSS already understands this, and we are also convinced that the Department knows very well that there is little extra income to be had by taking adverts and trying to attract more non-CHC subscribers. The proposed switch to funding by subscription would assassinate *CHC NEWS* at just the time when CHCs need to talk to each other more than ever before.

Health News

The ten-year plan

The International Year of Disabled People is over but its spirit lives on in a new campaign backed by the major disablement societies. The Snowdon Council, named after its President, Lord Snowdon, hopes to draw up a ten-year plan of action for the integration of disabled people, based on Rehabilitation International's *Charter for the 80s* which was issued in November. The plan will cover employment, leisure, sport, transport, mobility and access, and the prevention of disability. The Council will also help to maintain activities set up during IYDP and will be looking at ways of providing information to disabled people Details from IYDP Press Office, 26 Bedford Square, London WC1. Tel: 01-636 3464.

Regulating abortion

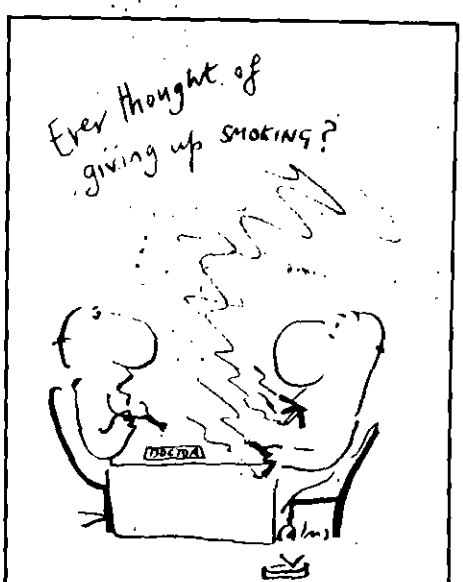
If you can't change the law, change the regulations — this seems to be the thinking behind a move by civil servants which threatens to restrict the availability of abortion within the law.

The Abortion Act 1967 leaves the decision on abortion entirely to doctors' discretion, but requires that they complete a notification form giving details of every abortion performed. In March the DHSS issued a revised form which limits the conditions under which doctors may exercise their discretion, by insisting that they must record a medical condition when notifying the reason for an abortion.

Yet the Abortion Act requires only a *risk* of damage to physical or mental health, and states that "in determining... such risk... account may be taken of the woman's actual or reasonably foreseeable environment".

Previous forms in use since the Act became law have included an opportunity to specify non-medical grounds, but doctors failing to record a medical condition on the revised form have received copies of a letter from Sir Henry Yellowlees, Chief Medical Officer at the DHSS, which says "non-medical factors alone do not provide legal justification for termination", and goes on to imply that if a doctor believes a woman's health is at risk the expected medical effect of that risk must be specified.

This seems to introduce a new concept in the field of prevention. Will we now find doctors having to specify exactly which disease a smoker risks before advising their patient to give up cigarettes?



ASK THE DOCTOR ...

Everyone is saying Stop!

The New Year has brought a flood of valuable anti-smoking activity. The poster shown here comes from a new kit produced jointly by the Health Education Council and ASH, to help GPs persuade their patients to give up smoking. The BBC has launched *So you want to stop smoking*, a series of six Sunday-evening TV programmes, and an HEC booklet of the same name is being sent to viewers who write in.

ASH has also produced *Smoking prevention: A health promotion guide for the NHS*, a handbook aimed at members and officers of health authorities. And on 3 March the National Society of Non-Smokers will hold its seventh national Don't Smoke Day, asking the new DHAs to set up anti-smoking advice centres and implement DHSS advice on smoking in NHS premises.

Free copies of the publications mentioned above from the HEC at 78 New Oxford Street, London WC1 (Tel: 01-637 1881) and ASH, 27 Mortimer Street, London W1 (01-637 9843). The NSNS is at Latimer House, 40 Hanson Street, London W1 (01-636 9103).

Continued on next page

Health News

Speech therapy survey

A survey carried out with the help of CHCs has found that speech therapy staffing levels in 28 health areas are still 40% or more below the official target set in 1972. This finding seems slightly less depressing in the light of a 1976 survey which showed 12 of the 14 English RHAs to be 40% or more below target.

The target level of six speech therapists per 100,000 population was set in 1972 by the Quirk report (see *CHC NEWS 60* page six), and the new survey was carried out by AFASIC — the Association For All Speech Impaired Children. A questionnaire sent to all CHCs in August 1980 produced figures for 71 of the 98 AHAs in England and Wales, of which four had exceeded the target, 11 were in the 80-100% bracket, 28 at 60-80% and 28 at 40-60%. Recruitment problems were partly to blame. Copies of survey from AFASIC, 347 Central Markets, London EC1. Please send SAE.

Screening for cancer

The DHSS committee on gynaecological cytology has decided not to recommend regular cervical smears for women under 35, despite the increasing incidence of cervical cancer in younger women.

The committtee's *Report of the Working Party on the Age and Frequency of Screening 1980/81* has been circulated to professional bodies and the consultation period is now over.

At present smears are recommended for women under 35 only if they have been pregnant on three or more occasions, but many women who do not fall into this category have smears taken at family planning clinics. The new recommendations will formalise this pattern, with screening of women in clinics at 22 if they have had no smear before, and at 30 if no smear has been taken for five years. The test will also be done early in each pregnancy.

Unfortunately the women most likely to fall through the contraception and ante-natal care net are those most likely to contract cervical cancer, since mortality statistics show it to have the steepest social class gradient of any cancer.

While the outcome of the committee's recommendations is still awaited, the DHSS has announced in circular HC(81)14 (WHC(81)19 in Wales) plans for the run-down of the central screening register at Southport, long criticised as inefficient, and the transfer of its five-year recall functions to district registers.

The central register has already stopped accepting cytology forms and will continue recalling women for screening only until the end of 1982. Health authorities have been asked to devise their own recall schemes to take over by 1 April 1983.

Closing ranks...

Nine professions supplementary to medicine (PSMs) should be protected from unregistered practitioners, suggests a DHSS consultative paper. The professions covered are chiropodists, dieticians, medical laboratory scientific officers, occupational therapists, orthoptists, physiotherapists, radiographers, remedial gymnasts and speech therapists. All but the last are already covered by the PSM Act 1960, which prevents unregistered people working in the NHS. It is proposed to extend this so that unregistered and untrained people would no longer be permitted to practise outside the NHS under the PSM titles.

...and opening doors to GPs

After many years of campaigning, GPs have gained open access to physiotherapy departments, and physio services may be extended into the community. The news comes in a DHSS "position paper", called *Physiotherapy in the community and open access to physiotherapy departments for GPs.* Until now treatment could be had only if prescribed and supervised by hospital specialists. The degree of access will depend on workloads in individual departments.

Home Safety Year

The Royal Society for the Prevention of Accidents began working to publicise hazards in the home in 1932, and has declared 1982 its Home Safety Golden Jubilee Year. Activities during the year will include a nationwide touring exhibition, poster campaigns and a major home safety conference. Details from Janice Cave, RoSPA, Cannon House, The Priory Queensway, Birmingham B4 6BS. Tel: 021-233 2461.

The right questions

Over 2300 viewers contacted Thames TV's *Money-Go-Round* programme following an item giving advice on what to ask your doctor when you are offered a prescription. Each enquirer was sent a leaflet listing 15 simple questions to ask about a prescription, and suggesting that "sometimes, when you know all the facts, you will not want it". Leaflets from Thames TV, 149 Tottenham Court Road, London W1P 9LL.

Pricey services

The latest "mini budget" in November brought more large increases in charges for prescriptions and dental and ophthalmic services. From 1 April 1982 they will be as follows:

Prescription charges will go up to £1.30 per item. Annual "season tickets" will increase from £15 to £20.

Dental charges will be a maximum of £13 for routine work (up from £9). The maximum for other kinds of treatment will go from £60 to £90. More expensive items will be at or above 50% of costs.

Spectacle lens charges will be a maximum of £15 instead of £8.30.

New rules

Continued from page one

18-24 members, with most councils "at or near the lower end of this range". Local authorities will continue to appoint half the membership and voluntary organisations one third, "for the time being". Members will be allowed a third consecutive term of office where their first term was for less than four years.

NHS employees and family practitioners should not be appointed as members of a CHC matching their employing or contractual authority. Local councillors appointed as CHC members are given one month's grace following their defeat at the polls in local government elections, during which time the local authority has the option of confirming that it wishes their CHC membership to continue. RHAs are to take over responsibility for declaring CHC seats vacant where the member has failed to attend meetings for six months without reasonable cause.

RHAs are given the option of establishing a new CHC for each DHA, or of allowing existing CHCs to continue — with appropriate adjustments to membership size — where district boundaries remain more or less unchanged. In either event, the new arrangements must be completed within the period 1 April to 1 September.

The Secretary of State expects CHC observers to be admitted to the non-confidential parts of "shadow" DHA meetings, and this relationship should be continued beyond 1 April where new CHCs are to be established later in the year.

There should be "no general increase" in the resources allocated to CHCs by RHAs, and where the number of CHCs in a region is being reduced the Secretary of State expects "some savings" to be made. Posts with the new CHCs will be filled by "slotting in" of existing staff or by competition, depending on local agreement through the Whitley Council procedures, and in the latter case the selection should be made by a CHC committee. The Association of CHCs for England and Wales will continue "subject to continuing support from CHCs".

An appendix to the circular says DHAs should "make every effort to consult CHCs in good time on all matters of interest to them". Arrangements for CHC visits to NHS premises should be agreed with DHAs, and private hospitals and nursing homes should also allow CHC visits where they are providing patient services under contract to the NHS. On complaints, members and staff of CHCs may continue to act as the "patient's friend" at FPC service committee hearings, though the Secretary of State "does not see this as a formal role for CHCs". FPCs are urged to admit CHC observers on a voluntary basis, but this will not be made compulsory.

Circular HRC(74)4, the Department's original guidance on CHCs, has now been cancelled, so there is now no longer any official list of "matters to which CHCs might wish to direct their attention".

IYDP WAS THAT THE YEAR THAT WAS?

*by Pat Saunders**

Remember that enormous sausage at the Hyde Park kids' party in the Year of the Child? Is that all you remember of the achievements of that Year? Do any of these Years achieve much? Well the International Year of Disabled People certainly made considerably more impact than its predecessors.

We have been made to crystallise our thoughts and ambitions. A new influx of people, finance and expertise has become involved with the problems of disability, and in the Year they have solved problems which have defied the rest of us. Now IYDP has just finished we should take stock and set targets for the future.

Is there a disabled person on your CHC? More than anything else the Year spelt out the need for disabled people to participate in society. IYDP marked the end of a period in which kindly, paternalistic but rather patronising voluntary associations ministered to the needs of groups of people assumed to be incapable of managing their own affairs. The new disablement organisations have committees and sometimes salaried staff who are disabled themselves.

Improved care, better financial provision, access to information, elimination of mobility problems, all these have contributed to the emergence of a mainstream concept from IYDP — "Enable the Disabled". This was the Year *of* Disabled People, not *for* Disabled People — the year when society realised that 3½ million disabled people were a neglected resource rather than a continuing liability, and the business world discovered that handicapped people represent a substantial proportion of the buying public.

This enhanced status of the disabled person has come about largely because a declared object of IYDP was a public awareness campaign to inform able-bodied people of the aims, problems and aspirations of disabled folk. Disabled people have appeared on TV and radio; they have written books, articles and plays; they have spoken in clubs, pubs and churches; in schools, colleges and universities; to Round Tables and Ladies Circles.

Chalk up to IYDP a few other achievements. The widespread publicity spurred on many local fund-raising efforts, their aims ranging from special vehicles to rehabilitation research centres. Who can say that the spirit of England is dead when a young tetraplegic like Neil Slatter completes a 1200-mile journey around England and Scotland in his wheelchair to raise over £40,000 for wheelchairs for other handicapped people! Over 80 towns formed IYDP committees and many will continue beyond the end of the year under new names. Over 40 towns now have Access Committees to deal with the problems of the built environment — and often hospitals present the biggest problems.

The Crossroads Care Attendant Scheme (see *CHC NEWS 59 and 66* page 15) is slowly spreading across the country and many CHCs are involved. British Rail has produced disabled people's rail cards at half price, and many nature trails, parks and museums have become accessible to disabled people. Many new DIALs (Disability Information and Advice Centres) have opened up, often with the help of CHCs.

Many, however, would say that the failures of the IYDP in Britain exceed the successes. This was the year of cuts — in social security, social services and health — the year when the Royal Association for Disability and Rehabilitation set up a special department to take to court recalcitrant local authorities bent on saving money by non-compliance with the provisions of the Chronically Sick and Disabled Persons Act. The town-based Disablement Advisory Committees, which brought together employers, trade unionists and members of voluntary organisations to discuss employment of disabled people, were disbanded by the Government against the stated views of the majority of the disablement organisations, and they are about to do away in effect with existing protection for employed disabled people by making the quota system voluntary.

Little has been done to implement the Warnock Report in integrating disabled children into ordinary schools, and education for 16 to 19 year-olds is almost non-existent.

For over fifteen years the need for a disability income has been recognised; a Gallup poll just 14 months ago showed over 50% of the population in favour. Yet Government thinking failed in IYDP to produce even a discussion paper, and in real terms most disabled people suffered cuts in income. Our (relatively) new Committee on Restrictions against the Disabled (CORAD) has been strangely silent throughout the Year and debate on anti-discriminatory law seems no further forward.

On the local front it has been said that the energy of IYDP committees has alienated those who have been working steadily in the disability field for years, and they have upset some by giving the disabled a "special people" image at a time when the keynote should be participation and equality.

The Disabled Persons Act 1981 came into effect in November with stiffer penalties for misuse of the orange disc parking scheme and minor and completely toothless improvemennts in the law on access.

As a CHC member, which of those problems illuminated by IYDP should form part of forward policy making in your district?

First, a hard look is needed at the precarious position of disabled people in hospital. Pressure sores alone cost the NHS £70 million a year, and how much is that in human misery? Second, the transfer of permanently disabled people from inappropriate hospital locations to the community must be accelerated. Third, there is a need to rationalise the provision of aids for disabled people. Many people are without essential equipment because they and their professional advisors are baffled by the system. Disabled people need information — if there is no DIAL in your town think about starting one. Lastly, the journey from hospital bed to workplace is taken by the disabled person through the application of a science we call *rehabilitation*. Why is rehabilitation such a poor relation in the academic medical training structure?

Photo: Maria Bartha

Pat Saunders is a tetraplegic and a member of Portsmouth and SE Hampshire CHC. He is also the director of Portsmouth and District DIAL.

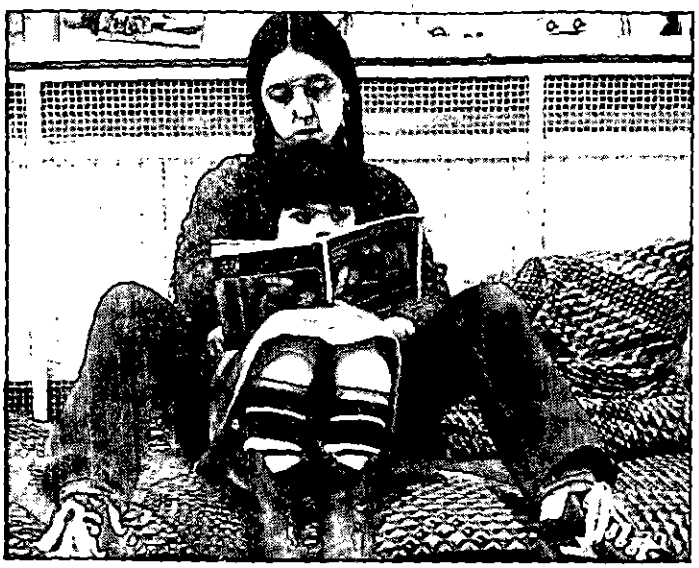


Photo: Liz Heron

Can official reports change children's lives?

*by Rick Rogers**

"It sometimes seems that the setting up of a government enquiry is not so much a prelude to action as a device for avoiding action" (1). That was Professor Peter Tizard's comment on the Government's response to the Short report on perinatal and neonatal mortality. But he could have been referring to any of the numerous official enquiries into the needs of children since the Platt report in 1959.

Link the Tizard comment with one by the Central Policy Review Staff that "young children do not as yet have any high political priority and their needs tend to be regarded as optional extras" (2), and you begin to wonder why anyone bothers with enquiries.

Given that committees of enquiry are formed ostensibly to deal with a current or approaching crisis in services, *immediacy* is the one basic ingredient lacking in government responses to their eventual recommendations. So their value does not appear to lie in making governments act promptly or decisively — except perhaps to say No.

For example, in August 1980 the Black report on inequalities in health was summarily dismissed by the then Social Services Secretary Patrick Jenkin. David Ennals took over a year to respond to the Court report on child health services. The Department of the Environment waited 14 months before acting on the Lawther report on lead pollution. Both those latter responses fell far short of what was and is needed. And twenty years of sterling work by the National Association for the Welfare of Children in Hospital, to win across-the-board implementation of the Platt recommendations on the welfare of children in hospital, has still not been enough. None the less, government-appointed committees of enquiry have long been, and remain, a popular means of investigating and reporting on the education, health and social wellbeing of children.

They have originated in three main ways: as part of the permanent central advisory councils set up by Acts of Parliament, for education in 1944, and for health in 1948 (The Central Health Services Council was abolished in 1980; the Central Advisory Council on Education has been moribund since 1968); as a one-off committee set up by a government department, which is officially disbanded after it has reported; and as part of the work of a Parliamentary Select Committee of MPs, able to call on evidence and witnesses, including Ministers.

But the fundamental problems that bedevil committees of enquiry lie not so much in their setting up and composition (long though that struggle might often be), but rather in what happens after they have reported. Politicians and pressure groups agree that no machinery exists to keep up the momentum for official action on children's needs, nor to provide advice free from departmental rivalries and prejudices and from the vested interests of other groups.

The abolition of the vital if flawed Children's Committee — one of the few concrete gains from the official response to the Court report — has worsened the outlook for effective provision for and representation of children (3). Three alternative ideas are currently being suggested:

- A Minister for Children — or for the family — who could cut across departmental boundaries to ensure that children's interests are properly formulated, canvassed, identified and acted on.
- A powerful and comprehensive Ombudsman service to handle children's affairs. A national Children's Legal Centre is already operating, and other groups and national agencies are in the process of developing Ombudsman-type projects.
- A Children's Council to fill the gap left by the Children's Committee, but with more "muscle" and independence.

All of this is still on the drawing board, or in the experimental stage. We are currently left just holding those enquiry reports. How then can they be of use? Once it is accepted that such reports represent not the last but the first stage in the process of achieving improvements, the value of committees of enquiry becomes clearer:

First, they can bring together and legitimise radical, progressive or just plain common-sense ideas, and win for them a broader professional and public acceptance. They may also highlight for a wider audience what has become common practice within the professions.

Second, they can receive and absorb a range of evidence and opinion, and undertake detailed research. Their reports thereby become definitive documents on a particular service — a prime example being the Court report on child health services.

Third, enquiry reports can document, publicise, encourage and establish good practice in hospitals, clinics schools and local authority departments — as well as in the day-to-day contact between professionals, parents and children. The Platt report is an obvious example.

Finally, reports can help to win general consent about the direction in which particular services — and the NHS in general — should be going. This is what has been called "their unique capacity to create a consensus for change" (4). Even where wide gaps in agreement exist — as with the Warnock recommendations on special education and Houghton on the custody and adoption of children, at least a focus is provided. All sides know they have to debate the issues because some kind of decision is to be taken.

In this way enquiry reports can have an educative role, spreading ideas and information irrespective of the negative responses of government or professional bodies. They also have a publicity role — the issues get discussed in the media — and they have a lobbying role. Indeed, members of both the Court and the Warnock committees stayed together as *ad hoc* groups, after they were officially wound up, to work for the implementation of their recommendations.

These reports may be poor substitutes for enlightened government, for national legislation and local implementation, or for more and better-directed resources. But in a period when all these are thin on the ground, it would be folly to ignore the tools these reports do put into our hands.

References

1. *Who's holding the baby now?* Spastics Society, July 1981.
2. See two reports from the CPRS: *Services for young children with working mothers*, HMSO 1978, and *People and their families*, HMSO 1980.
3. *Too important to leave to chance*, by Peg Belson. *CHC NEWS* November 1981, page six.
4. *Much to do about education*, by Anne Corbett, Macmillan, 1978.

**Rick Rogers is education correspondent of the New Statesman, and a former editor of CHC NEWS. He is also the author of* Crowther to Warnock: How fourteen reports tried to change children's lives, *Heinemann Educational, 1980, £4.95.*

Book reviews

Getting it right? The 1982 reorganisation of the NHS

by Norman Chaplin, £2.75 (inc post) from the Institute of Health Service Administrators, 75 Portland Place, London W1N 4AN

In a booklet of 40 pages, the chapter on CHCs occupies just over a page. That page will add nothing to the awareness of even the most uninformed CHC member. On top of that, it starts off with a gratuitously slighting comment which is neither funny nor accurate. Should CHCs therefore give this booklet a miss? It would be a pity of they did. Within a small compass it does gather together the bits and pieces of information, official and unofficial, that have appeared as this reorganisation has got underway.

The final chapter gives a shopping list of problems which CHCs can certainly use for their own ends in devising possible strategies for dialogues with the new DHAs. For instance, it mentions the "difficulty" new small authorities will have in achieving "distance" from day-to-day pressures and interests. This is very true, and might suggest to CHCs that they soon give thought to formal relationships with DHAs that enable them to be seen as not just another "little local difficulty" amongst many.

Secretaries and Chairmen of CHCs should find the booklet useful, and it could be helpful for members who are new to the council and the NHS scene.

Jack Hallas, Lecturer in Health Policy Studies, University of Leeds

Abortion politics

by David Marsh and Joanna Chambers, Junction Books Ltd., £4.95

Members of Parliament told the authors of this book that they had received postbags on abortion which were two or three times as large as on any other issue. Since 1967, when abortion was made more freely available, there have been repeated attempts to restrict the circumstances in which a woman can have a pregnancy terminated. This book looks at the tremendous battle between the pro-abortion lobby and the anti-abortionists, which took place in the winter of 1979/80 over the private members' Bill sponsored by John Corrie M^{P}.

If the Bill had been enacted, it was reckoned that the number of abortions performed in England and Wales would have been cut by as much as two thirds.

Several factors account for the Bill's eventual defeat, although at the time the outcome was by no means certain. The medical profession, or rather the BMA, radically shifted its position. In 1967 it had said that social abortions were medically unethical. By 1979 the BMA voted almost unanimously to deplore "persistent attacks on the (1967) Abortion Act", and it lobbied MPs accordingly.

The pro-abortion lobby defending the 1967 Act had become much better organised and politically skilled, both inside and outside Parliament. The massive TUC-sponsored demonstration attested to this.

Marsh and Chambers' book will certainly become required reading for lobbyists on the abortion issue, should the matter be raised again in Parliament. But it is quite a specialised book, full of detail about committees and the heady pressure of the House of Commons. Fascinating.

Janet Hadley

Going home — a guide for helping the patient on leaving hospital

edited by J E Peter Simpson and Ruth Levitt, Churchill Livingstone, £7.95

Importance is now attached to patient care within the community, yet concern is expressed that hospital discharge may cause a breakdown in continuity of care and impose problems on patients and families. *Going home* seeks to identify problems and suggest ways in which they may be overcome.

Needs vary according to type of illness, age and social conditions of patients. Separate chapters consider a wide range of physical and mental disorders. Other chapters discuss primary health care and the responsibilities of GPs, community nurses and health visitors, as well as the work of local authority social service departments, with their teams of social workers, occupational therapists, home helps, residential staff and the like. Social security benefits are outlined and reference is made to the role of voluntary organisations.

The book is well indexed and is easy to read. It will be acceptable to health professionals and yet be readily understood by the lay public. To CHC members it can be strongly recomended as it will help them to have a realistic understanding of the needs of patients and the problems which professionals must face as they attempt to meet those needs.

Olive Keywood, Worcester CHC

The provision of care for the elderly

edited by John Kinnaird et al, Churchill Livingstone, £10

The impact of ageing

edited by David Hobman, Croom Helm, £12.95

Both these books are collections of papers about old people and the help they need.

John Kinnaird et al have produced an excellent package. Probably because the papers were written for a conference, they are brisk, informative and thoroughly engaging. They are just what we need to interest people in this exciting and rapidly developing field of care. There is a gap though, in the omission of any paper specifically about quality of life.

This is not omitted from David Hobman's book. Olive Stephenson provides a very thought-provoking chapter on dependency and what it *feels* like. This is, nevertheless, a much less satisfactory collection. David Hobman provides us with a curate's egg — good in parts. Some papers are too long, others are confusing, and one or two are quite brilliant, like Bernard Isaacs' sparkling contribution.

Both books have an international input which provides a most useful dimension. Both books lack a feminist perspective, which is serious in books about a section of our population which is predominantly female.

Mary Marshall, University of Liverpool

A charter for the disabled

by Eda Topliss and Bryan Gould, Basil Blackwell, £3.95

This very readable book presents two complementary views of the 1970 Chronically Sick and Disabled Persons Act. In the early chapters Brian Gould draws upon his parliamentary experience to give us a graphic, blow-by-blow story of the passage through Parliament of Alf Morris's famous private member's bill. This Act is the cornerstone of the philosophy of national and local government provision for disabled people. The input from the national "disabled" voluntary organisations, the race against time (the Bill became law ten days *after* the declaration of a General Election), and the interplay between the parliamentary personalities of both Houses, all make fascinating reading.

Many hours of public debate and thousands of words have been written about the achievements and failures of the CSDP Act and in the second part of the book Eda Topliss provides an excellent critical analysis. The inclusion in the Act of escape clauses like "insofar as it is both practical and reasonable" has given it the reputation of being a toothless tiger—and certainly provision under the Act varies widely from place to place.

Though well-intentioned, the majority of CHC members are ill-informed about the needs of disabled people. At this time, when provision for the handicapped and the relative responsibilities of health and social services are under review, this straight-forward, unbiassed book makes a timely impact. We should all be thinking about many of the issues raised by the authors who tell so well the story of Alf Morris's famous Act and the ten years that followed.

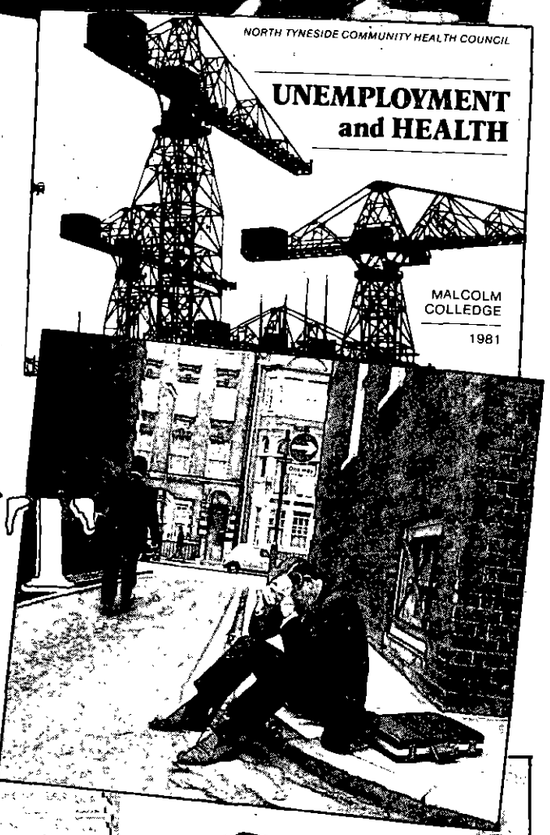
Pat Saunders, Member, Portsmouth CHC

Books received

Data analysis: A basic introduction by David Fruin (National Institute for Social Work Paper No 11, £3). If you're weak on maths and baffled by tables and stats, this book could help — it's aimed at social work students.

THE UNEMPLOYMENT EPIDEMIC

*by Steve Parry**



Photos: Raissa Page

Suicide, premature death from heart disease, cirrhosis of the liver and an increasing number of first admissions to mental hospital have all recently been associated with rising rates of unemployment. There is a growing belief that high unemployment has a wide-ranging impact on standards of public and personal health.

Concern about the problems that being without work can bring is also expressed in research. The studies most frequently referred to are those of Professor Harvey Brenner, a specialist in operational research at John Hopkins University in the USA (1), and of Dr Leonard Fagin, a consultant psychiatrist at Claybury Hospital in Essex (2). But their work is supported by others. Malcolm Colledge's study of unemployment and health in the north east of England, commissioned by North Tyneside CHC, is an important addition (3). Other relevant work is described towards the end of this article.

Effects of unemployment

Joblessness affects the individuals concerned, their families and even whole communities. By and large the response to unemployment falls into three stages, beginning with a "holiday period" immediately after job loss. There then follows an "anxiety period", dominated by self-doubt, anxiety and more urgent attempts to find work. Problems in structuring time, and ironically a reduction in social activities and pastimes, are typical. Growing demoralisation, shortage of money and exclusion from the social opportunities which work affords are frequently the cause. Without work it appears that many people find it impossible to enjoy leisure.

Finally there is a "resignation period", usually associated with being unemployed for more than a year. Individuals tend to become resigned to unemployment, lower their expectations and reduce their level of social activity to one which offers few if any challenges. The precise experience of individuals and the length of each stage will differ, and depends on the circumstances in which the job was lost.

Dr Fagin's study for the DHSS, *Unemployment and health in families,* suggests that many of the above symptoms are exhibited by the *families* of the unemployed as well. Dr Fagin has stressed his surprise at the extent to which he found that ill-health was the "over-riding" response to unemployment. It was as if "health problems were unwittingly selected as the main avenue of expression of the most obvious distress that most of these families were experiencing".

Following the loss of a job, many of the male breadwinners in Dr Fagin's study experienced clinical depression with feelings of sadness, hopelessness and self-blame, lethargy, lack of energy and loss of self-esteem, insomnia, withdrawal and poor communication, suicidal thoughts, impulsive and sometimes violent outbursts, and increased use of tobacco and alcohol. Their wives often exhibited the same symptoms of anxiety, despair and apathy, and increased marital tension was found.

Following the onset of unemployment, individuals or spouses with a previous history of poor health sometimes suffered relapses or an aggravation of their previous illness. Job loss was sometimes accompanied by physical symptoms which can have a psychological cause, for example asthma, skin lesions such as psoriasis, backaches and headaches. Children were also affected, but this depended on age. It was common for children under 12 to become accident-prone, to suffer minor bouts of illness such as earache, and to become sullen or attention-seeking.

Unemployed people's relationship to their former job, their perception of society's attitude to joblessness, their chances of finding work, the strength of marital and family relationships, the employment status of their spouse, the degree of financial stress imposed by unemployment, their ability to fill the free time with other activities, interests or marginal employment, all contribute to the physical and mental well being of the unemployed and their families.

Statistical links

Professor Brenner has also demonstrated that the rate of unemployment is associated with a number of indicators of health, both mental and physical. The unemployment rate has been linked to the general death rate, to the cardiovascular mortality rate, to the mortality rate from cirrhosis of the liver, to the suicide rate, to the rate of first admissions to mental hospital, as well as to the murder rate.

Brenner's initial work was undertaken in the USA, but in 1979 he showed that similar conclusions could be drawn for the period 1936-1976 in the UK. A further paper analysing trends in mortality from several major causes in England, Wales and Scotland during the period 1950-1978 is expected soon, and its preliminary findings echo his earlier results. The net effect of long-term economic growth has been to improve health, while economic declines are associated with both short- and medium-term consequences for illness and survival.

Ill-health during periods of high unemployment may not only be suffered by the unemployed and their families. Brenner claims that the stress which affects them also takes its toll on those in work. Heightened competition between firms leads to what he calls "work overload" — those in work are threatened by their own potential job loss and by restriction in opportunities for changing jobs. It has also been argued that economic pressures on companies, together with reduced bargaining strength among trade unions, may mean that health and safety standards at work could decline, with consequences for occupational health.

The threat of redundancy can itself affect health. In 1968, research in the USA revealed that serum uric acid levels, cholesterol levels and blood pressure levels were high among people threatened with redundancy. Interestingly, normal levels did not return until the individuals concerned regained employment. In September 1980 a Gallup poll revealed that the proportion of people who thought that their own job was under threat had risen from 27% to 38% between June and September of that year. At the time the jobless total was two million.

Persuasive though this work is, it is not without its critics (4). The DHSS has commissioned a study at Queen Mary College, London, to repeat Brenner's work using official DHSS statistics. The researchers claim that his work is open to dispute. Others claim that there is little or no causal relationship between unemployment and ill-health except in cases of long-term unemployment lasting more than one year. Certainly those investigating the ways in which unemployment affects health agree that it is difficult to pinpoint how changes occur, though stress and poverty seem to be important.

It is also difficult to disentangle the effects of unemployment and other socio-economic factors, such as bad housing. Furthermore, the inter-relationship between health and joblessness is a complicated one. Certainly men and women in poor health have difficulty securing work. It is also true that in some cases unemployment could have a beneficial effect on an individual's standard of health, if the work was regarded as unpleasant or difficult.

Further evidence

Many of these qualifications raise important issues. But while individual pieces of work can be criticised, the weight of evidence described in other work seems to confirm a close link between unemployment and worsening standards of health:

Mental health: An Australian economist called Bunn has found that 18 months after a change in the unemployment rate there is a corresponding change in drug prescribing and in consultations. Research in Britain demonstrates that joblessness and mental health are often connected. A study of school leavers in 1980 suggested that those youngsters who did not manage to find stable jobs were considerably more vulnerable to psychiatric disorders than those who did. Another similar study concluded that unemployment affects the young more severely than adults, especially by increasing aggression.

Suicide: The link between unemployment

Continued on next page

Photo: Tony Othen

* *Until recently Steve Parry was research assistant at Bolton CHC.*

Healthline

Investigating CHCs

Can the NHS Ombudsman investigate the work of a CHC?
This has been clarified in correspondence between the Health Service Commissioner for England and the Association of CHCs, and the answer is No. CHCs are not amongst the bodies listed in Section 109 of the NHS Act 1977 as 'subject to investigation' by the Health Service Commissioner.

Appeals against FPCs

Which CHCs have had experience of appealing against the decisions of family practitioner committee complaint hearings?
There was a question about this in our *CHCs at work 1980* survey (*CHC NEWS 65* pages 8-10). Forty-one CHCs said they had helped complainants to appeal against FPC service committee decisions: Sutton and West Merton, Blackpool, Wigan, SW Herts, Ealing, North Warwickshire, Harrow, East Herts, Kensington Chelsea and Westminster South, Barnsley, Central Nottinghamshire, West Essex, Worthing, East Dorset, Rugby, Central Birmingham, Coventry, Dudley, East Birmingham, Walsall, West Birmingham, Bury, Salop, Worcester, Kettering, South Tees, Grimsby, Newcastle, North Tyneside, Islington, Bolton, Norwich, Newham, Tower Hamlets, South Gwent, Neath/Afan, Swansea/Lliw Valley, Wirral Southern, Liverpool Eastern, Peterborough and Kings Lynn.

Out-of-hours chemists

When do chemists have to be open, outside of normal shop-opening hours?
Chemists are self-employed traders, providing NHS pharmacy services under the terms of a contract with the local family practitioner committee. When they enter into this contract they agree to accept the hours of service required by the FPC.
Agreements on hours of service can vary from one area to another, depending on local needs, but the usual requirement is that the chemist participate in an out-of-hours rota service for up to one hour per week. The rota service is intended to cover doctors' evening surgeries, early-closing days, Sundays, and public holidays. In a single or two-chemist district, where a rota service is not practicable, the FPC may require chemists to open out of normal hours in lieu of rota service, also for up to one hour per week.

Hospital tapes

Is there an organisation which supplies tape recordings of books for use by hospital patients?
Yes, there is a charity called The British Library of Tape Recordings for Hospital Patients (BLOT for short), which has a range of about 700 "books" available, including children's books, science fiction, short stories, poetry, detection, historical novels, classics, biographies, religion, sport etc. For copyright reasons BLOT tapes can only be played back on special equipment, which the charity sells to hospitals at cost price, currently about £60. A year's subscription costs a hospital £40, and provided the hospital has an ophthalmic or geriatric department the tapes can be sent through the post free of charge as "articles for the blind". Some of the tapes are available in cassette form, for use with special playback machines designed for easy use by the blind and physically handicapped. For details contact BLOT at 12 Lant Street, London SE1 1QR. Tel: 01-407 9417/8.

School health services

Which CHCs have taken a special interest in the school health services?
Kettering, Harrow, Wycombe, Aylesbury and Milton Keynes, and Medway CHCs have all written reports and surveys. Among other CHCs which have taken a less formal interest, we know of North Notts, West Roding, West Somerset, and Plymouth.
The government guidance on school health services is contained in circulars HRC(74)5, HSC(IS)2 and HSC(IS)5.

The Healthline column publishes selected items from the work of our information service. This service is for CHC members and staff, and for others interested in the NHS and the work of CHCs. To contact the information service write to CHC NEWS, 362 Euston Road, London NW1 3BL, or ring us on 01-388 4943.

UNEMPLOYMENT EPIDEMIC

Continued from previous page
and suicide is difficult to establish but seems to exist. In the depression of the 1930s the suicide rate in Britain peaked. In 1931 there were about 6000 suicides. In 1972, after a long period of decline, the figure had dropped to 3800, but by 1978 there were 4000 suicides. This rising trend seems to be continuing. Studies of men who committed suicide while of working age have shown that between 25% and 50% were out of work when they killed themselves.
Physical health: Research in the 1940s suggested that within three years of an increase in unemployment, deaths from rheumatic heart disease also rose. The Black report on *Inequalities in health*, published in 1980, demonstrated that poverty and ill-health are closely associated, so that rising unemployment can be expected to lead to declining standards of health, for example through poor diet.
Perinatal mortality: A doctor in a Yorkshire town badly hit by the recession in the clothing industry recently warned that although the local perinatal mortality rate (ie the rate of still-births and deaths in the first week of life) has been halved in recent years, "the stress that unemployment brought to family life often led to increased smoking and drinking by the mother. This was harmful to the foetus. When a family's living standards drop, bulk foods rather than high-protein foods are substituted, which means an expectant mother is not always taking in the nourishment she needs to produce a healthy child". Such an assessment would be supported by the Black report, which shows that the health of babies is closely linked to the health of the mother from childhood to pregnancy. One study of groups of women who were born during the great depression of 1926-1937 suggests that during the 1940s and 1950s they were more likely to give birth to children without a brain. So it seems that some of the costs of recent unemployment may not be felt for many years to come.
Violence: Fagin's study of the impact of unemployment on families, while describing examples of tension and conflict, did not reveal any firm evidence that this had developed into family violence. However, a survey of child abuse in Dundee found that 30% of the battered children studied had unemployed fathers, and the researchers concluded that stress factors such as unemployment and mental illness can turn a potential child abuser into a batterer. The National Society of the Prevention of Cruelty to Children has reported an increase in child abuse and while this can be linked to a number of different causes the NSPCC concludes that the threat of economic recession, high unemployment, rising prices and diminished support from public funds are all factors which "add to family tensions and the risk of children becoming scapegoats".

If we accept that deepening recession and unemployment can lead to worsening health in the community, then what is the social cost? Two Cambridge economists have estimated that a rise in unemployment of one million could give rise to additional public expenditure of £280m on health and community services over a five-year period. Those working for improved standards of health may find these costs difficult to bear.

Further reading

1. *Mental illness and the economy*, by Harvey Brenner. Harvard University Press, 1973.
2. *Unemployment and health in families*, by Leonard Fagin. DHSS 1981, £6.
3. *Unemployment and health*, by Malcolm Colledge. £2.50 inc post from North Tyneside CHC, Stephenson House, Stephenson Street, North Shields, Tyne and Wear NE30 1FT.
4. See for instance *Mortality and unemployment*, by H S E Gravelle et al, The Lancet, 26 September 1981, pages 675-679.
Suggestions for further reading, and references for the research work described in this article, can be obtained from Steve Parry at 128 Bromwich Street, Bolton, Lancs BL2 1LL. When writing, please send a stamped addressed envelope.

Caring in the community

*by Irene Bellerby, Administrative Assistant, South Tees CHC**

Community-based care aims to provide for people's needs in a flexible way which maintains links with ordinary life, family and friends. The new DHSS study (1) attempts to identify problem areas which may prevent community care achieving its full potential.

Community care means different things to different people. It can be used to refer to those services provided outside institutions, or to a philosophy of care based on minimising the disruption of ordinary living. It is often taken to mean local authority rather than NHS services, overlooking the contribution of the community health services — GPs, district nurses, health visitors etc — which deal with some 90% of the illness seen by the NHS.

It is often assumed that community care will prove to be cheaper, and at least as effective, but this belief has never been thoroughly examined. Early discharge schemes, day surgery and long-term care in the community carry implications both for the individuals concerned and for the "informal carers" — their family and friends.

Caring for a sick, disabled or elderly person may mean a loss of employment opportunities, and can result in depression, anxiety, strained relationships and a sense of isolation. Yet many families prefer to care for their sick patients at home, even though this entails hardship. Treatment provided in the community is often more in accordance with the family's wishes than hospital care.

Only a small proportion of **elderly** people receive community-based or residential services. Few of those who receive services do so on an intensive basis, and very few people seem to receive the intensive help that one might expect would need to be given if a real community-based alternative was being offered.

During the 1970s there have been increases in the provision of sheltered housing, home-care and day-care services, but the numbers in long-term residential and hospital care have stayed roughly constant. Coordination of services between the NHS and social services is most important. Otherwise one gets situations where, for instance, an old person attends a day centre on the one day meals are delivered to the home locally — simply because that is the only day when transport to the centre is available.

Most **mentally ill** people discharged from long-term care live at home on continuing medication but with little community support, other than from their GP and community psychiatric nurse. Most are free of symptoms and glad to be home, but they and their relatives tend to lead somewhat deprived lives. There has been an increase in day hospital, group home and supervised lodging schemes. Local authority day centre provision has grown more slowly than might have been expected.

The **elderly severely mentally infirm** make heavy demands on home support services, and often even a high level of support is insufficient to prevent the need for residential care. In view of the increasing pressure which can be expected as the population continues to age, a high priority should be given to the psychiatric needs of elderly people.

Relatively few **mentally handicapped** adults seem to be transferred from hospital to residential care. There has been an increase in the number of residential places for adults, and in the number of adult training centre places, but this growth is not being maintained. There is relatively little group home provision. The number of mentally handicapped children in hospital care has fallen, though growth in local authority provision has not been matched by the decline in numbers in hospital care. Much of the burden of home care for these children is falling on relatives and friends.

Early discharge and day surgery can result in individual patients being treated at a lower cost to the NHS. But one consequence is likely to be an increase in patient "throughput", which might in itself require more resources. These procedures can be as clinically effective as longer stays in hospital, but extra strain is placed on the informal carers. There are also implications for the workload of the community nursing service, and to a lesser extent for GPs. Adequate district nursing support for early discharge and day surgery is essential.

Day hospitals tend to have an important social function for patients, in addition to their rehabilitative function, and so have a low patient throughput. Transport is a particular problem in relation to day hospitals and day centres. The cost of transport can make day hospital treatment relatively expensive — accounting in some cases for about half the cost of each visit.

All community-based care depends on a high level of commitment from **informal carers** — their importance cannot be overestimated. But it cannot be assumed that informal care can be limitlessly increased. More spare time and earlier retirement is counterbalanced by the geographical separation of generations, and by more paid working by married women.

Statutory and voluntary agencies must recognise that an essential part of their function is to complement or supplement the care provided by natural caring networks. Traditional services such as day centres and home helps may be as important for the relief they provide to informal carers as for their benefit to patients. The availability of support can make all the difference to people's decisons on whether or not they can continue looking after family, friends and neighbours.

Where natural support networks are absent or deficient there also needs to be greater recognition of the potential of the organised **voluntary sector**. There has been an increase in "mutual aid" groups and neighbourhood schemes over the last five years. Voluntary organisations become particularly important when statutory resources are severely constrained, and when new forms of service need to be developed.

Good community care is a complex, interdependent network of facilities and resources. Changes in the provision of one service carry implications for the others. Coordination and communication are extremely important. Commitment to community care exists, but this could be undermined unless there is a shift in resources to match the shift in responsibilities. The DHSS study clearly states that the option of home-based care is often only available because much of the burden falls on relatives and friends. It is time to recognise this and to provide support for the supporters.

Photo: Tony Othen

This article is a shortened version of South Tees CHC's News Sheet No 75. A limited supply of these is available from the CHC at 1 Grange Road, Middlesbrough. Please send SAE.

1. *Report of a study on community care*, DHSS 1981, £3.85.

WHAT NEXT?

Finally we have the new DHSS guidance on the future role and membership of community health councils — circular HC(81)15. Finally in England, that is to say, for at the time this issue went to press the equivalent Welsh circular had not yet appeared. On these two pages we consider how the new ground-rules may affect the future work of CHCs.

Under a cloud again

by John Austin-Walker, Vice-Chairman of the Association of CHCs for England and Wales, and a Member of Bexley CHC

Once again community health councils are under a cloud of uncertainty, thanks to the apparent lack of interest of the new Secretary of State and to an indifferent new circular on CHCs.

Paragraph two of the circular gives no cause for optimism, since it is clearly the intention of the Government to reconsider the case for the retention of CHCs. In the meantime the *effectiveness* of CHCs could be reduced as a direct result of two Government actions: cutting off the funding of *CHC NEWS*, and reducing the size of CHC memberships. The Association of CHCs is putting a detailed case for the retention of *CHC NEWS* to the Secretary of State, but I believe that a sound information base and a means of exchange of ideas and views is essential to the effective operation of what are essentially local bodies. *CHC NEWS* makes a unique contribution in this field, and its loss — or indeed any diminution in its role — will surely have an adverse effect on CHCs.

Those CHCs which face a cut in membership will also be hampered in their work. What possible justification can there be for the reduction? Very few members ever claim any expenses, and these and the additional postage and printing costs have only a marginal effect on CHC budgets. I am sure that to ensure the continued effective operation of sub-committees, working parties, study groups etc CHCs will have to increase the number of co-opted members who serve on these, and in that event there will be no financial savings.

I know that many CHCs will be disappointed by the retention of the present balance between local authority and voluntary organisation appointees, though this may be more of an issue in rural than in urban areas. My own view is that the new district health authorities should have increased local authority representation, whereas this has actually been *reduced* compared with the existing area authorities. If DHAs had at least 50% local authority members this would be the first major step towards democratic control of the health service — something we should campaign for. With increased local authority representation on DHAs it would then be easier to argue the case for more voluntary organisation representation on CHCs.

Clearly the "two term" rule was unfair on members who had not completed two full terms of office, and hopefully the new rule will avoid this unfairness. Paragraph five, however, is most ambiguously worded, and after telephoning the DHSS as an innocent member of the public, and having been transferred to three different extensions, I am still awaiting clarification! Many CHCs will also welcome the power being given to RHAs to declare seats vacant where a member fails to attend for six months.

Arguments will already have started in the regions as to how the new CHCs will be constituted. My own view is that they should be wholly reconstituted, since it would be grossly unfair to reduce the size by "lopping off" retiring members. My own CHC is concerned about paragraph three of appendix two, which bars voluntary organisations from taking part in the procedure for selecting new voluntary sector appointees where they already have a representative on the CHC. We feel that because the voluntary members represent the whole community all organisations should be involved in their selection. We are also opposed to the rule set out in paragraph six of the circular, which bars from CHC membership ex-NHS employees who have been dismissed for reasons other than redundancy.

Bexley CHC welcomes the statement in paragraph seven of appendix one that the Secretary of State "sees no objection to individual CHC members *or officers*" providing assistance to members of the public at FPC service committee hearings (my italics). In our area the family practitioner committee has until now refused to allow complainants to be represented by CHC secretaries, on the grounds that they are NHS employees!

Perhaps what the circular does *not* say is more important. The Secretary of State does not propose to issue guidelines on the role of CHCs — this will probably be a good thing where there is a cooperative and productive working relationship between the authority and the CHC, but on the other hand guidelines would be valuable in the case of obstructive DHAs. Bexley CHC is also disappointed that the rights of CHCs to be consulted when new NHS services are being planned are not spelled out, nor is there any mention of the rights of CHCs in relation to RHAs. The latter issue is one which we feel will be of increasing importance in the reorganised NHS.

No doubt there will be sighs of relief now that the circular is out. But if the uncertainty about the future is frustrating to members, its effect on staff could be devastating. We have to begin the campaign to convince Ministers and MPs of the value of CHCs all over again — though the press, the public and most NHS workers are already convinced. Our aim should be to get a commitment to support and adequately fund CHCs into the General Election manifesto of each of the political parties.

A rag-bag of changes

by Mary Merricks, Secretary, Cambridge CHC

The years 1980 and 1981 were uncertain ones for CHCs, and 1982 seems likely to perpetuate some of the agonies. At a time when many CHCs were beginning to reap the rewards of painstaking public relations work in their early years, they were faced first with the threat of complete extinction and then with the threat of reduced powers.

Now we are offered a rag-bag of changes, of varying significance, embodied in a circular which is in one place so badly drafted that its actual meaning is unclear (paragraph five). One hopes that where there is doubt or room for discussion about interpretation of the circular, regional health authorities will consult with CHCs themselves.

The most potentially damaging provision is that CHCs are to be reduced in size. Except in the smallest districts, a membership of 18 is unlikely to give a CHC a reasonable geographical spread of members. More seriously, such a small CHC will find difficulty in arranging even occasional visits to all the hospitals, clinics and health centres in its district. Deprived of nearly half their "eyes and ears" and with a depleted workforce — for members *are* the CHC's workforce — some CHCs will feel their task is not just challenging but impossible.

There is logic in the decision to retain the largest share of seats on the CHC for local authority nominees, the "generalists", even though too many CHCs have found that the local authority members have been their weakest brethren. In many cases it is the voluntary organisation members, the "specialists", who have provided the council's backbone. However, the present decision — taken together with paragraph 22's exhortation to appointing bodies to

Taking a wider brief

*by Ruth Levitt**

We need not make heavy weather of this new circular about CHCs. We should simply see it as another vote of confidence and pass on to the work waiting to be done. It does not contain anything particularly surprising or dramatic, and even though one could quibble about some points it definitely gives CHCs endorsement and support for their continuing work.

There is, of course, a price to pay for all this official scrutiny. If CHCs were voluntary bodies, able to define and pursue their own objectives free from any government control, they might feel a lot less hemmed in. But since CHCs obtain distinct advantages from posssessing recognised rights and responsibilities, not least a guaranteed supply of money plus sanctioned involvement in planning

Pressure groups and voluntary organisations have to raise their own funds from month to month and year to year, and cannot assume financial security. As a result they feel much more precarious and vulnerable than CHCs when the economic climate becomes difficult. They do not usually have CHCs' access to official information, nor their rights to observe and participate in decision-making. Whatever the scope for improving CHCs' formal powers, they already unquestionably possess a workable statutory foundation which has so far withstood the test of seven difficult years very well.

But the consequences of official status need to be seen for what they are. Ministers, helped and encouraged by their civil servants, cannot resist involvement with small detail, even though their concern ought arguably to be with the major questions of health policy. They tend to feel more in control of things when tinkering with matters such as the structure of the NHS and the position of CHCs. Grappling with more fundamental issues often leaves Ministers feeling inadequate and overwhelmed, so they tend to put them to one side if they can.

It would therefore be naive of CHCs to expect to be left alone to get on with their business unscrutinised. The costs and benefits of having "statutory" rank should be seen for what they are; and undue worry about the fine print in the circular can probably be avoided. What the circular does provide, though, is an opportunity to think about the *limitations* on CHCs' scope for effective action which the legal status may create.

It is fairly clear after seven years' experience that most CHCs have concentrated on health *services* as the focus of their attention. They have realised that health itself is rather a different subject, but they have allowed themselves to follow the lead the NHS provides in focussing almost exclusively on services and plans for the treatment of ill-health. A minority of CHCs have felt uncomfortable about this bias, and have made great efforts to reduce the preoccupation with treatment services by giving a more conscious priority to health itself — its promotion and maintenance.

It is now possible to say that as long as CHCs stick faithfully to a narrow, NHS-labelled brief it is unlikely that they will achieve significant improvements in the health of their communities. But if they recognise that health is determined by many factors way beyond the reach and responsibility of the NHS alone, they will appreciate how broad their own field of attention ideally needs to be. The Royal Commission on the NHS said: "The curative and caring services make the essential contribution to the allevation of suffering and always will, but we regret that more emphasis has not been placed in the past on the preventive role of the NHS. This must change if there are to be substantial improvements in health in the future"

Following this advice is an important first step, but the "preventive role of the NHS" alone is not sufficiently powerful to bring about lasting improvements in health. Wider aspects, involving related services and policies which affect health, need to be explored. There is nothing in the new circular precluding CHCs from this, and a careful reading of all official guidance about CHCs shows just how flexibly the "rules" have always been set out.

The partnership between providers and consumers in health care is not the same as the partnership between providers and consumers of material goods. Although this parallel is often drawn it is quite misleading, since professional health workers cannot and do not provide health in the same way that car manufacturers provide cars. Health workers provide treatment services — not at all the same thing as health itself. CHCs have an opportunity to explore their role as partners in the achievement of their community's health, and to decide just how narrowly or widely they are prepared to tackle their important responsibilities.

confirm that prospective members can afford the time to do the job properly, and with the suggestion made in the same paragraph that local authorities might usefully appoint members from parish, town or community councils — *could* have a strengthening effect on CHCs, especially in the rural districts.

The extraordinary paragraph five, about terms of office, will have to be clarified. For the moment, it is sufficient to welcome the ruling that members who inherit the tail-end of somebody else's term of office will still, if they wish, be eligible to serve for two further full terms. Likewise there is good sense in the provision that local authority members who are defeated in a local government election should not from that moment lose their CHC membership. They are to enjoy a month's grace, and if their local authority wishes they may even continue in membership. This seems an entirely sensible decision, which may help to protect CHCs from excessive and damaging change.

Probably the most negative aspect of this circular is that which is true of the whole 1982 reorganisation — the valuable time it will waste. Many CHC secretaries will have to "write off" the equivalent of at least one or two working weeks as a result of the new guidance. I doubt if this is a good thing.

To sum up, this circular for which we have all been waiting for months with bated breath heralds few major changes for CHCs. We still have the same job to do, in largely unchanged circumstances. Most of us would have welcomed some positive measures to strengthen CHCs, but these have not been included in the package. Even so, there is still room for most of us to tap the human and other resources in our local community, to strengthen those resources which come to us through official channels. Our conviction as to the value of the work we do, and our realism about the current economic climate, will increase our determination to go on doing the job for which we were set up. But we are clearly still to some extent on trial, and it behoves us to remember this.

**Ruth Levitt is a former editor of CHC NEWS, and a former member of Kensington, Chelsea and Westminster North East CHC.*

Parliament

Seat belts

The new seat-belt regulations are open to comment until 8 February and should come into force in the summer. They will apply to drivers and front-seat passengers in cars registered on or since 1 January 1965, light vans from 1 April 1967 and three-wheeled vehicles from 1 September 1970. Children under 14 will have to wear seat belts if they travel in front seats. Exemptions for medical reasons, local delivery rounds and drivers reversing are provided for in the Transport Act 1981 and claims for other exemptions will be accepted "only on the most compelling reasons". Guidelines for medical exemptions are still under discussion with the BMA. A publicity campaign will explain the new regulations to the public and manufacturers will be encouraged to provide advice on comfort. Failure to wear a seat belt will attract a fine of up to £50. (Department of Transport press notice, 8 December)

Volunteers?

Only a month was given for comments on the DHSS consultative paper, *Opportunities for volunteering*, which invites suggestions from selected organisations on how to expand opportunities for unemployed people to do voluntary work in the health and personal social services. £4 million is available for neighbourhood care, community and self-help groups and voluntary and statutory agencies. Priority will be given to schemes that will secure lasting benefit from increased volunteer involvement (Chris Patten, Bath, 7 December)

Doctors' hours

A conference will be held on 12 February to discuss hours worked by junior doctors, following the recommendation from the Social Services Select Committee that the maximum should be reduced to 80 hours a week. Health Minister Dr Vaughan says this has been agreed policy for some years, but long hours arise from the need to provide round-the-clock medical cover. Plans to double the number of consultants will help in the long term, but earlier action is needed (Frank Haynes, Ashfield, 7 December)

Sickle cell disease

The DHSS has passed on to health authorities the suggestion from the Home Affairs Committee that hospitals in high risk areas *should consider* providing neonatal and adult screening for sickle cell disease.
In the Afro-Carribean community 1 in 10 is a healthy sickle cell trait carrier and 1 in 400 babies is born with sickle cell disease (Reg Freeson, Brent East, 12 November)

Home insulation

From 31 December 1981 the 90% grant for home insulation will be extended to severely disabled people receiving supplementary allowances, rent rebate or allowance or rate rebate if they also receive mobility or attendance allowance (Michael Shersby, Uxbridge, 9 December)

Kidney patients

Around 2200 people develop chronic renal failure every year in the UK, but numbers of new patients starting treatment were:

1978	1182
1979	1206
1980	1373

Figures for treatment in the UK compare badly with France and West Germany, especially for patients over 65, and Health Minister Dr Vaughan accepts that facilities are insufficient to meet the estimated need.
(Lewis Carter-Jones, Eccles, 29 October, and John Hannam, Exeter, 26 October)

Mobility

New regulations provide an overlap period of about six months for drivers of invalidity vehicles wanting to change to the mobility allowance, currently £16.50 per week. This will allow them to keep the invalid trike while using the allowance to learn to drive a car (DHSS press release 23 December)

Psycho-geriatricians

Out of 199 English health districts 105 have a consultant psychologist with a special interest in the elderly. Within RHAs consultant cover varies considerably. SW Thames is top of the league with 13 of its 14 districts covered, but West Midlands in bottom place has a consultant in only 6 of its 22 districts (Lewis Carter-Jones, Eccles, 29 December)
At 30 September 1980 there were 405 consultant geriatricians and 1083 consultants in mental illness in England and Wales. Within the previous year 23 advertisements for consultant posts mentioned the psychiatry of old age—but additional training posts in this field have been authorised (Jock Stallard, St Pancras North, 16 November)

Extremely irritating

by Christine Orton, Information Officer, National Eczema Society

In one form or another eczema is thought to affect around 4% of the population, causing intense irritation and discomfort to sufferers. In its acute stages the red, spotty rash can be very disfiguring and can influence large areas of people's lives, from what they eat to what they wear to what sort of job they have.

Yet in spite of this there are many who consider eczema to be a fairly trivial problem, easily controlled by steroid creams with, perhaps, a touch of will-power thrown in.

A few years ago I wrote an article for a national newspaper about my eight year old son's eczema. I described the irritation and soreness that had plagued him almost since birth, his self-conciousness about his appearance, the nights of broken sleep, our constant search for successful treatments and our fears about the over-use of steroid preparations.

Within days the newspaper office and our home were inundated with hundreds of letters from people all over the country saying that our experience was just like theirs. We all came together for a meeting in London, and the *National Eczema Society* was formed. By the following year the society had been registered as a charity and now, six years later, we have a quarterly magazine, over 50 local branches, a head office in London and an annual grant from the DHSS.

The society has three main aims — to give moral support, to educate both ourselves and others on the management and meaning of a condition such as eczema, and to raise money for research. Countless members have been reassured and often given practical help by meeting each other and by attending national conferences and branch meetings, where they can hear medical advice not so easily available in a crowded, busy surgery.

Publicity about eczema has brought the disorder to the attention of a much wider public. Each year a special week focuses on its problems and now far more people know that eczema is not infectious, a fear that must be one of the main reasons for the stigma surrounding skin conditions in general.

As well as the magazine *Exchange* the society now has a range of leaflets, including one explaining the condition to children and another about the safe use of steroids. Through such literature patients and their families are able to learn about the management of the social and emotional effects of eczema as well as the physical ones.

Through the NES Research Fund many thousands of pounds have been raised and distributed to various research projects on different aspects of eczema, including the mysteries of dietary treatments and immunology. And on top of all this comes the comfort of knowing one is not alone. As one mother put it recently, in a letter to the society magazine: "Thank you for just being there."

For more details send an SAE to the National Eczema Society, Tavistock House North, Tavistock Square, London, WC1H 9SR. Christine Orton has written a book covering other skin conditions and self-help groups, entitled *Learning to live with skin disorders*, published by Souvenir Press in their Human Horizons series.

Scanner

Bad fit, bad feet

The trouble with children's shoes, says this report, is that they are often outgrown before *they are outworn, and this can* hide the fact that young feet are being damaged, sometimes permanently. The report shows that three-quarters of all adults suffer from foot complaints, many of which originate in *childhood, points out that* there is no overall policy to promote foot health in children and ends with questions directed at those bodies which *should* be involved. A guide to fitting and buying children's *shoes is included. From the* National Consumer Council, 18 Queen Anne's Gate, London, SW1 (£1 inc post).

Bored sick?

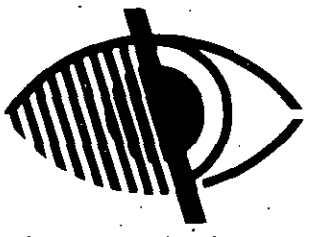
The Unemployment Alliance has turned its attention to the links between unemployment and ill health. Its report concedes that more research is needed, but says there is enough evidence of a link between the two to justify immediate remedial action. The Alliance is supported by a *range of voluntary* organisations including MIND, the Disability Alliance, Age Concern and the Child Poverty Action Group. Its report is *Ill health and unemployment* by Jennie Popay, from 26 Bedford Square, London, WC1B 3HU (£1 inc post).

Maternity action

Is the name of a new bi-monthly magazine from the Maternity Alliance, which campaigns for improvements in services for pregnancy, childbirth and the first year of life. The Alliance has just moved office, so *Maternity action* can now be obtained from The Maternity Alliance, 309 Kentish Town Road, London, NW5. Tel: 01-267 7477. Free to members, *subscription £3 per annum.*

Drinking sensibly

Is the title of the latest booklet in the DHSS *Prevention and health* series. It pulls together evidence of the sharp increase in alcohol-related deaths since 1970, lists the effects of alcohol misuse on health, accidents, employment, crime and family life, and discusses costs in terms of deaths and illness, court actions, traffic accidents and the burden on the economy. Speculation on the causes of excessive drinking is followed by a chapter on health education to encourage people to drink sensibly, and another on identifying those who do not. But the booklet shies away from Government intervention through price and legal controls, citing the importance of the alcohol industry to employment, revenue and the balance of payments. Copies £2.95 from HMSO.



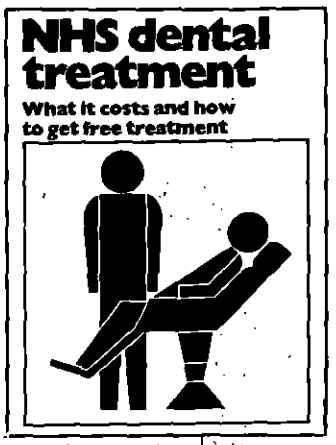
This is a new identification symbol for partially sighted people. Available as a lapel badge or card, it will also be used in libraries and shops where services for visually disabled people can be found. Enquiries to the Partially Sighted Society, 40 Wordsworth Street, Hove, BN3 5BH. Tel: 02373 736053.

Disabled living

Is another new magazine, to be launched in March as a "high-quality" monthly aimed at *disabled people as consumers.* Regular space will be devoted to specialised products and services. *Disabled living* will be on sale at bookstalls and newsagents at the end of March, price 60p.

Into the community

In June 1980 a conference was *held to share experiences of* practical alternatives to hospital care for mentally handicapped children. *Bringing mentally handicapped children out of hospital* was commissioned by the DHSS to *describe these schemes for a* wider audience, and its publication coincides with that of the Government guidelines on the £1-for-£1 scheme to encourage community projects for children in long-stay hospitals. The booklet looks at the size and scope of the task ahead and describes a variety of ways of helping these children. By Ann Shearer, copies from the King's Fund Centre, 126 Albert Street, *London,* NW1 7NF (£1).



DHSS leaflets

New leaflets on dental treatment (D11), glases (G11), milk and vitamins (MV11) and prescriptions (P11) now replace leaflets NHS4 and 6, M11 and form FP91. A revised version of leaflet NI12 on unemployment benefit has also been issued.

When your child is very severely handicapped

The prospects seem bleak and this sober Spastics Society leaflet does not offer any false hopes to parents whose child is born with or acquires severe mental *and* physical handicap. It is a starting-off leaflet with a list of helpful organisations and ideas for further reading. It also tries to begin to answer the questions that parents ask themselves when faced with such a tragedy. *Facing the future* Spastics Society, 12 Park Crescent, London W1N 4EQ. Send sae for single copy.

Health Circulars

HC(81)11: an increase in licence fees for nurses' agencies and a requirement to keep records of knowledge of English in nurses trained outside the UK.
HC(81)12: transfers of staff *under NHS reorganisation.*
WHC(81)13: the Welsh version of the circular on patients' complaints.
HN(81)34: sets out the issues for RHAs when examining DHA management plans.
HN(81)38: extends to 16-18 year olds in full-time education remission of optical charges on grounds of low income.
HN(FP)(81)45: exemption *from prescription charges for* women whose babies are stillborn or die in the first year of life.

CHC Directory: Changes

Changes to the CHC Directory are published on this page in each issue of CHC NEWS. Please let us know if your entry needs updating. Single copies of the directory are available free — send an A4-size self-addressed envelope and 25p in stamps.

Page 2: Darlington CHC *Chairman: Mrs P Exelby*
Page 2: South Tees CHC Chairman: Mrs Joan Thornton
Page 3: Beverley CHC *Chairman: Mrs M E Fox*
Page 3: York CHC Chairman: Coun. W J Anderson
Page 3: Dewsbury CHC *Chairman: Mrs Joanna Cole*
Page 6: North West Herts CHC Chairman: Mrs Heather Rutt
Page 6: Ealing CHC *119 Uxbridge Road, Hanwell, London W7.* Tel: 01-579 2211
Page 8: Tunbridge Wells CHC *Chairman: Mrs Kathleen Meade*
Page 9: Cuckfield and Crawley CHC Chairman: Mrs J A Shepheard
Page 9: East Surrey CHC Chairman: Mrs B M Dempster
Page 9: Bromley CHC Chairman: Mrs Karen D Street. Secretary: Mrs Jean Coupe
Page 10: Winchester and Central Hampshire CHC Chairman: Mrs F M Sheldon
Page 11: Weston CHC Chairman: Coun. Alan Ham
Page 11: Northampton CHC Chairman: Mr Philip Wilkinson. Secretary: Mrs Jacqueline Walker.
Page 13: North Warwickshire CHC Chairman: Mr David T Hopkins
Page 13: South Warwickshire CHC Chairman: Coun. A E Fitchett
Page 13: South Birmingham CHC Chairman: Mrs A Court
Page 14: Macclesfield CHC Chairman: Coun. J Herwald Morris
Page 15: Stockport CHC Chairman: Dr C E Davies
Page 17: Aberconwy CHC Secretary: Alan Challoner
Page 18: Association of South Western Regional Chairmen and Secretaries Chairman: Coun. Alan Ham
Page 19: North Western Regional Association of CHC Secretaries c/o Salford CHC, 1 Hulme Place, The Crescent, Salford, M5 4QA. Secretary: Michael J Walbank. Tel: 061-737 1500.

News from CHCs

☐ **SE Cumbria CHC** followed up its survey report on services for the young physically handicapped with a one-day conference, attended by local handicapped people, members of voluntary organisations and health and social services staff. Speakers included CHC member David Caldwell, who advises British Rail on disabled people's mobility needs, and Claudia Flanders, an **Ealing CHC** member, who does a similar advisory job for the National Bus Company. SE Cumbria has also produced a survey report on the transport difficulties encountered by people visiting NHS premises, for discussion with the county council transport department and voluntary transport organisers.

☐ Government suggestions that the NHS could in future be financed through health insurance schemes have prompted **Leeds Western CHC** to set up a working party, to look into the implications for the service.

☐ The **Association of Scottish LHCs** has succeeded in its campaign to bring Scottish GP locums and deputies within the scope of the NHS complaints procedure. Under Scots law GPs and other professionals cannot be held responsible for the actions of other people, and until now this has meant that locums not contracted to the Scottish health boards were immune from complaint unless the patient was prepared to take legal action. The problem was first publicised by **Hamilton/East Kilbride** and **Edinburgh LHCs**, and at its AGM last year the ASLHC decided to press the Scottish Office to close this "responsibility gap". A group of over 20 Scottish MPs took the matter up, and the Scottish Office has now issued a circular making GPs responsible for the actions of their locums

☐ Also in Scotland, the four LHCs in the **Dumfries and Galloway** health area have decided to amalgamate into a single council to serve the area's 143,000 population.

☐ The sale of health centres to GPs practising from them is not in the long-term public interest and so should not be encouraged. The **Association of CHCs** will be putting this view strongly to Social Services Secretary Norman Fowler at the request of **Peterborough CHC**, which says it is opposed to such sales "except in the most exceptional circumstances".

☐ **East Berkshire CHC** has been cold-shouldered by its "shadow" district health authority, by not being allowed to send an observer to the authority's meetings. Most CHCs in the Oxford and West Midlands regions have been granted observer status, and the CHC is concerned that decisions of great significance may be taken in secret at the "shadow" meetings with no chance for the NHS consumers' voice to be heard. CHC secretary Juliet Mattinson said: "It is an incomprehensible decision since they will have to accept a CHC observer from 1 April. It doesn't seem the best way to start a constructive relationship, which is what the CHC wants".

☐ **Salford CHC** is running a series of six weekly meetings on women and health: on stress, pre-menstrual tension, coping with children, children's health, contraception and nutrition. The Wednesday-morning sessions will be held in a local church and will last about ninety minutes, with a creche available.

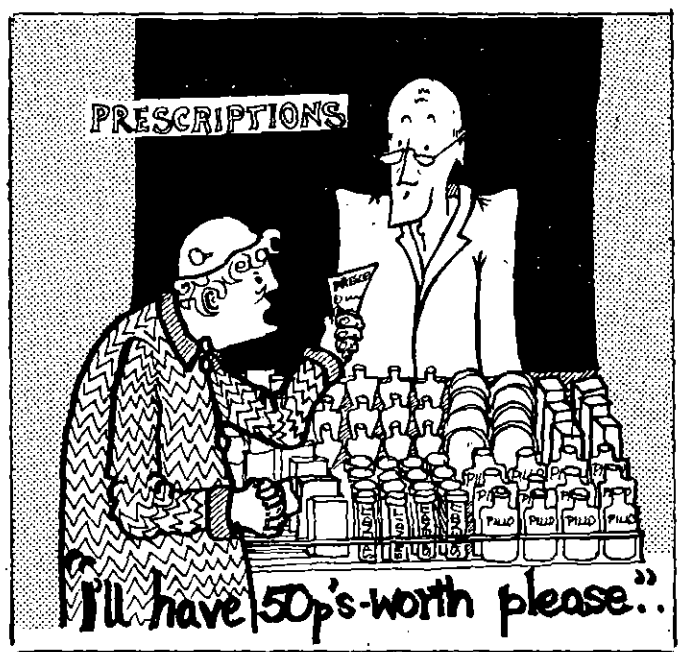
In 100 pages The Wandsworth women's health book *spans the whole range of women's health issues, including sections on infertility, pre-menstrual tension, mental health, nutrition, self-examination and violence to women. Well-researched and beautifully illustrated, it is available free from* **Wandsworth and East Merton CHC**

☐ In correspondence with the DHSS, **Central Derbyshire CHC** has discovered that the stocking of DHSS leaflets is left to the discretion of local offices. The CHC has written to all post offices and DHSS offices in its district, listing all the DHSS leaflets which contain information on health matters, pointing out which ones the CHC considers particularly useful, and asking office managers to bear the list in mind when reordering. **ACHCEW** is considering whether to ask the DHSS and the PO to issue central guidance on this.

☐ **Durham CHC**'s secretary Joe Hennessey has been awarded the OBE in this year's New Year's Honours List.

☐ With the aid of local GPs, hospital staff and MPs, **Bexley CHC** has fought off a proposal to close a GP ward at Queen Mary's Hospital, Sidcup. The AHA wanted to close the 29-bed ward temporarily to save money. Former Prime Minister Edward Heath led a deputation to meet Health Minister Dr Gerard Vaughan, who eventually agreed with the CHC that the ward should stay open.

☐ A new maternity unit in the **Macclesfield** district will quite possibly be the only such unit in the north west without a bath, claims the CHC. It accepts that there is a school of professional thought which prefers showers to baths, but feels that it should have been consulted for the consumer viewpoint at the planning stage of the new building. The CHC has made its views known to district and through the local media, and plans to carry out a consumer preference survey when the unit has been operating for a reasonable length of time.



☐ *Prescription charges are the subject of* **Brent CHC**'s *second Health Rights Leaflet, with sections on free prescriptions, exemption certificates and "season tickets". The leaflet goes on to contrast cuts and shortages in the NHS with increases in defence spending, and to challenge the idea that people are visiting their doctors too often and expecting "a pill for every ill".*

Other CHC publications

☐ Good practices in mental health in Camden (**North and South Camden CHCs**), Hospital food for ethnic minority patients (**Haringey CHC**), Alcoholism services for Haringey (**Haringey CHC**), Report on a children's hospital visiting survey (**Stockport CHC**), The health care of the elderly (**Torbay CHC**), Your NHS: Your rights and obligations (versions in Bengali, Hindi, Punjabi, Urdu and English; **Walsall CHC**), I am labelled disabled (65p inc post from **Brent CHC**), and Healthy play—healthy children (report of a conference held in July 1979, £1 inc post from William Smith Booksellers Ltd, 35 London Street, Reading; **West Berkshire CHC**).