CHC NEWS

For Community Health Councils May 1982 No 76

FOCUS ON RIGHTS

A major campaign to strengthen the rights of health service consumers and community health councils is being launched by the National Consumer Council, to coincide with the publication of its guide *Patients' rights* (1).

The NCC's Consumer Congress '82, meeting in Guildford at the end of March, welcomed the new guide "as a description of the existing rights and responsibilities of patients and doctors" but noted with concern "the limited and vague nature of those rights and lack of effective redress and representation for consumers of the NHS".

Four proposals emerging from the congress workshop on consumers in the national health service were adopted:

- That patients be given fundamental rights regarding access to information (including case records) and standards of care (including clinical judgement) backed up by an effective complaints and redress procedure.
- That family practitioner committees and health authorities be required to publish information about their policies and the services they provide.
- That CHCs be given a statutory right to membership of family practitioner committees, and
- That CHCs be given an absolute right to information on all matters affecting the delivery of health services in their district.

Delegates voted 130-10 to call on the NCC to campaign for the implementation of these four points, and it was agreed that the NHS should be given top priority during the coming year. The campaign was felt to be particularly urgent because of the possible effects of reorganisation, and some delegates also warned that successive governments had eroded the basic NHS principle of access to good medical care irrespective of ability to pay.

Photo: Raissa Page

It was suggested that health authorities should publish statistics about the type of care provided by particular consultants, so that patients would be in a position to make informed choices. Full information about the possible side effects of drugs should be made available to patients, for instance so that pregnant women could decide whether or not to accept drugs during labour.

According to the NCC's John Ward, publication of *Patients' rights* later this month will be followed by an "energetic consultation phase" in which CHCs will be the prime target. The NCC will be looking for evidence about the ways in which patients' rights are ignored or inadequate, and will press for tough new legislation if this seems justified. CHC members may be sent individual questionnaires and invited to local or regional meetings, and the NCC may be able to help CHCs develop new techniques for monitoring local services where this could throw light onto questions of rights.

CHCs will be sent 30 free copies of the *Patients' rights* guide and 150 free copies of the accompanying leaflet. Further copies of the guide will be available to CHCs at a special discount rate, and the NCC hopes that CHCs will help by acting as local distribution points for the guide and leaflet. Further information from John Ward, Tel: 01-222 9501.

1. *Patients' rights: A guide to rights and responsibilities of patients and doctors in the NHS*, £1.50 inc post from the National Consumer Council, 18 Queen Anne's Gate, London SW1H 9AA.

Our survival plans

The DHSS is making a grant of £30,000 to *CHC NEWS*, to ease our transition to a subscription funding basis. The grant should keep the magazine afloat until the end of September, and its announcement seems to mark the failure of the Association of CHCs' campaign to retain central funding. *CHC NEWS* will continue to be available free to all CHCs until the October issue — but the Editorial Board is appealing to CHCs to make their subscription intentions clear as soon as possible, so that the future of the magazine can be properly planned. For details see letter on next page.

Planning changes

New guidance on health service planning suggests that community health councils should be consulted informally by DHAs throughout the development of strategic plans and operational programmes.

The new DHSS circular (2) says that CHCs may be represented on district planning teams "where they have a significant contribution to make", but if they are not "some other method of informal consultation should be found". CHCs will still be entitled to formal consultation, but "if opportunities for informal consultation are taken the formal consultation stage can be much shortened."

DHAs will be the basic planning units in the new system, issuing ten-year *strategic plans* every five years. Operational planning will now consist of an *annual programme* setting out the DHA's firm development proposals for the year ahead (the *operational programme*) and its provisional proposals for the subsequent year (the *forward programme*).

2. *The NHS planning system*, DHSS circular HC(82)6, March 1982.

INSIDE ...

Your letters

The future of *CHC NEWS*

John Austin-Walker, Chairman, CHC NEWS Editorial Board

In March I wrote to all CHC secretaries about the decision by the DHSS to cease central funding of *CHC NEWS*. At its last meeting, the Editorial Board felt that I should make a statement on its behalf to all readers of the magazine.

Since civil servants first communicated the decision to us, without consultation, we have been attempting to reverse the DHSS decision. Despite an effective campaign, there seems little prospect of the Government changing its mind. However, the DHSS has agreed to provide an interim grant of £30,000, to assist the transition from central funding to a subscription basis, and this should keep the magazine going until September.

That *CHC NEWS* has continued to appear at all during the last few months is in itself remarkable. In the uncertain situation we have been unable to fill the vacant post of assistant editor, and we have been short-staffed since mid-October. The board wishes to thank Dave Bradney and Gill Kent for all their hard work during a time of staff shortage, when their own positions have been and remain so uncertain.

In my letter to secretaries I enclosed a questionnaire and sought an urgent response from CHCs. We recognise the difficulties that CHCs may have in responding during the uncertain period of reorganisation, but the Editorial Board has a responsibility to ensure continued publication and also has responsibilities to its staff. It would be tragic if the new CHCs, many of them reduced in size, had to operate without a major source of information and a means of exchanging views.

A number of suggestions have been made by CHCs and individuals, and I wish to assure readers that these are all being seriously considered by the board. We are exploring the possibilities of increasing income by way of grants and donations, and from increased sales to DHAs and other "outside" bodies. We are also looking at suggestions for reducing costs. It must be stressed, however, that about 45% of expenditure goes on staffing, and we do not consider that it is feasible to operate the Information Service and produce *CHC NEWS* at its present size and regularity with a staff of less than two.

Actual production costs amount to about 30% of expenditure, and again we do not think that major savings can be made. We are looking seriously, however, at different methods of printing and possibly a different format. The board has looked at some immediate cost-cutting suggestions which it has decided not to implement. For example, it has been suggested that we might dispense with photographs, but these costs amount to only 0.7-1% of total expenditure. The savings would be minimal therefore, compared with the effect on the magazine.

Other suggestions such as reducing office overheads and services (12% and 9% respectively of our expenditure) are being looked at, but any decisions here would have an obvious and far-reaching effect upon the Association of CHCs, with which these items are shared. Even if substantial savings could be identified in these areas, which we doubt, they could not be implemented in the short-term and would have to be carried out in consultation with ACHCEW.

If we can get some decisions now which ensure the survival of *CHC NEWS* in its present form for at least another year, then we shall have time to plan its future with more certainty and with greater consultation. Notwithstanding the difficulties of finance and reorganisation we hope that readers will ensure that their CHC responds to the questionnaire as soon as possible, and we hope we can count on your support in this difficult period. The board will of course present a full report with recommendations to the ACHCEW annual meeting in Coventry next month.

"Clamp-down" comment

Harold Greenfield, Member, Cambridge CHC

I would like to comment on Cambridge CHC's dispute with its RHA over paying legal fees for the rehearing of an FPC complaint — reported in *CHC NEWS 74* pages one and eight.

As a member of the CHC I would like to emphasise that the decision to give the patient in question legal representation out of CHC funds was not unanimous. I spoke against it myself. My view, which I suspect had the support of others present, was that we should help this patient by providing information and assistance, offering to attend the hearing in support, and so on, but should stop short of directing our already very limited funds to the provision of legal aid. No matter how compassionate we may feel about a particular case, the fact remains that CHCs are operating on "shoe-string" budgets. We should aim to spend our resources to the advantage of the community at large.

Nevertheless, in support of my Chairman's basic instinct to help someone in need, I was ready to make a personal contribution to this case, as I am sure anyone would do when confronted with a person in distress.

The CHC's role in such cases is to take up the challenge and fight for the patient's right to have proper representation so that similar situations do not arise in the future.

CHC NEWS

MAY 1982 **No 76**

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

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CHC NEWS is distributed free of charge to members and secretaries of Community Health Councils in England and Wales. It is also available to subscribers at £10.00 per annum (less 20% discount if five or more copies of each issue are ordered). Overseas rates on application.
CHC NEWS is published by the Association of Community Health Councils for England and Wales. It is designed by Ray Eden and printed by Feb Edge Litho (1979) Ltd., 3-4 The Oval, London E2.

Debendox development

Catherine Tricker, Debendox Action Group, 47 Mildred Avenue, Watford, Herts.

It certainly came as welcome news that a resolution had been passed at last year's Annual General Meeting of ACHCEW, calling for the suspension of the anti-nausea drug Debendox pending full research into its effects on the foetus.

Since the formation of our Action Group we have been pressing for the removal of dicyclomine hydrochloride from Debendox just as it was removed in the United States over five years ago, on the grounds of safety and efficacy. Until now, the drug company has maintained that there was no intention to remove this ingredient in the UK. But it has now been announced that the company proposes to reformulate Debendox to exclude dicyclomine.

Unfortunately its removal does *not* leave us with a safe and harmless drug. New animal studies from California and West Germany also implicate doxylamine succinate, one of the two remaining ingredients, as a teratogen — capable of producing birth defects.

Meanwhile, the prescription rate for Debendox is on the increase again despite the cautionary note sent to doctors last year warning against its use in early pregnancy. It can only be regarded as irresponsible for doctors to continue to prescribe a drug for pregnant women which is regarded by so many as potentially damaging.

Grants for travel

The Secretary, Allan Brooking NHS Travel Fellowship, UTF House, 26 King Square, Bristol, BS2 8HY

NHS staff of all disciplines are invited to apply for travel grants from this new charity. Subjects proposed for study should be of a non-clinical nature and broadly related to the organisation of health services. Applicants should submit an essay of between 1000 and 2000 words. Further information and application forms from the address above. Closing date for applications is 31 May.

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.

Comment

No-one has ever pretended that the Chronically Sick and Disabled Persons Act conferred inalienable rights upon disabled people. Local authorities have a duty to provide certain basic services for those in need, but are expected to assess that need themselves and to draw up their own criteria for assessment.

Since 1970 organisations for and of disabled people have nagged and cajoled councils to acknowledge their responsibilities towards their disabled populations, particularly under Section 2 of the Act, which specifies services essential for the maintenance of independence in the community — home adaptations, home helps and so on.

After a decade of delays and disappointment, fourteen charities combined under the stewardship of the Royal Association for Disability and Rehabilitation (RADAR) to set up a year-long project centralising the handling of complaints to investigate how the Act could be enforced.

The results of the project have just been published (1) and are shaming. Complaints were brought against 101 local authorities out of 116 in England and Wales. Some 555 cases were investigated throughout the year, involving 643 people, half of whom were over 60.

The outcome was unsatisfactory in many of these cases. The most disturbing finding of the project was the attitude of the Secretary of State, who would query a council's decision only in the case of a named individual, while refusing to consider the many anonymus people in the area equally affected by that decision.

But recent events suggest a change in this attitude. Liverpool City Council has agreed to provide telephones for several hundred people on a waiting list after RADAR took up the case of an individual. After deciding in favour of the person, the Secretary of State wrote to the council *about the waiting list itself*. Ministerial powers under the Act are considerable but this is the first time they have been used in this way — let's hope it's not the last.

Putting teeth in the Act price £3 inc post from RADAR, 25 Mortimer Street, London W1.

Health News

Real-terms cuts are on the way

Significant cuts in services seem inevitable in many health districts during 1982/83 — despite the Government's Budget promise of 1.7% overall growth in spending on hospital and community services.

This is the gloomy forecast of a financial analysis (1) prepared by the National Association of Health Authorities, which points out that DHAs will need at least 1% growth to cope with the demands of an ageing population and advances in high-technology medicine. Authorities have also been told to fund part of their growth through 0.2% efficiency savings, so the actual amount of "new money" for the development of services could be less than 0.5% overall.

Because the Resource Allocation Working Party (RAWP) formula is continuing to operate, regions this year have been allocated growth rates ranging from 0.3%-0.46% (Thames regions) to 3.25% (East Anglian). An "average" DHA in NW Thames, with a budget of £40m and a growth rate of 0.3%, will be getting only £120,000 more than a year ago, even though it will need an extra £400,000 to cope with population and technological changes. This represents a 0.7% cut.

If inflation during the year is 11% rather than the 9% the Government has allowed, another £200,000 will be needed. If NHS pay settlements average 5½% instead of the 4% allowed, that will add a further £220,000 to the bill. The overall cut would then be 1.7%. Similar calculations for the West Midlands region, with a 2.2% growth allocation, show real growth of just 0.15%. For East Anglia, with a supposed growth rate of 3.25%, real growth of 1.2% would be possible.

The outlook for the next two years is no better. Cash increases of 6.2% and 5.3% have been allowed, with 0.5% to be found by DHAs through further efficiency savings in each year. So if inflation and pay awards combine to boost costs beyond the increases allowed, further cuts in services will be needed.

The whole system of calculating health authorities' revenue allocations has now been switched from "volume planning" to "cash planning", meaning that shortfalls in inflation funding will not automatically be made good at the beginning of each year and so may be perpetuated indefinitely into the future. Volume planning gave health authorities confidence in future growth rates, and NAHA warns that because of the new system planning may lose credibility, leading to "ineffective use of resources and waste of public money"

● Another NAHA survey (2) has shown that at least 88 university-funded medical and dental staff posts with a commitment to the NHS are currently "frozen" in England and Wales, because of financial cuts imposed by the University Grants Committee. The total annual cost of these posts is about £1.23m, and NAHA is pressing the UGC to protect such posts where patient services could be affected.

1. *The financial situation of the NHS*, copies from NAHA, Park House, 40 Edgbaston Park Road, Birmingham B15 2RT
2. *UGC cuts and the NHS*, as above.

Infectious hospitals

Hospital inpatients with an infectious disease are almost as likely to have caught it after admission as before, according to the deputy director of the Public Health Laboratory Service (3). Dr Peter Meers says a survey of over 18,000 hospital patients carried out in 1980 found that 9.2% had hospital-acquired infection (HAI), as against 9.9% whose infections had begun before admission. In special care baby units, 16.8% of all babies had HAI, and amongst orthopaedic patients the figure was 13.1%. Dr Meers warns that hospital doctors and nurses often deny the existence of HAI, because it is taken so much for granted.

3. *Infection in hospitals*, by P D Meers. Nursing Times, 10 March 1982, page 416.

Inspecting private homes

An independent authority should be set up to register, inspect and advise private residential homes, says Age Concern England in its response to the DHSS consultative document *A good home* (see circular HN(82)6 for details). At the moment local authorities carry out these functions, but Age Concern believes that spending cuts are putting local authorities under undue pressure to keep private homes running. An independent authority would be better placed to set national standards, keep tabs on unsatisfactory proprietors and solve the problems which arise when a home cannot easily be categorised as residential or nursing. An independent authority could also cover private nursing homes, which at present are inspected and registered by health authorities.

Hazards of lifting

The health service union Cohse is calling on health authorities to give adequate training in lifting techniques to all staff who handle heavy loads in the course of their work. Lifting is widely acknowledged to be one of the most hazardous aspects of NHS work, and a national survey carried out by Cohse has shown that under a quarter of all health authorities include training in lifting techniques in their health and safety policies. Most nurses were at least given rudimentary training in lifting, but training was rarely provided for porters, ancillary workers and technical staff. Health authorities have a duty under the Health and Safety Act 1974 to provide training in lifting.

● Article on occupational health in the NHS, see next page.

HOSPITAL AS WORKPLACE...

*by Francis J Cox**

The origins of occupational health go back to Roman times, with crude measures to control dust in mines. Modern definitions of occupational health have a three-pronged focus. The International Labour Organisation described it as:

- Protection of staff against hazards arising from work or working conditions.
- Adaptation of work to staff and their assignment to jobs for which they are suited.
- Contributing to the highest possible degree of physical and mental well-being of the staff (1).

The final part of this definition mirrors the World Health Organization definition of health, but the particular focus of occupational health is environmental and preventative rather than curative or therapeutic. Identifying hazards, avoiding potential risks, environmental surveillance and health education are crucial.

Occupational health services developed initially in the traditionally hazardous heavy industries. Why then is an occupational health service desirable for NHS staff? To most people a hospital represents a safe, clean, warm and caring environment, but to those who work in the NHS the picture is somewhat different.

Antiquated buildings — sometimes former workhouses — are in a poor state of repair and obviously not suited to the demands of modern medicine. Even some of the newer hospitals are riddled with asbestos.

Risks to staff have resulted from the more widespread use of x-ray and nuclear radiation and infections such as hepatitis and TB are recurring problems — hospital staff are not magically immune to infection.

Laundries, path labs, kitchens and pharmacies all present unique risks and hazards. Anaesthetists and theatre personnel are especially vulnerable to leaking gases, which have been shown to cause birth defects, miscarriages and possibly cancer.

Lifting patients and equipment is a major cause of back injury.

Finally, the emotional strains and stresses and the physical demands of NHS employment, particularly nursing, are frequently overlooked.

The risks and hazards are clear, but concern and vigilance about health and safety have developed late in the NHS. Among the main reasons for this has been the ethos of the primacy of the patient. "Florence Nightingale" attitudes of self-effacement still predominate, especially amongst nurses. Many view occupational health services as diverting scarce resources away from patient care. But, just as staff are not magically immune to patients' infections, so patients and visitors are not especially protected from the hospital environment.

Furthermore, working conditions crucially affect staff morale and sickness absence. For example, where shortages of nurses result in ward closures, a 50% reduction in sickness absence in a large hospital could represent an extra ward remaining open for a year. And staff morale has much bearing on the quality of patient care.

From the inception of the NHS the need for occupational health services for NHS staff was accepted. However it was not until the *Tunbridge report* (2) in 1968 that it was considered at national policy level. The report recommended the "early establishment" of such services and that these should be run by suitably qualified staff. The functions of these services were to cover both "curative" and "preventative" aspects, including pre-employment medicals, routine medicals, examination or advice after sickness absence, maintenance of immunisation and staff health records, advice on environmental health and safety conditions (including planning of new buildings), health education, research, initial treatment of staff injured or sick at work, liaison with GPs and counselling.

Progress was slow and uneven because no extra funds were allocated by the DHSS for this purpose. As late as 1979 the Royal Commission on the NHS said: "The NHS should assume the same responsibility as any other employer for the health and safety of its staff and set up an occupational health service" (3). Yet the latest DHSS priorities document *Care in action* (4) makes no mention of staff health and safety *at all*, and guidelines promised by the Department in 1977 (5) have yet to materialise.

This lack of commitment at governmental level has meant that development of occupational health services in the NHS has been sporadic. Studies undertaken since the Tunbridge report (notably by the Health and Safety Executive) and my own research show that staff health services in the NHS have several distinct characteristics.

- There are wide variations in service from area to area.
- Services are generally poorly funded, having to compete with other specialties for finance.
- Management lacks awareness and motivation in the field of staff health.
- Occupational health personnel are generally poorly qualified.
- The emphasis is almost exclusively on "treatment" or medical examinations rather than on "prevention" or environmental surveillance.

As I have explained, the false dichotomy between staff health and patient care is a major reason for lack of progress in occupational health for NHS staff. The inadequacies of existing services are heightened by the predominancy in the NHS of the "medical model", which sees treatment of illness through medical intervention as the only proper aim of the health service, thus making environmental concerns take low priority. Many consultants appear bemused at why a special service is required for staff health!

The legal position of the NHS has always been anomalous. Although technically covered by the 1974 Health and Safety at Work Act, there are no provisions for enforcement because the NHS, as Crown property, is immune from accountability. This situation is compounded by general complacency among NHS managers.

The current "no policy" position of the DHSS itself, indicated in *Care in action*, makes the future of NHS staff welfare look gloomy. Low priority for staff health services has led to the under-financing of those services that exist. These still have to compete directly with patient care for funds, and many services have no separate budgets, funds being allocated from areas such as the general nursing budget.

This has inevitably led to inadequate staffing levels. Staff are less qualified than their counterparts in industry. Occupational health physicians in the NHS lack the conventional hospital grading structure and are consequently poorly paid and of low status, and there is no scope for specialist health and safety teams, including toxicologists, occupational hygienists and epidemiologists, to develop as they have done in industry.

In addition to all this, staff and trade unions are often suspicious of occupational health departments, seeing them as "tools of management". Departments with limited objectives — such as the reduction of sickness absence — and too close a link with administration or line management *are* open to such criticism, and issues of independence and accountability are current subjects of debate.

Solutions to the inadequacies of staff health services in the NHS seem far off without a firm governmental commitment in cash as well as words. This is something that CHCs should be concerned with. CHCs also have a part in exploding the myth that staff welfare means neglect of patient welfare. Education and publicity around health and safety issues is greatly needed.

Together with the TUC and NHS unions, CHCs should press the Government to review its position on Crown immunity, and CHCs' special relationship with health authorities should be used to increase members' and managers' awareness of the importance of staff health to patient care.

Data on accidents and ill-health amongst hospital staff is scant. There is a need for sound research programmes into this, and CHCs can help by initiating such research.

Issues relating to practice require resolution as well. Clinicians need to break away from traditional treatment roles and tackle pressing environmental problems. A team approach should be adopted so that physicians and nurses have equal importance, especially in policy making. Inadequacies of pay, grading and training in staff health services also need to be resolved.

In the final analysis management have prime responsibility. They must ensure that occupational health departments are not "tools" of management, policing staff sick leave without regard to the factors that cause sickness.

Throughout my study of occupational health services in the NHS the most striking aspect I found was the degree of unresolved conflict on every major issue, but there is an encouraging level of debate amongst all involved in the field, both nationally and locally. CHCs should also enter this debate and become active in working for improvements.

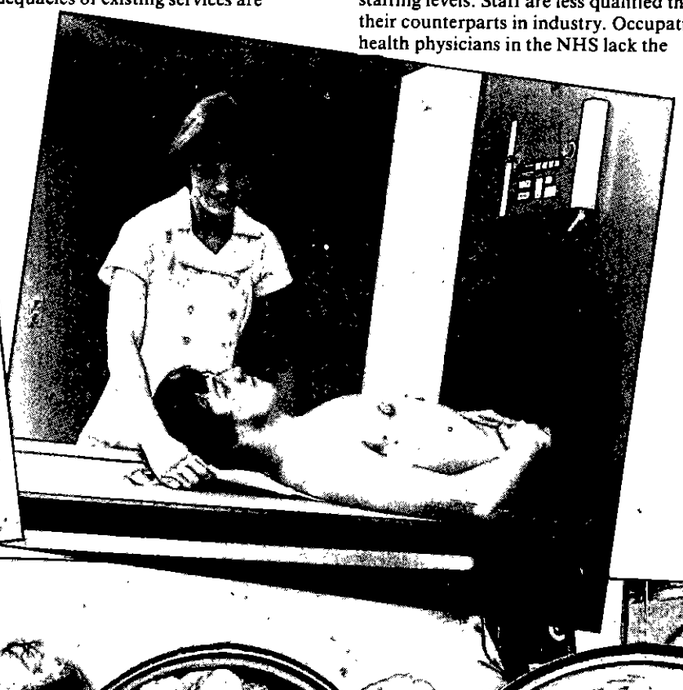

Photo: EMI

Photo: Maria Bartha

Photos: Raissa Page

**Francis Cox is the author of *Occupational health services for the staff of the NHS: Current policies and problems,* working paper No 54 in a series published by the Health Services Management Unit of Manchester University, 1981. Price £2 from the Unit at Manchester Business School, Booth Street West, Manchester M15 6PB.

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1. Summary of recommendation 112, para 1. *International Labour Conference* 1959.
2. *Report of the joint committee on the care of the health of hospital staff,* Ministry of Health and Scottish Home and Health Department. HMSO 1968.
3. *Report of the Royal Commission on NHS.* Cmnd 7615, HMSO July 1979.
4. *Care in action,* a handbook of policies and priorities for the health and personal social services in England. HMSO 1981.
5. *Occupational health services: the way ahead,* Health and Safety Commission. HMSO 1977.

GETTING IT RIGHT

*by Jo Garcia**

Most CHC reports on maternity services are based on surveys of service users. My studies of these reports have prompted some suggestions about how to make the best use of the time and energy of CHC workers — and avoid some of the pitfalls of surveys.

An important first step is to decide on the aspect of maternity care to be investigated. Sometimes a focus is already present, eg the closure of a small hospital. The temptation to cover all aspects of maternity care should be resisted. In order to set priorities for a survey, CHCs can use various means to find out about areas of particular concern. Familiarity with the basic pattern of care is essential. Confusion between, say, antenatal care and antenatal classes can make reports unintelligible. One CHC team mentions that it had discussions with groups of mothers about their care before designing the questionnaires. Letters to CHCs from parents often highlight subjects of importance.

There is a strong case to be made for involving those who provide maternity care at an early stage in the discussions. Midwives, doctors and others are often dissatisfied about the same things which distress service users. If their help is sought at the beginning of a project they will probably be more willing to support and cooperate with a survey, and also to take note of the findings. Some reports make it clear that a good relationship was established with appropriate medical, midwifery and administrative staff. In others, difficulties are described or hinted at. It helps if survey reports give some details of the collaboration with care-givers and any other groups who may have taken part in the research.

Many reports mention the involvement of someone with experience of survey design and analysis. If possible, help of this kind should be sought from the beginning of the project. A further point stressed by those who do surveys is the value of a pilot study. It is often very hard for those who design a questionnaire to envisage how the questions will work in practice. Testing out the survey on a small group of respondents almost always pays dividends in terms of later work.

The design of an appropriate questionnaire and the selection of mothers to be interviewed depend on the specific issues to be addressed and the degree of help offered by maternity staff in identifying and contacting mothers. Reports should contain information about the way that mothers were chosen; how, where and when they were contacted, and by whom; and details of the number of questionnaires distributed, completed and used in the analysis. Where possible, the mothers surveyed should be compared with all mothers giving birth in that hospital or district, to check on the extent to which the sample is representative. Basic characteristics for comparison are age, number of children, area of residence, socio-economic status and marital status. This information should be obtainable through the information department or library of your district health authority. It is also helpful to include a copy of the questionnaire in the report.

It may be useful to issue a summary report for press release and wide distribution, with a full version available for those more directly involved in the survey. In one or two cases, reports describe the responses of maternity workers and administrators to recommendations arising from the surveys. Where it is posible to include this element without too much delay, it can provide a valuable basis for encouraging a dialogue between users and providers. Report writers should guard against two pitfalls regarding the use of language. On the one hand,technical terms sometimes appear without adequate explanation; on the other hand, medical words are occasionally mis-spelled or used incorrectly —something which can alienate professional readers.

Many CHC reports include comments directly quoted from the questionnaires. These quotations can often bring a report to life and are a valuable complement to the tables of results. Most women have quite a lot to say about their experiences of pregnancy and birth, and so questionnaires should allow space for them to express themselves in their own words.

CHCs are well-placed to follow up interesting experiments and attempts to improve the services in their districts. The defects in maternity services *are* important, but are often well-documented. It is sometimes more productive to focus on positive attempts to change the quality of care. CHCs can help to evaluate these new departures, and in doing so they should take advantage of the desire of some care-givers to improve the quality of care and to respond to consumer views. This will not be easy because of the defensive attitudes that exist among care-givers in the face of consumer pressure for change. But it is difficult to see how real improvements can be made without an increasing dialogue between consumers, their representatives and those who plan, administer and provide health care.

Photo: Waltham Forest Guardian

** Jo Garcia works at the National Perinatal Epidemiology Unit, Radcliffe Infirmary, Oxford OX2 6HE. Her two previous articles about CHC research into maternity care, in* CHC NEWS 70 and 72, *looked at antenatal care and care at and around the time of birth.*

Book reviews

Caring for the mentally ill in the community

by Charles Butterworth and David Skidmore. Croom Helm, £11.95

This is a basic guide to working with the mentally ill in the community and will be valuable for those whose training and experience has been in a hospital setting. The first section explores society's concept of sickness and considers the effects hospital and community care have on a patient's responses and expectations. It goes on to discuss ways of involving the family in treatment and support. The second part of the book looks at treatment practice and includes case studies. It emphasises the importance of seeing each patient as an individual and involving patients and their families to the maximum in planning and carrying out treatment. A thought-provoking introduction to community care for those concerned with mental health.

Hilary Roberts, Member, Greenwich CHC

Incontinence and its management

Ed Dorothy Mandelstam. Croom Helm, £9.95

Incontinence is distressing to its victims and is often the "final straw" which leads a family to seek institutional care for the aged and handicapped. This book considers its causes and treatment, equipment and

Scanner

NHS briefings

The Institute for Health Studies at Hull University has published *1982 Reorganisation of the NHS: Guidance for DHA members*, a 22-page briefing with sections on NHS structure, members, finance, planning and industrial relations. £1 inc post from Philip Tether, 49 Salmon Grove, Hull HU6 7RX. Cheques payable to The University of Hull.

The National Association of Health Authorities has revised and updated its *NHS handbook*, which now contains 27 articles on the health service, including CHCs, planning and the role of the DHA member. £11.30 inc post from NAHA, 40 Edgbaston Park Road, Birmingham.

Private medicine

Managing the mixed economy of health, a report from the University of Birmingham's Health Services Management Centre, argues that by using the right combination of incentives and controls health authorities can protect their basic social policy aims while using the private sector to bolster NHS resources. £3 inc post from HSMC, Park House, 40 Edgbaston Park Road, Birmingham B15 2RT.

New buildings

The third edition of the King's Fund guide *Commissioning hospital buildings* updates material in the 1975 edition, emphasising the present financial constraints. Distributed by Oxford University Press, £9.50.

Tackling local radio

The National Extension College has published a local radio kit, to help community groups make the best use of local radio stations. The kit, including a handbook and a tape cassette demonstrating interview techniques, costs £4.95 inc post from the NEC, 18 Brooklands Avenue, Cambridge.

Other publications

The principle of normalisation: A foundation for effective services, £2.25 inc post from the Campaign for Mentally Handicapped People, 16 Fitzroy Square, London W1P 5HQ.

I can't talk like you, an illustrated children's book about speech problems, commissioned by the Association for All Speech Impaired Children. Dinosaur Publications, 70p (ISBN 0 85122 3443).

Male midwives: A report of two studies, DHSS £2.55.

Policies and postures in smoking control (reprint of an article in British Medical Journal), from Linda Marks, Unit for the Study of Health Policy, Guy's Hospital Medical School, London SE1 1YR.

The status of complementary medicine in the UK (report about alternative medicine), £3.50 inc post from the Threshold Foundation Bureau, 7 Regency Terrace, London SW7.

The fetal alcohol syndrome (briefing sheet), 15p from the National Children's Bureau, 8 Wakley Street, London EC1.

Costing care: The costs of alternative patterns of care for the elderly, £2 inc post from the Joint Unit for Social Services Research, The University, Sheffield S10 2TN.

Glass: The invisible hazard in everyone's home, £1.20 inc post from the Child Accident Prevention Trust, Faculty of Clinical Sciences, School of Medicine, University College London, University Street, London WC1E 6JJ.

Guidelines for occupational health services from the Health and Safety Executive, published by HMSO, £2.50.

Health circulars

HN(82)11: Gives details of increases from 1 April in prescription charges (now up to £1.30), prepayment certificates, elastic stockings, wigs and fabric supports.

HN(82)12: Lists the new charges for dental treatment and appliances supplied through the general dental service, and for dentures supplied through the hospital dental service.

HC(82)4: Accompanies a White Paper (Cmnd. 8479, £3.05), setting out the Government's response to the House of Commons Social Services Committee's report on medical education. The committee's recommendations of a freeze in the number of senior house officers and a rapid increase in the number of consultants are accepted.

HC(82)7 and WHC(82)11: Announce new NHS charges for private resident and non-resident patients, and give advice on the management of private treatment within the NHS — eg admission and identification of private patients, and recovery of charges.

HC(82)8: Gives guidance on the *NHS Functions Regulations 1982* (SI 1982/287), which lay down the powers and duties of RHAs and DHAs in the NHS.

WHC(82)6: The Welsh equivalent of HC(82)2 — gives guidance on the transition to the new health authorities.

WHC(82)7: About professional advisory machinery in Wales, excepting medicine, for which see WHC(82)2.

PM(82)4 and PM(82)5: Announce the issue by DHSS of a *Report on the training of portering staff*, and the publication of handbooks for use in training hospital porters.

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: East Cumbria CHC Chairman: F M Allason
Page 4: Leeds Eastern CHC Tel: Leeds 439998
Page 4: Wakefield Western CHC Secretary: Ms L A M Pattenson
Page 6: North Herts CHC 7/8 Brand Street, Hitchin, Herts. Tel: Hitchin 59629
Page 7: South District CHC 50 Tufton Street, London SW1. Tel: 01-222 6957.
Page 7: North East District CHC has merged with **South Camden CHC** to form **Bloomsbury CHC,** in the North East Thames Region (see below).
Page 7: South Camden CHC has merged with **KCW North East District CHC** to form **Bloomsbury CHC,** with address, phone number and secretary as for South Camden. Chairman not yet elected.
Page 9: Guy's CHC Chairman: Richard Kay
Page 14: Halton CHC Secretary: Alan Winship

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design of homes, the implications for staffing and support for relatives. It is intended for professional readers and is in places very technical, but will be of value to those who are concerned with the social problems encountered in community care and with the shortage of health service and local authority accommodation for these often vulnerable and rejected people.

Olive Keywood, Member, Worcester CHC

The directory for the disabled

by Ann Darnborough and Derek Kinrade. Woodhead-Faulkner, £6.50

This is the third edition of the standard reference book for disabled people, their relatives and the caring professions. It covers statutory services, social security, equipment, employment and education, sport and leisure, and personal problems such as sex and incontinence. Many hundreds of addresses are given and the reader is always able to pursue an enquiry further.

Pat Saunders, Member, Portsmouth and SE Hampshire CHC

Books received

Rural medicine: Obstacles and solutions for self-sufficiency by Stanley Wallack and Sandra Kretz (Lexington Books £16, ISBN 0 669 03691 9)

Design for health care by Anthony Cox and Philip Groves (Butterworths, £18).

The breast by Andrew and Penny Stanway (Granada £1.95, ISBN 0 583 13464 5)

Critical issues in health policy by Ralph Straetz, Marvin Lieberman and Alice Sardell (Lexington Books £17.50, ISBN 0 669 04504 7)

Health-care finance by Robert Buchanan (Lexington Books £12.50, ISBN 0669 04035 5)

The nurse and the childbearing family by Deborah Blumenthal Bash and Winifred Atlas Gold (John Wiley £12, ISBN 0 471 05520 4)

News from CHCs

☐ Criticism of the **Association of CHCs'** support for the newly-formed Campaign for Lead-free Air (CLEAR) has led the association to canvass the views of all its member CHCs. At ACHCEW's Standing Committee meeting in February, **Sefton Northern CHC** complained that the association's position on lead was "ultra vires" constitutionally and was "in support of a political pressure group, which is a procedure many CHCs would vehemently contest and which must affect their views on continued membership". ACHCEW's letter to CHCs rehearses the Standing Committee's involvement with the lead in petrol issue, explaining that a resolution calling for lead-free petrol was adopted as early as January 1979. It accepts that when CHCs were asked in December 1980 some 31 of the 75 which replied were not in favour of any additional action on lead, but comments that in such a situation it is difficult to know whether CHCs which do not reply can be taken not to object. About ten CHCs attended the ACHCEW seminar on lead pollution held in Birmingham last October, but its two resolutions were subsequently endorsed by the Standing Committee, and by 6 April had been adopted by 67 CHCs.

☐ The Social Services Secretary Norman Fowler has accepted the recommendation of the **Association of CHCs** in appointing Mr E A Hebron to the Prescription Pricing Authority, which covers dispensing by chemists and appliance contractors. Mr Hebron is a member of ACHCEW's Standing Committee and Chairman of **Wirral Southern CHC.**

☐ Sir William van Straubenzee thinks CHCs are "a complete waste of time". This was his response to ACHCEW's letter asking MPs to support central funding for *CHC NEWS.* **East Berkshire** CHC decided to challenge the Wokingham Tory MP on his assertion that "in my constituency the CHCs are simply talking shops", and wrote to him asking for a meeting. He agreed, and at the meeting explained his belief that "there is an inherent weakness in an organisation ... which has no executive powers". The role of CHCs in supporting members of the public could be provided by "people in public positions", he said. He is an ardent opponent of CHCs and believes that Ministers intend to abolish them at the next review. Since the meeting he has written to the CHC Chairman threatening to raise the argument publicly.

☐ A letter from **Bury CHC** has caused a row between the DHSS and the BMA over medical check-ups. After a number of complaints from patients who had been charged for examinations by their doctors the CHC wrote to the DHSS for clarification. The reply said check-ups *can* be considered part of a GP's personal medical service and GPs charging their own NHS patients for doing so would be in breach of their terms of service. The BMA is unhappy with this because it has just opened negotiations with the DHSS to permit GPs to charge their own NHS patients for "patient-initiated" examinations. But the letter does not give patients the right to demand medical checks. GPs are not obliged to perform check-ups if they think them unnecessary and can refer patients to other doctors for examinations to be done privately.

☐ **Humberside** CHCs have published the results of a survey, *The home care of elderly stroke patients,* which was funded by a Short Term Employment Programme from the Manpower Services Commission. The four CHCs worked in co-operation with the University of Hull Institute of Health Studies, which provided a research team and access to the records of elderly stroke patients in Hull. The report will be available from **Hull CHC,** price to be finalised.

☐ North West Thames RHA has admitted its involvement in the use of a controversial questionnaire issued by a three-doctor group practice in Fulham, but denies being in on the drafting of the form. **South Hammersmith CHC** was alerted to the questionnaire by a prospective patient who changed her mind about registering with the practice after seeing the form. Patients are asked to "underline whether you are White/Negro/Asian/other" and women are asked how many miscarriages or abortions they have had. The CHC emphasises that it has never received complaints about the doctors' medical standards, but it is "shocked" at the use of the form. The questionnaire formed part of a funding application three years ago for research into patterns of disease. The RHA gave the practice a regional research grant to purchase equipment for the processing of information about patients at the practice. But questions such as "date of menopause?" have thrown doubt on the value of information gathered from the questionnaire. The CHC has called for immediate withdrawal of the form, and has referred the matter to its family practitioner committee and to the local community relations council.

☐ It's my life doctor *looks at people's experiences of seven common medical problems in the light of environmental and social causes of ill health, and makes suggestions about how health care can be made more appropriate to needs. Available from* **Brent CHC,** *65p inc post.*

☐ Another CHC has clashed with its RHA over staff changes during the reorganisation period. (See *CHC NEWS 75* page 8). When Ray Allen, Secretary of **Great Yarmouth and Waveney CHC,** announced his retirement the East Anglian RHA stipulated that his successor should be appointed from among NHS personnel in the region, saying that CHC staff are covered by special Whitley Council arrangements for administrative staff affected by reorganisation. Regional advertising failed to attract suitable applicants so the RHA advertised nationally but insisted on retaining the restriction to NHS staff. The final choice of secretary *is* acceptable to the CHC but members are angry at the way the RHA handled the appointment procedure, and feel that CHCs' credibility in the eyes of the public will be harmed if NHS staff are appointed to CHCs against the wishes of the members.

☐ Three **London** CHCs have produced profiles of their districts for the use of incoming DHA members, to supplement official profiles prepared by district planning officers. Four major reports, four smaller studies and comments on the district operational plan are included in *Collected works 1979-81* from **Soho and Marylebone CHC** (the North East district of Kensington, Chelsea and Westminster). **Waltham Forest CHC** puts the case that its district is comparable to a deprived inner city borough and should have special help in its *Information paper for the Waltham Forest DHA.* **North Camden CHC's** *Profile of services in the Hampstead health district* was originally conceived as a briefing paper for members of the new DHA but has grown to include details of local voluntary organisations and social services as well as NHS services in the district and priorities for development.

Other CHC publications

☐ Unemployment and health: report of a seminar. International Year of Disabled People 1981: Report of the Bolton Committee (both from **Bolton CHC**). A review of continuing care: the needs of dying people and their families and the principles and practice of their care (**Central Derbyshire CHC**), Primary health care in the Harlow health district: report of 1981 conference in the prevention and health series (**West Essex and District CHC**), Birth in Leeds (**Leeds Western CHC**).