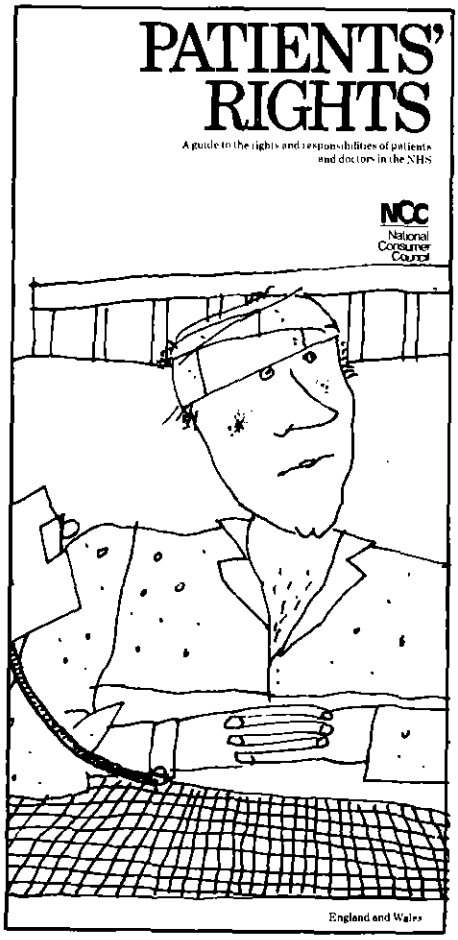
CHC NEWS

For Community Health Councils

August/September 1982 No 79



Reluctance to point out when things go wrong is in the interests of neither the health service nor the patients themselves, says the National Consumer Council's new *Patients' rights*. Subtitled *A guide to the rights and responsibilities of patients and doctors in the NHS*, the booklet takes a broad definition of "rights" to include "reasonable expectations" patients may hold because of doctors' contractual duties, ethical code and obligations under common law.

It emphasises, though, that not all these expectations are enforceable in a court of law, and says patients should accept responsibility for their own health by dropping harmful habits and by following the treatment the doctor outlines for them.

Sample copies have been sent to every health authority, family practitioner committee and health education office, as well as over 100 advice-giving organisations, and it is hoped to supply a copy for reference use by each of the 900 Citizens Advice Bureaux. The NCC is hoping that CHCs will be the main distribution point for the booklet and its summarising leaflet. Every CHC has been sent 25 booklets and 150 leaflets free, and further stocks can be ordered from the Association of CHCs.

Bitter disappointment greets plans for community care

The Government intends to push ahead with plans to move long-stay hospital patients into the community, but will provide no extra money to support them there. A £15 million programme of pilot projects will be funded out of existing joint finance money, currently £85 million. The end of term announcement in Parliament by Secretary of State Norman Fowler drew a swift and critical response from organisations representing those most likely to be affected — the elderly, the handicapped and the mentally ill.

Ministers plan to increase flexibility in the use of existing funds in a two-stage approach. Firstly, measures requiring no legislation include:

- Permitting district health authorities to transfer money *with* patients — DHAs will be able to guarantee annual payments to bodies taking over the care of patients
- Extending the maximum period of joint funding from seven to thirteen years with 100% joint cash up to ten years
- Reserving £15 million of joint finance for projects to develop and assess the transfer programme.

A circular giving guidance on these steps is expected in the autumn, but action will depend on the discretion of DHAs.

The second stage depends on the Government's legislation timetable. Joint funding rules will be amended to permit payments for education and housing.

Health Minister Kenneth Clarke admitted at a press conference to explain the plans that DHAs could hit a spending "hump" when maintaining half-full institutions *as well as* paying for former patients in the community.

The flexibility of the Government's approach was generally welcomed, but lack of extra cash was cited as a major obstacle by national bodies commenting on the scheme. Age Concern accused the Government of "failure to face the facts" and the Spastics Society said it was "bitterly disappointed" by lack of additional funds.

The National Council for Voluntary Organisations expressed disappointment that its suggestion, supported by over 100 national bodies, for a community care fund was rejected in the Government's plans. Ministers believe a third agency in the field would create a duplication of efforts.

Plans were first unveiled over a year ago in the consultation paper *Care in the community*, reported in *CHC NEWS* 69 page 1. The document, which proposed seven possible ways of speeding up transfers, was given a cautious welcome by statutory and voluntary bodies, and over 700 responses were forwarded to the DHSS.

But repeated warnings have been given of the dangers of seeing community care as a "cheap option". Comments have emphasised that proper provision must be made if existing community facilities, already strained by local authority expenditure cuts, are not to be overwhelmed by the additional burdens of supporting former long-stay patients.

These warnings have taken on new urgency in the light of revelations from the House of Commons select committee on social services* that only a handful of local authorities are likely to achieve the growth in social service expenditure needed to maintain service levels in 1982/3.

* *Second report from the social services committee – 1982 white paper: public expenditure on the social services, HMSO £4.35.*

INSIDE....

Coming in October

CHC NEWS 80 will be especially for new members of CHCs, with reports on complaints — dental and otherwise — health planning and finance, the in-patient's day, and resources, including those important Government reports you never have time to read. Plus, of course, all our regular columns. Publication day is 1 October.

Fluoride and ethics

Robert Ivor Owen, Chairman, Anglesey CHC

Though Chairman of this CHC, I write in my capacity as an elected member of the Isle of Anglesey borough council and from my personal experience. I must stress that I see no clash between these interests.

There is no issue in Anglesey that arouses stronger feeling than does fluoridation — flat rejection of the treatment on moral grounds, scepticism as to its efficiency and safety, and outraged disbelief that when people in Anglesey have indicated through their elected representatives their desire to have it stopped, it continues to be imposed by a body — Gwynedd health authority — consisting mainly of people living elsewhere who do not seek to have fluoride added to their own water supplies.

It was with some concern therefore that I read your report (*CHC NEWS* 75 page 3) of Sir Richard Doll's research showing no evidence of a link between fluoridation and cancer. The implication is that the case against fluoridation stands or falls by this. *It does not.*

The main contentions of those opposed to fluoridation are that it is irredeemably immoral to treat people without their consent, that it is unethical to treat them without regard to individual needs and constitutions, that any beneficial effect is too slight to be detected without cooked-up statistical studies, and that it is inconceivable that general health can be improved by the indiscriminate use of an enzyme-inhibiting poison.

One of the papers actually accepts that cancer mortality has been shown to have "slightly" increased in the fluoridated American cities. I think *slightly* gives the game away — it shows the attitude of the fluoridators to the odd cancer death now and again as a fair price to pay for the benefits which they claim but others dispute.

CHC NEWS

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The views expressed in signed contributions are not necessarily to be taken as those of CHC NEWS or the Association of CHCs.

My CHC is asking the Secretary of State for Wales to meet a deputation of its members to discuss our concern.

● And elsewhere in Wales... see page 5.

Praise indeed!

Gill Lucas, Secretary, Camberwell CHC

I thought staff and readers might like to learn of praise from an unexpected source — I was sitting in on a lecture by Sir Douglas Black to medical students at King's recently when I was delighted to hear him say that he thought the best précis of his report he had seen — before the TUC issued their booklet — was in *CHC NEWS*.

Could this be why the Government has removed your grant?

Postal votes part three

Shirley McCarthy, Secretary, North West Herts CHC

CHC NEWS 72 published a letter from us about Electoral Registration Officers taking a narrow view of the discretion they are permitted over counter-signatories on a disabled person's application for a postal vote.

The second paragraph of our letter seems to have been overlooked by CHCs which responded. Pat Seers of North Hammersmith and Acton CHC discovered that the London borough of Ealing allows the application to be completed by someone known to the applicant while the borough of Hammersmith and Fulham accepts a declaration signed by nurses, social workers or similar professionals, or by election (party) agents. Interestingly, that borough does not require medical certificates or signed applications from registered blind people.

But our main point remains unanswered — it is iniquitous to demand that a disabled person's request for a postal vote must be supported by a counter-signatory when those whose employment takes them away from home can obtain a postal vote without endorsement.

I am contacting the major disablement organisations in the hope that they can take up this fundamental point.

More on politics

Tegwen Wivell, Assistant, South Gwent CHC

I am surprised that Martyn Smith of West Birmingham CHC should allow himself to be quoted in *CHC NEWS* 78 (letters page) as being chairman of the Liberal Party Health Panel, and even more surprised that *CHC NEWS* feels it worthy of mention since CHCs are surely meant to be seen as non-political bodies. Obviously CHC secretaries have their own political views and that is their business — but please let's stick to health matters in *CHC NEWS* and not bring party politics into focus.

If secretaries of CHCs make it loudly known that they belong to any particular party they are bound to antagonise people of opposite views. In my opinion they should keep their views to themselves and get on with the job they are paid for doing — monitoring the work of their particular health authority.

Designed for CHCs

Chris Ham, Lecturer, School for Advanced Urban Studies, University of Bristol

I thought your readers would like to know about our new handbook for CHC members and two seminars for new members I am planning for the autumn.

The handbook is a completely revised and updated version of the training package for CHC members. It provides basic information about the NHS and CHCs and is divided into four sections — how the NHS works, how CHCs work, CHCs: the story so far, and a policy guide. It also contains suggestions on where to obtain further information.

The handbook is available at £4 per copy (post and packing extra) from SAUS, Rodney Lodge, Grange Road, Bristol, BS8 4EA.

The seminars will be held in London on the 1 and 4 October, and again are aimed specifically at new members. They will focus on the role of the CHC, the job of its members, and key policy issues facing the NHS in the 1980s. There will be places for up to 50 members on each seminar. Further details from us at the address above.

Restricted information

Marcia Saunders, Secretary, Islington CHC

Our district management team has decided — without consulting us *or* the DHA members — that the complete public papers of Islington DHA will be available to the public for an annual subscription of £25. Is this a record? Or do any other DHAs display as disheartening and cynical an attitude as our own?

Wanted

The section where we publish letters in shortened form from readers asking other readers for help of one kind or another.

Copies of any recent publicity leaflets used to get the message of CHCs across to the public.
— Mid-Essex CHC

Information from CHCs in districts with operational well-women clinics on how the clinics have been working — including financial costs. We are keen to present these facts to our DMO after winning a long struggle to have the possibility of a clinic in our district considered.
— Barnsley CHC

Information on casualty department closures and any safeguards instigated at the time.
– *Islington CHC*

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

There is no doubt that health services in Britain face difficult months ahead. People returning from their summer holidays to posts which may still feel unfamiliar, adapting to a reorganised NHS which is still too new to be comfortable, will have to come to terms with the repercussions of a number of recent developments which will have lasting implications for the structure and performance of the NHS in years to come.

The main problem, as ever, is money. At the time of writing strikers and administrators are catching their breath after five days of industrial action, and preparing themselves for the next onslaught. Government Ministers are sanguine in the face of the extraordinary amount of public sympathy generated during the strike.

Indeed, Mr Fowler is reported to have taken a month's leave in the French countryside, though near-daily press releases stating his views on the iniquity of union action tend to throw doubt on that report.

Yet low pay is surely symptomatic of chronic underfunding in a country that spends less of its gross national product on its people's health than other comparable nations.

Certainly the Government has no doubts on the links between pay and funding. In the middle of July Mr Fowler released his revised cash allocations for each RHA, adjusted to deduct nearly half the standing pay offer.

The allocations are bad news, especially for those regions which have traditionally been the worst off, and which are supposed to benefit from a yearly reallocation of resources. This year they will bear a disproportionate share of the pay bill.

The new allocations cut away at growth money, which in many regions is itself dependent this year on health authorities finding the savings to finance it. If they fail to save enough then we are in the realm of real cuts.

The picture for future years is even more bleak, with the paper promise of growth wiped out.

CHCs cannot escape the implications of these developments. They are likely to be squeezed hard by RHAs looking for "superfluous" activities from which to trim their management savings. At the same time the patients' watchdogs will be scrambling for footholds amongst the various review procedures through which the Government seeks to keep a firm grip on NHS spending.

As if the complications of budgets revisions were not hard enough for lay members of CHCs to grasp, there is also a plethora of reviews and scrutinies, pilot schemes and accounting procedures lately announced. The most diligent amongst us will have difficulty keeping up with developments.

This is where *CHC NEWS* comes in. Or rather, bows out.

There has never, one might feel, been a more important time for CHCs to be informed on national developments and how they will affect local services. Unfortunately, this the moment when we must say goodbye to a number of our readers.

We are painfully aware of the difficulties many CHCs face in paying their subscriptions to *CHC NEWS*. A national news gathering and sharing concern is obviously very expensive to run, but we are making strenuous efforts to bring down the cost to CHCs, so perhaps we will say hello again in April to some of our lost readers.

Health News

"Hard sell" fails to save Opren

The anti-inflammatory drug benoxaprofen — known by its brand name Opren — was the subject of "hard sell" tactics by sales representatives just weeks before its product licence was suspended by Health Ministers.

Doctors at the University College Hospital in London have confirmed that they were visted by a saleswoman from Dista Products, the drug's UK distributors, in an attempt to persuade them to prescribe the drug for their elderly patients. She said reports in the British Medical Journal showing a disturbingly high incidence of side effects in the over-70s did not take into account the large number of patients using the drug.

She later phoned to see if Opren had been prescribed, and doctors at the geriatric research unit were sent "glossy" literature defending the drug against a storm of adverse reports in the medical press.

Dista Products were asked in June by the Committee on Safety of Medicines (CSM) to halve the recommended dose for the over 65s after 36 deaths had ocurred in patients taking the drug. Reports of the drug's side effects accounted for a rise of almost 30% in adverse reports to the CSM last year, and in a climate of increasing concern Health Minister Kenneth Clarke asked the CSM in July to look again at the drug. In early August the licence to supply and promote the drug was suspended for three months, and the CSM revealed that 61 deaths had been linked with its use.

Doctors can continue to prescribe Opren, however, and though pharmacists have been advised to query prescriptions, they are obliged to dispense the drug if doctors prescribe it.

The DHSS has confirmed that it has no plans to withdraw existing supplies. Even if the ban on supplying Opren becomes permanent there is nothing to stop doctors prescribing the drug while stocks last, said a spokesman.

New row over plans to charge overseas visitors

New controversy has followed the release of a draft health circular instructing health authorities to set up a complex interrogation system when the *NHS (charges to overseas visitors) (No 2) regulations — SI no 863* come into force on 1 October.

Considerable opposition greeted the announcement earlier this year of plans for the system of charges (see *CHC NEWS* 75 page 1). The detailed instructions now released have not allayed the fears of those who believe race relations in this country will be seriously damaged by attempts to identify those few overseas visitors who try to defraud the NHS.

The DHSS intends, in effect, to throw an inquisitor's net around hospital services. The aim will be to ensure that no patient gets medical treatment until liability to pay has been assessed. Emergency treatment will be exempt from this, but the exemption ends if the patient needs a hospital bed.

Patients deemed liable to pay — after assessment using an elaborate system of flow charts — will have to deposit the full cost of treatment before treatment begins.

London law centres have set up a *No pass laws to health* campaign* to co-ordinate opposition and monitor the regulations in action. Campaigners are particularly critical of an instruction telling registration clerks at the initial stage of assessment to make no attempt to overcome difficulties in communicating with patients. Those with a poor grasp of English will pass to the intensive second stage of questioning if they cannot make their residency qualifications clear.

Opposition to the new regulations is also growing amongst hospital administrators, who have been told to ensure that every hospital has at least two officers trained to carry out the intensive stage of questioning.

*The campaign can be contacted c/o Camden Community Law Centre, 146 Kentish Town Road, London NW1 9QC. Tel: 485 6672. A conference is planned for December.

Red light for health insurance — green light for the private sector

Secretary of State Norman Fowler has finally announced that he intends to take no action to change the basis of funding the NHS by introducing compulsory health insurance. Instead he will encourage the expansion of the private sector alongside the NHS.

Continued on next page

Health News

Continued from last page

Measures will include a circular likely to instruct health authorities to adopt pilot schemes for the privatisation of ancillary workers' jobs.

The announcement ends months of speculation around a DHSS working party report which examined health systems in countries such as West Germany and the US. The report was never published, but former Health Minister Gerard Vaughan was known to be keen on the idea of subtracting the cost of health services from taxation. It seems that Mr Fowler did not agree.

His message came at the end of a month that saw the public launching of a committee to combat private medicine. *NHS unlimited** aims to highlight the shortcomings of private medicine by collecting and circulating information on its rapid development and on the involvement of US corporations. Four memoranda have been published giving background details on private hospitals and their owners, the legal position and Government policy, information sought by the committee, and planning permission for private hospitals.

*The committee can be contacted c/o the chairman Frank Dobson MP, House of Commons, Westminster, London, SW1A OAA. Memoranda cost 50p each and a bi-monthly *Briefing* is available to members.

Raising the dust on asbestos

Action to tighten up on asbestos in the workplace was under way before public outrage was aroused by the Yorkshire TV documentary *Alice — a fight for life*, says the Health and Safety Executive (HSE).

A spokeswoman said this month that "there had been murmurings" within the HSE over the length of time it was taking to agree uniform EEC directives on marketing asbestos and on controlling asbestos levels in the workplace.

Concern was at its height during a world symposium on asbestos held in Montreal in May, two months before the television programme was shown. HSE officials were said then to be ready to urge the Health and Safety Commission — the policy-making body of the HSE — to implement controls in the UK without waiting for the European directives, which are expected in 1985.

At a meeting in mid-July the Commission ratified a decision to move ahead as quickly as possible with licensing employers involved in stripping asbestos lagging, and with a series of prohibitions — on the use of blue asbestos, on straying asbestos, and on a list, yet to be drawn up, of asbestos products.

That meeting deferred a decision on reducing the permitted level of airborne asbestos fibres in factories. It is this decision that is likely to cause argument in the future, since many authorities claim there is no known safe level for airborne fibres.

The present level is euphemistically called the two fibre standard — which permits two *million* fibres per millilitres of air, the average amount breathed by an individual *every hour*.

Soon after we go to press the Commission will hear a proposal from its chairman Bill Simpson to reduce the standard to one fibre — one million fibres per millilitre. Mr Simpson is also chairman of the Advisory Committee on Asbestos, which the television programme claimed never heard certain important evidence on asbestos-related diseases.

Sir Richard Doll's cancer epidemiology unit in Oxford estimats that 5% of workers exposed at the one fibre level will die of the asbestos diseases.

In 1979 employers in breach of the asbestos regulations — including the two fibre standard — were fined an average of £153 for each breach.

Volunteering in Wales

Welsh Secretary of State Nicholas Edwards has appointed a national committee to handle applications for the £200,000 available to Welsh organisations under the *Opportunities for volunteering* scheme (see *CHC NEWS* 78 page 3).

Application forms and further details from the Council of Social Service for Wales, Llys Ifor Crescent Road, Caerphilly, Mid Glamorgan.

CHCs are not so bad, say doctors

BMA members agreed to disagree with the Government line on CHCs when they voted at their annual representatives' meeting to defeat a motion expressing the view put forward in *Patient's first*, that reorganisation has made CHCs superfluous because the new district health authorities are closer to the grass roots. Doctors agreed that CHCs have "come of age" and can be valuable — when they are not acting as "complaints factories".

Not just a stick to beat the victims with

Evidence that neural tube defects such as spina bifida occur in the embryo a matter of days after conception has convinced the Maternity Alliance of the need to campaign around preconception care.

The Alliance, which works for improvements in services during pregnancy and childbirth — held a seminar to launch its new campaign and to present *Getting fit for pregnancy*, the first leaflet in a *Know your facts* series.

Low birthweight in babies has been linked to poor health in the parents before conception, so the emphasis is on good diet, giving up smoking, and medical checks before a woman becomes pregnant.

The leaflet's author Angela Phillips emphasised that care must be taken if the idea of preconception care is not to degenerate into just another excuse to blame women for their own problems when they are fighting against difficult circumstances.

She said the campaign for preconception care must be taken into the heartland of health hazard issues, and called for the involvement of trades unions to beat environmental and occupational dangers. Free with an sae to prospective parents, the leaflet is available in bulk at 5p per copy plus postage and packing. From the Maternity Alliance, 309 Kentish Town Road, London, NW5 2TJ. Tel: 01-267 3255.

Scrutinising the NHS

Between September and March eight regional health authorities will be undertaking "Rayner" scrutinies into a variety of NHS procedures. They are:

- Northern RHA — preparation of briefs for hospital building schemes
- East Anglia — advertising for staff
- North East Thames — supplies storage
- South East Thames — catering costs
- Wessex — cost and efficiency of officers' meetings
- Oxford — management of residential property *and* acquiring, distributing and recovering aids
- West Midlands — ambulance services
- North Western — collecting owed income.

Another three regions are considering scrutinies, so the list may be lengthened later this year.

A route past the barriers when things go wrong

People suffering the effects of medical accidents find the attitudes of hospital staff quite bewildering, says writer Peter Ransley, who chairs a new group which hopes to help in these cases. *Action for the victims of medical accidents** believes that where there is the possibility of suing for negligence staff automatically erect barriers to communication by treating the patient as an opponent.

The need for AVMA became clear after an overwhelming response to the BBC TV play *Minor complications* by Peter Ransley, screened in November 1980 and recently repeated.

Based on a true story, the play told how a woman found it impossible to get information on her condition after a routine operation left her seriously damaged. Many people wrote to say they had experienced similar problems in getting the facts on what had happened to them in hospital.

A steering committee was formed, and AVMA has now gained a grant from the Greater London Council to set up an advice centre with expert legal help for victims who want to go to court over their treatment.

Practical advice will be available for those who cannot bring a case of negligence.

A campaign for no-fault compensation was ruled out by AVMA because charity laws forbid action on an objective which would entail a change in the law. But the group has examined the issue and feels no-fault schemes are unlikely to be set up in the UK in this decade.

* AVMA has not yet found premises but from 1 September will operate from the home of the Director Arnold Simanowitz, 121 Auckland Road, London, SE19 2DN. Tel: 01-653 0879.

FLUORIDATION
-A question of democracy

by Brian Maunder, Secretary, Swansea/Lliw Valley CHC

The fluoridation of water supplies was an issue for the Swansea/Lliw Valley CHC almost from its inception. In 1975 the West Glamorgan health authority sought views on the subject and the CHC, which was in its infancy and without a clear policy of its own on public consultation, simply agreed to the HA's proposals.

The resulting furore showed the CHC quite clearly that whatever *it* thought its role was, the *public* were in no doubt — it was there to canvass grass-root opinion and reflect it vigorously. On the issue of fluoridation the CHC seemed to the public to have decided arbitrarily and with no public mandate.

During the following eighteen months the issue of fluoridation was consistently raised at public meetings, either by representatives of local groups or by individual members of the community. Although the CHC was initially troubled that this interest was orchestrated, it became increasingly clear that this was not the case.

The CHC decided it should seek to establish the community's views in an organised fashion, and a public ballot was held through the leading local evening paper. The response to the ballot was remarkable — not only did we receive over twice the minimum number of forms required for statistical validity, but 78% of the respondents were against fluoridation of the county's water supplies.

The CHC reversed its previous decision and asked the HA to do likewise. It refused, but gave fluoridation the lowest priority in its planning cycle proposals and in 1980 we were assured that it would be allocated no finance.

Here the matter rested until last September when the HA was granted an additional sum of money on a "one-off" basis and decided without any consultation to use this to fund fluoridation.

Following the decision the CHC wrote to the Secretary of State for Wales, expressing its concern over the HA's high-handed and undemocratic handling of the matter and asking him to advise the HA of the need to demonstrate public support prior to fluoridation.

We received a curt if not discourteous reply which in effect supported the HA's actions.

At this stage we approached Alan Williams, MP for Swansea West, and a list of possible future tactics was drawn up for endorsement by the CHC.

It was decided to call on the Secretary of State to hold a public inquiry into the HA's actions, and to make a further test of public opinion by circulating a petition opposing fluoridation. It was also decided to approach local Euro MPs for referral of the matter to the European Parliament, and to investigate the legality of the Welsh Water Authority adding substances to the water supply for purposes other than purification. A meeting was called between local authority leaders and CHC representatives, resulting in their full support.

At a meeting in December between the chairmen of the HA and the CHC the HA's chairman accepted that he had acted improperly at the September meeting and agreed to send a letter of apology to the CHC's observer to the HA. That letter was never received.

Meanwhile, a petition of 15,000 signatures was raised in only ten days and through the good offices of Alan Williams arrangements were made to present it to Wyn Roberts, Parliamentary Under-Secretary, at the Welsh Office in London in February.

As a result of this meeting a letter was sent to the HA by Mr Roberts, saying:

"You will know doubts have been expressed in some quarters whether water authorities have the power to add fluoride to the water supply... There are two test cases on this point, one of which, that involving Strathclyde, is at a fairly advanced stage.

In these circumstances, I have refrained from actively urging authorities to proceed further until we know the outcome. The Government is also paying a good deal of attention to alternative ways of introducing fluoride and indeed to alternative preventative methods generally.

I do think that the petition of 15,000 signatures collected in a comparatively short period raises questions about the local acceptability of your present proposal and you may wish to think again whether you ought to undertake, in association with the CHCs in your area, some new soundings of opinion on this question."

At the HA meeting in February the Minister's advice was dismissed out of hand.

However, the HA's fluoridation plans have been hindered by a disagreement between the DHSS and the Welsh Water Authority, which is refusing to accept the standard indemnity offered by the DHSS to protect water authorities from the consequences of litigation.

Water authority members disagreed with their officers' advice to accept the indemnity, and have refused to allow fluoridation plans to go ahead in Glamorgan or Hereford, which receives its water from Wales.

This CHC has had no opportunity to examine the indemnity document, and is curious as to what it contains. Two questions have arisen from the argument. Firstly, why does the water authority feel the indemnity is inadequate — is it because of the hazards of fluoridation? And secondly, why has the DHSS refused to amend the indemnity if, as it says, it believes there are no hazards? The answers to these questions could have implications for fluoridation programmes throughout the country.

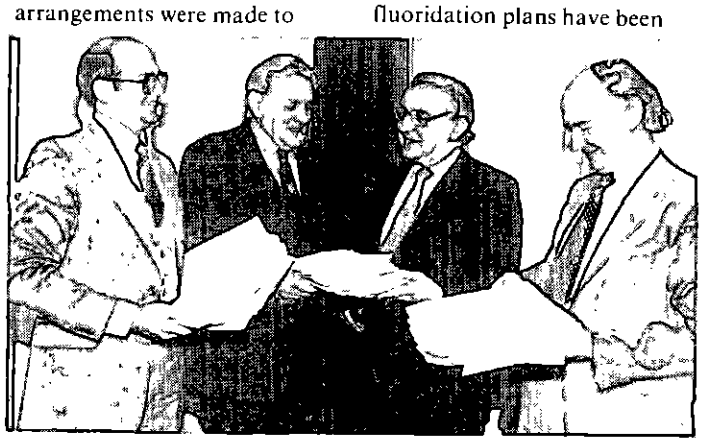
West Glamorgan health authority says it still intends to impose fluoridation, but is waiting for an explanation of the legal basis for the water authority's decision.

The HA chairman's promise of an apology to the CHC observer was rescinded at a subsequent meeting and no reason for this was offered. The CHC is very unhappy about this development, since it endangers the relationship of trust which is so necessary between HA and CHC.

Our problems with fluoride demonstrate clearly the difficulty which the public has in ensuring that public bodies act democratically. However, the CHC is determined to represent the public to the utmost of its ability.

Euro MPs Ann Clwyd and Wyn Griffiths have now taken up the issue and are pursuing the question of legality through the labyrinth of the European Parliament. We expect their efforts to take time to come to fruition, but we can wait.

As well as the argument over indemnity, changes to the system of water supply in the area have now delayed the HA's plans by two years or more, so the fight promises to be a long one.

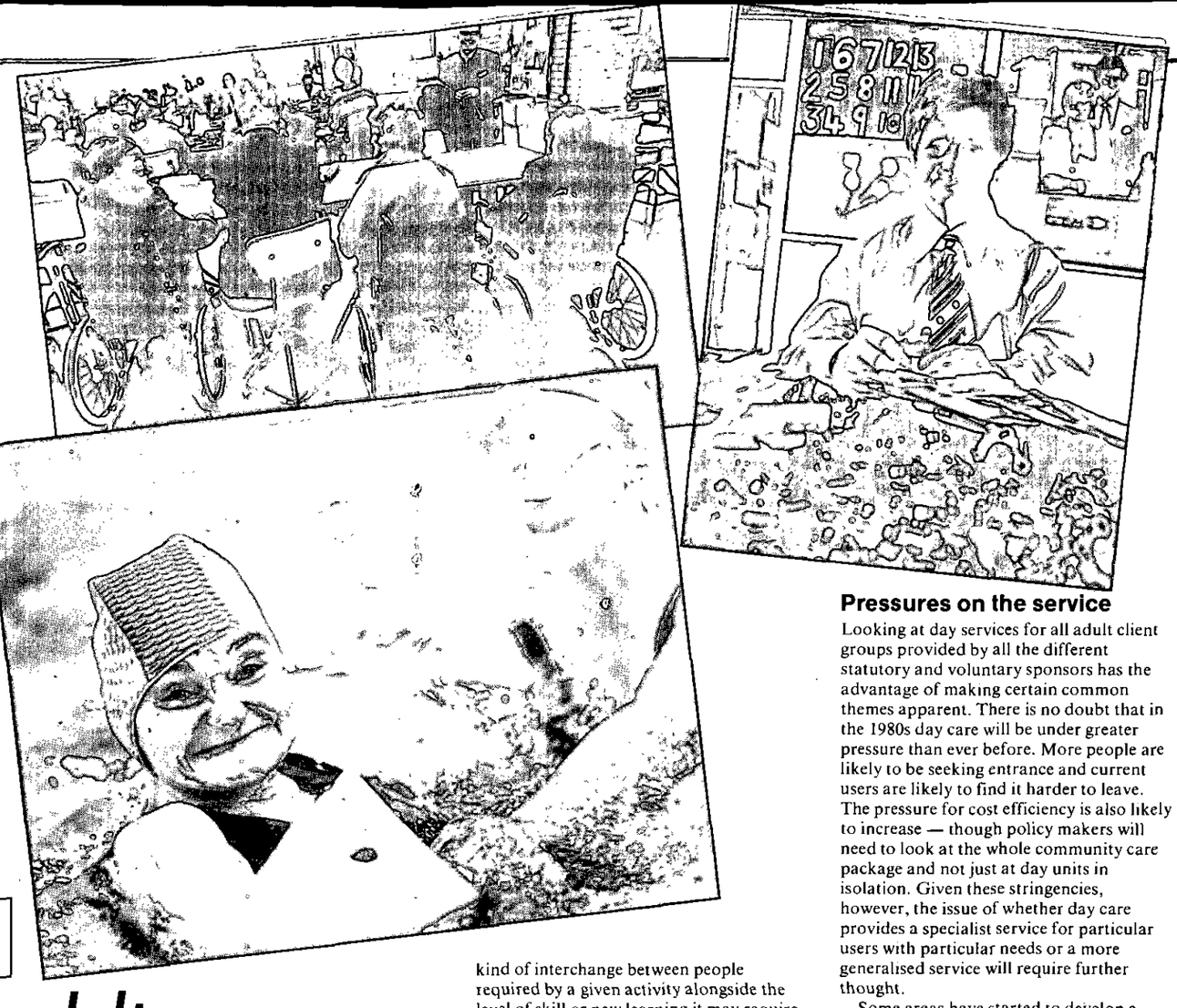


Handing over 15,000 signatures. From left to right – Brian Maunder, Councillor Arthur Morris, Welsh Under-secretary Wyn Roberts and MP Alan Williams

Photo: South Wales Evening Post

THE DAY CARE BOOM —Units for adults

by Carol Edwards, Research Officer, National Institute for Social Work



Photos: Raissa Page

Day care units for adults began to spring up after the Second World War, although before then some occupational centres had existed for mentally and physically handicapped adults. In 1959 about 200 day units for adults were operating. In the next ten years the number increased sixfold and by 1976 there were about 2600 day units in England and Wales. Expansion in Scotland has also been rapid (3). Although the present economic climate has no doubt altered this pattern of expansion, some growth is still occurring.

Local authority social service departments provide the largest share — about 45% — of these units, followed by health authorities and voluntary organisations which provide roughly one quarter each. The remainder are provided by other statutory organisations such as the probation service.

Day units usually see themselves as providing a service for a particular slice of the adult population, and an analysis of who sponsors the service for each client group can dramatically alter the overall provider pattern described above. For instance, voluntary organisations provide more day centres for the elderly than the other providers (about 40%), while the health authorities are by far the biggest sponsors of day care for the mentally ill (about 75%).

The day care boom was at its height in the 1970s and saw growth not only in the number of units and places provided but also in the kinds of units available. For example, none of the day centres for young families, for offenders or for a mix of user groups — say the physically handicapped with the mentally ill — existed before 1970.

In addition the venues chosen for day care became more innovative — a converted bus provides day care for young mentally handicapped adults in North Yorkshire (4), a caravan is used in Sunderland to provide a mobile day centre for the elderly (5) and in Dorset there is a travelling day hospital for the mentally ill (6).

Nevertheless day units offer very few places when compared to the estimated number of people who constitute a particular age or disability group and who therefore might wish to make use of day services. The only exception to this are mentally handicapped adults who are relatively well provided with places.

The survey

The figures above come from a five-year national survey by the National Institute for Social Work (1 and 2). We focused on the units and the amount of provision, but also wanted to reflect the "spark" of day care, which comes from the participants — the people who attend the units and the staff who work in them. We tapped their knowledge, experience, enthusiasms and reservations through individual interviews with 888 users and 559 members of staff.

One striking feature of the users' replies was that 95% of their comments related to life within the day unit, without direct reference to how the unit affected their lives outside.

The most commonly mentioned benefit of attendance was the opportunity for social contacts of all types. Secondly, attendance was said to help users by improving their self-confidence, self-esteem and other more general feelings about themselves. The third aspect most frequently mentioned by users was that it gave them a way of spending their time and to many going to a day unit seemed to give meaning and purpose to their lives.

Perhaps surprisingly, very few users mentioned that they had acquired a skill, received treatment or got any of the more tangible benefits associated with day unit attendance.

While four out of five users said they would recommend a day unit to others, we assume that dissatisfied users had already "voted with their feet" and no longer attended the unit. Almost nothing is known about this latter group and they might be able to provide useful information to local organisations like CHCs which are concerned to improve their day services.

Nearly all of the staff found some aspect of their work satisfying, but about 80% of them found other aspects frustrating and almost everyone could recommend changes which they believed would improve services. These recommendations cut across the categories which for other purposes can be used to differentiate the staff, such as their age, experience, and so on.

Improvements

More staff wanted changes to the organisation of their units than any other area of improvement. Staff in health authority day hospitals were somewhat less critical of central management than their social service counterparts but there was a common thread to all.

Complaints that central management was out of touch, uninterested, slow or just indecisive were most frequently voiced. Internal improvements to the units' organisation were also sought, as was better communication between staff. The need for more resources was also raised frequently. Finally, links outside the day unit — particularly with the local community and users' families — were a common target for improvement.

In contrast the largest group of users — about a quarter — focused on the programme of activities they were offered in the unit as their "bête noire".

The contract and industrial work available in 40% of units was often criticised. Not only was the purpose of such work questioned but also its repetitive nature and low skill requirement. More variety of work, a more consistent flow of work, work providing more personal involvement and more challenging work were all suggested. How such work is to be rewarded — if at all — was often an issue, as was how work could link to opportunities for employment outside the day unit.

The social side of day unit attendance is highly valued but not accepted uncritically. Within the context of the limitations placed on users by their disabilities, many users seemed to want at least some social activities which are designed to awake and develop their capacities. Attention to the kind of interchange between people required by a given activity alongside the level of skill or new learning it may require could help development in this area.

The notion that staff can or will have all the ideas for developing the social life of a unit while users stand by as passive recipients obviously needs to be shelved, but some areas have gone even further to develop a management partnership between the users and the social service department officers (7).

A third aspect which was of particular concern to day hospital users was the treatments of various kinds which they received from doctors, nurses and therapists. Users wanted an increase in the amount of individual attention from staff — particularly doctors. They also wanted more remedial therapy, better supervision of their drugs and more information about their conditions and the impact illness would have on their future.

These kinds of problems crop up again and again in the NHS, but day hospitals may present opportunities not available elsewhere for ameliorating these problems. For example, group rather than individual therapy may be possible, relatives' groups could help planned treatments at home and finally, users in day hospitals may be better placed to help *each other* than users of other health service facilities.

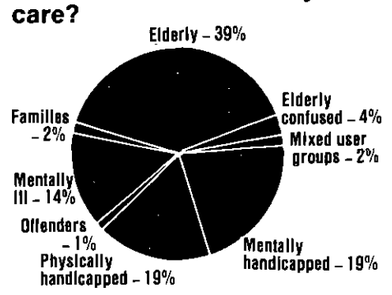
Pressures on the service

Looking at day services for all adult client groups provided by all the different statutory and voluntary sponsors has the advantage of making certain common themes apparent. There is no doubt that in the 1980s day care will be under greater pressure than ever before. More people are likely to be seeking entrance and current users are likely to find it harder to leave. The pressure for cost efficiency is also likely to increase — though policy makers will need to look at the whole community care package and not just at day units in isolation. Given these stringencies, however, the issue of whether day care provides a specialist service for particular users with particular needs or a more generalised service will require further thought.

Some areas have started to develop a spectrum of day services which cater for a range of users' needs, and one key to their success may be that these areas are also relatively advanced in terms of co-ordination between the health service and the local social services department.

Other areas look to greater mixing of traditional client groups within existing day centres but with a new focus on the kinds of activities offered. Such "activity centres" may be better able to perform a preventative function across a range of age groups than the more usual types of day centres. By using a model of mutual help and concentrating on abilities instead of disabilities such centres may also be less stigmatising than other day centres.

Which adults receive day care?



Choices

A final theme worth mentioning is the importance of choice within the day care setting. If day care is to develop as a dynamic and lively part of community services the amount of choice available within the service must also be developed at every level. The users of day care should be able to choose the type of unit best suited to their needs and should have the liberty to define these needs themselves, even if in consultation with relatives and other outside helpers — the importance of relatives choosing to be relieved of their caring task for at least a few hours each week should not be overlooked.

Once a day unit has been chosen, each user's choice within the unit as to his or her preferred activities, interactions and so on ought to be encouraged. Yet very few day units seem to provide users with a profile of their aims and activities to make this choice easier.

Without the element of choice day care could become a dull and confining service for those who have already experienced some disadvantage.

Financial stringency should not be allowed to dampen anyone's commitment to pressing for better quality day services. Here CHCs have a very important role to play. There can be no single solution to helping people who find their way into day services, but a flexible approach with greater co-ordination between the various sponsors — particularly the health and social services — and a mindful ear to the views of participants, both staff and users, may provide some guidance for the future.

References

1. *Adult day care — somewhere to go* by Jan Carter. Allen and Unwin, 1981.
2. *The data of day care* by Carol Edwards and Jan Carter. 3 volumes. NISW, 5-7 Tavistock Place, London, WC1.
3. *Day services in Scotland* by J Tombs and J Tibbit. Central Research Unit Paper. Scottish Office, Social Work Research Branch, 43 Jeffrey Street, Edinburgh, EH1 1DN.
4. *A busload of opportunities* by S James and K Hodgson, in *Community care* No 404, 25 March 1982 pages 12-14.
5. *The Sunderland mobile day centre* by P Kaim-Caudle. Help the Aged 1977.
6. "From mental hospital to market town — Dorset's travelling day hospital" by J Shires in *New directions for psychiatric day services* MIND 1981.
7. *Handing back the power* by D Heptinstall, in *Community care* No 405, 1 April 1982 pages 10-12.

Further reading

1. *Day care centres — some developments in England 1970-1980* by Jean Symons. Centre on Environment for the Handicapped, 126 Albert Street, London NW1. Price £2.
2. *Day services for disabled people — do we care too much* by Linda K Tuckey in *Concern* Winter 1981-2, magazine of the National Children's Bureau, 8 Wakley Street, London, EC1.
3. *Gaining benefits from day care.* An action-research study in the take-up of welfare benefits by clients of two day centres, by Lib Skinner, Welfare Rights Officer, Community Services Department, Harlow Council, Town Hall, Harlow, Essex.

Book reviews

Inequalities in health: the Black Report

edited by Peter Townsend and Nick Davidson, Pelican £2.50

When the Black Report was first published in 1980, unemployment had just topped the two million mark. The authors of the report, led by Sir Douglas Black, president of the Royal College of Physicians, predicted that rising unemployment would only exacerbate the inequalities of health between social classes.

Now there are more than three million people without a job, and slowly research is beginning to establish that their hunch was correct.

Pelican books have performed a public service in making this report widely available for the first time. It is a scary totting up of how little the welfare state has achieved in reducing social inequalities in Britain. Bluntly, working class adults and children suffer more, much more, from sickness than their middle class counterparts. Chronic sickness, for example, occurs twice as much among unskilled manual workers as among professionals.

The inequalities in children's health are especially stark and the first objective of the Black committee's recommendations was to give children a better start in life. The committee called for a sharp shift in resources towards preventative measures and community care (when *that* woolly catch-all phrase has been better defined). The government continues studiously to ignore the Black Report.

The book is clearly written, as one would expect with a report Professor Peter Townsend has had a hand in. It is a readable testimony to what needs doing urgently for Britain's health.

Janet Hadley, ex-CHC NEWS

The epilepsy handbook

by Shelagh McGovern, Sheldon Press, £3.95

Epilepsy is a scare word for most people, almost like the word cancer. There are common misconceptions about people who suffer from it — falling down, twitching, foaming at the mouth: madness looms, surely? Such myths as this serve to aggravate the fear and shock which grips a person who learns that this is the problem they're going to have to live with. Families too, shrink in horror at the news.

Copies of Shelagh McGovern's book could usefully be stocked in the desk of every doctor whose job regularly involves breaking this news. A copy could be given to every bewildered patient (or parent of a patient) to take away and digest at leisure, as the questions come flooding in.

What *is* epilepsy? Is normal life still possible? Will my personality change? Can I bear children and bring them up? Will my epileptic child be backward?

There are chapters answering these questions and many more. The book tackles the problems facing young adults, children, the epileptic's family. It describes types of epilepsy, the drugs which help control the condition, and the driving licence laws. The writing is clear and the attitudes are positive. Until recently the author was secretary of the British Epilepsy Association.

Janet Hadley, ex-CHC NEWS

Anorexia nervosa — let me be

by A H Crisp, Academic Press, £8.60

Anorexia nervosa — a guide for sufferers and their families

by R L Palmer, Penguin, £1.75

Anorexia nervosa has been mistakenly called "the slimmers' disease" because sufferers, predominantly women, are recognised by their emaciated bodies. Both of these books attest that while anorexics have disrupted eating patterns, they also suffer from psychological disturbances including severe lack of confidence and depression.

Self-starvation gives the anorexic a sense of autonomy which she has been unable to gain elsewhere. According to these authors both aspects should be considered in treatment, rather than concentrating solely on getting the anorexic to put on weight. Both books are written by psychiatrists who have had considerable experience working with anorexics in hospital settings, so they tend to write more about clinical description and the problems of diagnosis, with less emphasis on treatment, self-help and long-term outcome.

The initial chapters of Professor Crisp's book cover clinical features, natural history and epidemiology of the condition, and are informative for the lay reader. But subsequent chapters deteriorate into homespun philosophy on the wider social issues — the pressures to slim, the position of women and the value of the family in society. The final chapter is one of the most interesting — it contains descriptions of their exeriences by anorexics and members of their families.

Palmer's book presents similar material, but in a less pompous style — and much cheaper!

My criticism of both books is that they are conceptually narrow. Anorexia nervosa is viewed as a disease and not placed in the general context of what is known about our eating habits. There is little assessment of the long-term social and psychological effects of suffering from anorexia nervosa.

Only passing references are made to Anorexic Aid and Anorexia Counselling Service, which provide community counselling services and encourage the formation of self-help groups. These groups arose because of the frustration experienced by sufferers and their families, who felt that their problems were not properly understood by the medical profession.

These books, especially Palmer's, could be read in conjunction with Sheila Macleod's *The art of starvation* (Virago 1981), which provides a first-hand account of the problem and how it was dealt with, to provide the lay reader with an all-round picture of the condition.

Belinda Newman, Member, Camberwell CHC

Asthma — the facts

by Donald Lane and Anthony Storr, Oxford University Press, £2.95

This is the most comprehensive and helpful book on asthma I have read. Dr Lane deals with the causes, symptoms, treatment, prevention and self-help for patients in a very readable style which is detailed enough for the medical profession but easily understood by everyone.

All asthmatics will identify with psychiatrist Anthony Storr, who gives his personal experiences as an asthmatic in the introduction. I feel this should be read by the immediate family of asthmatics to give them a greater understanding of how an asthma attack feels.

I find it surprising, however, that although Dr Lane says "bronchodilators represent the foundation stone of therapy in bronchial asthma", he makes no mention of the portable nebulizer which patients can use at home. A nebulizer is a machine for delivering bronchodilating drugs in a fine water spray. The portable version is the greatest help and makes normal life possible for chronic patients — but it receives little publicity.

No two patients experience asthma in the same way, and successful management is achieved only by co-operation and understanding between GPs and their patients. The book should go a long way to help this. It should be read by all GPs — especially those who have no personal experience of the disease — and by all asthmatics.

Muriel Kent

Physical handicap

by Lesley Bell and Astrid Klemz, Woodhead-Faulkner, £5.75.

Written in non-technical language, this book is in four distinct sections which make for easy reference. Part one describes in plain terms the diseases and disabilities commonly met with by those working with handicapped people. Part two gives information on welfare legislation and includes a comprehensive survey of 59 voluntary organisations in the field. Parts three and four discuss the personal needs and provision for physically handicapped people.

Although written as a guide for staff in social service departments and voluntary agencies, CHC secretaries should find it a very handy reference book. It is useful for all workers with handicapped people to have some idea of what the other professions have to offer.

Ron Drew, Member, S Tyneside CHC

RECALLING THE PAST

*by Janet Simpson**

"They live by memory rather than by hope" wrote Aristotle about old people. Until recently "dwelling on the past" has had negative connotations — not a good thing for the old folks to indulge in. But now reminiscing has come to be seen as valuable and to be encouraged.

It is not surprising that the elderly spend more time than other age groups in thinking about the past. They have more years of experience to think over as well as more time in which to do so. Old people often express pride in the clarity with which they can recall by-gone events in great detail, while at the same time acknowledging that their memories for recent happenings are poor.

Psychologists recognise that recent memory declines in efficiency with advancing age — but beware the scientific literature on this subject, because it is a minefield of confusing terminology. Both "long-term" and "short-term" are used to describe the same stage of memory for recent happenings, depending on the theoretical model favoured by the author.

Reminiscence can be valuable in different ways. It has been associated with successful adaptation to old age. As this period of life offers few opportunities for achievement, some elderly people need to recall past accomplishments as a way of preserving a sense of identity and present significance. If an old person can look back and say "I would not change my life if I lived it over again" or "I can accept myself the way I am" she is likely to be well adjusted to the change of life-style forced upon her by senescence.

But if fortune has passed her by, opportunities have been missed, or painful loss experienced, she may avoid looking back. At the same time depression may set in and, as some evidence suggests, life expectancy may even be reduced.

Some one in this situation needs help to review the past, to reinterpret it and re-evaluate it in order to try to come to terms with what cannot be changed and to adjust to the present. Intervention of this sort is best left to an experienced therapist or counsellor.

At another level reminiscing can be a way of promoting social interaction among old people and between the generations. In less sophisticated cultures than ours, without libraries and archives of historical records, old people were the only link a group had with its past. They were valued for the stories they could tell — stories which formed part of a society's identity. Today the old no longer have such a role, though oral historians are giving it back to them.

Looking at old photographs and listening to recordings of old songs can spark off conversations about growing up and coping with life between the wars. It can be especially valuable for residents of homes for the elderly and patients in long-stay wards, particularly those of them who suffer some mental impairment. An otherwise confused lady may be stimulated to produce sentences of coherent speech when shown a picture of her old school or the trams she knew in her youth.

A volunteers' organiser at University College Hospital, St Pancras — Yvonne Bonifas — has used the Help the Aged package (see below) with patients on the geriatric wards. She has found that groups of six to eight elderly people with three to four helpers work best.

The patients obviously enjoyed the sessions and often showed more interest than they had done during other types of group activity. People with different levels of mental capability can be accommodated as long as a helper is assigned to every one or two of the more severely impaired.

Yvonne found that patients were more likely to talk to a helper than to each other unless a couple of them found they had something in common. Two ladies struck up a lively conversation during one session when they discovered that they both grew up in the same part of Kentish Town and had even attended the same school.

Just occasionally pictures might provoke adverse reactions. It was pictures of the last war — of soldiers taking leave of their families and of blitzed out houses — that were sometimes greeted at St Pancras with cries of "I don't want to look at that". But the same photographs gave another resident the chance to boast of how cheerfully she had coped with being bombed out seven times.

It is not only the elderly who benefit on these occasions. The staff who take part are often amazed to learn of their patients' exploits and find they can subsequently chat with them about topics which have arisen during the presentation. Because they know more about a patient she is revealed to them as an interesting individual and they can derive more pleasure from their own work. And of course, the patients themselves benefit from the increase in individual attention.

In this way reminiscence is valuable not only to old people themselves but also to the professionals who care for them and all the younger people who come into contact with them.

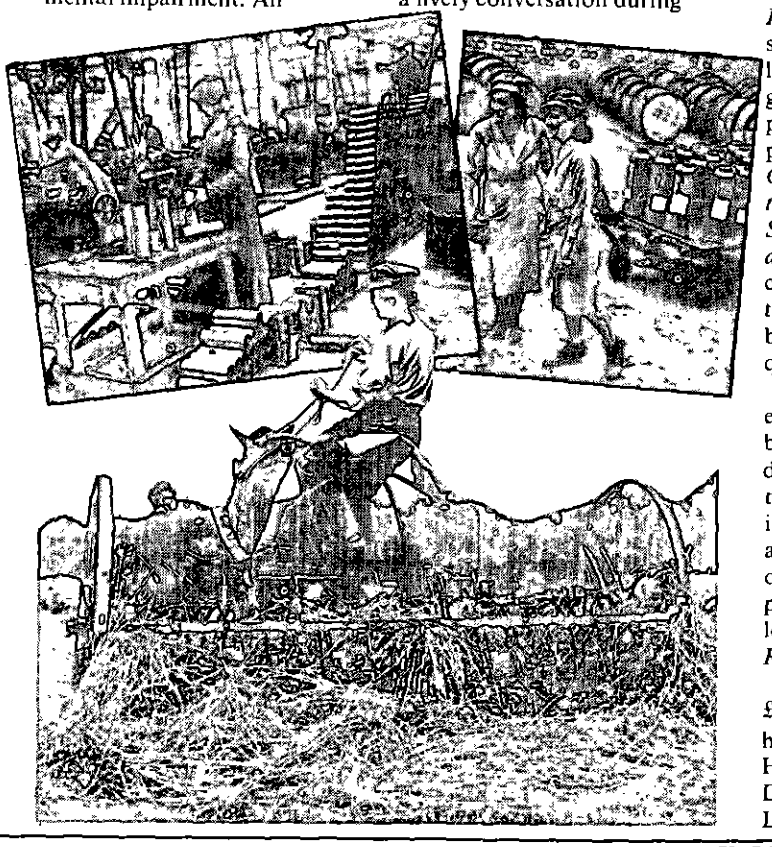


Photo: BBC Hulton Picture Library

Photos: Fox Photos Ltd

Help the Aged has recently published a set of materials for use in reminiscence groups. *Recall* is a series of tape and slide sequences which span the lifetimes of our oldest generations in sounds and pictures. It is available in three parts — *Childhood* and *The Great War*, *Youth* and *Living through the Thirties*, and *The Second World War* with *A different world*. Each part consists of 40 slides, a cassette tape and a booklet with background notes and cue questions for discussion.

Recall — a handbook explains more of the background theory and describes the development of the *Recall* project. It also includes a helpful reading list and suggestions for sources of oral history and period pictures, since it is hoped that local groups will supplement *Recall* with their own material.

The tape-slide sequences cost £12 per part (inc post) and the handbook costs £3 (inc post) from Help the Aged Education Department, 218 Upper Street, London, N1. Tel: 01-359 6316.

*Janet Simpson is a research psychologist at the geriatric research unit of the University College Hospital Medical School in London.

Parliament

Accounting for local decisions

The Government has announced five accountability initiatives for the NHS. They are:

- Annual regional reviews —Ministers will chair meetings to discuss future plans and past performances in each region, including districts' efficient use of resources.
- Performance indicators — to identify aspects of performance for examination at greater depth, regionally and at district level.
- Audit — trials have begun using independent commercial auditors to support the DHSS external audit into financial management.
- Rayner scrutinies — for short, intensive studies of areas affecting the efficiency of the NHS.
- Management advisory services — four regions are conducting two-year trials involving three approaches to setting up an advisory service. After trials the service may be extended to a national scheme (DHSS press release 82/185, 17 June).

Charging for postal votes

NHS patients who have been charged for certificates for which the GP is not entitled to charge — for example, postal vote applications — should write to the local Family Practitioner Committee *within eight weeks* of the event. Complaints may be investigated under the *NHS (service committees and tribunals) regulations 1974*. If a GP is found to be in breach of terms of service the amount could be withheld by the FPC and returned to the patient (Laurie Pavitt, Brent S, 26 May).

Test-tube babies

A broad-based departmental inquiry chaired by Mary Warnock will be set up to consider developments in medicine and science related to human fertilisation and embrylogy, including the social, ethical and legal aspects, and to consider policies and safeguards. The 16-member committee (six members are women) is expected to report in 1984 (Tony Marlow, Northampton N, 23 July).

Safeguards on dressings

Employers will be advised to obtain first aid dressing from approved manufacturers, following the inquiry into contaminated "sterile" dressings imported from India. The Health and Safety Executive will launch a scheme to inform employers and will monitor work-places to ensure that only dressings from approved sources are used. Supply of dressings to the public through retail outlets may be controlled under the Trades Description Act — this will be discussed with the local authorities' co-ordinating body on trading standards (Richard Page, Hertfordshire SW, 9 June).

Low pay

Estimates show that about one third of full-time NHS ancillary staff in England earn less than £82, the family income supplement prescribed level for a family with two children (Tom Pendry, Stalybridge and Hyde, 20 May).

Value of maternity

The maternity grant, increased to its present level of £25 in November 1969, would have to be increased to £112 to restore its 1969 value at March 1982 prices (Bob McTaggart, Glasgow Central, 14 May).

Supporting the homeless

The Social Services Secretary has a specific duty to provide and maintain resettlement units giving temporary board and lodging to homeless people, to influence them to lead a more settled life. There are 23 such units, mostly in urban areas, and Ministers feel this is broadly adequate. The DHSS also contributes funds to 35 voluntary organisations providing similar facilities (Dr Roger Thomas, Carmarthen, 18 May).

Appropriate care

The trend away from long-term hospital care for the mentally ill and mentally handicapped has meant a net increase in local authority residential and day care, whereas improvements in domiciliary support appear to have enabled a net reduction in residential care for physically handicapped people, between 1978 and 1981 (Alf Morris, Wythenshawe, 25 May). It is hoped to establish a set of experimental schemes for elderly patients with psychiatric disorders — not necessarily in the form of nursing homes. More than one pattern of care may be tried (Dr Roger Thomas, Carmarthen, 20 May).

Managing blood

A Special Health Authority will be set up to run the Central Blood Laboratories at Elstree and Oxford, which are at present managed jointly by the DHSS and N W Thames RHA (Robert McCrindle, Brentwood and Ongar, 18 May).

WHAT'S IN A NAME? –PARKINSON

by Peter Jewell, Welfare Director, Parkinson's Disease Society

The name of Parkinson recalls a GP who practised in the East End of London over 150 years ago. He was Dr James Parkinson and in 1817 he published *An essay on the shaking palsy*. His description of the condition which now carries his name is highly regarded even today. Although methods of treatment have advanced there is sadly still no known cure.

Parkinson's disease affects one in every thousand of the general population, but one in a hundred of elderly people. It is a chronic sickness of the nervous system which is slowly progressive but does respond to modern treatment. Both symptoms and development of the disease vary from patient to patient. The three main symptoms of tremor, rigidity and slowness of movement are brought about by a deterioration of certain cells at the base of the brain. Diagnosis can often be prompted by the patient's expressionless face, immobile posture, shuffling gait and difficulty in speech or writing. Treatment is principally by means of drug therapy, although the physical therapies can also play a useful part.

Patients can do a lot to help themselves, and one of the first tasks of the Parkinson's Disease Society when it was formed in 1969 was to provide booklets giving basic information about the condition, its treatment and how best to cope. Our literature is sent directly to any patient or caring relative who contacts us and many have testified to its value.

Self-help is also exemplified in the increasing number of local branches of our Society. These are all voluntarily staffed and at least one of over 60 branches inaugurated so far was set up at the instigation of and with continuing support from the local CHC. We urgently need more branches and our development officer will gladly liaise with CHCs willing to help in areas where none exists at present.

One member has described her involvement in branch activities as "a window on the world". Another member features in an excellent film entitled *A battle worth fighting*, showing a day in the life of a Parkinson's disease patient (available on hire from Concord Films Council, 201 Felixstowe Road, Ipswich, Suffolk.

In addition to helping patients and relatives with the problems arising from Parkinson's disease, the Society also aims to collect and disseminate information. A recent national epidemiological survey may help to point researchers in the right direction and, on a smaller scale, a survey of our own members' social needs is enabling the Society to develop relevant welfare facilities.

A further principal aim is of course to encourage and provide funds for research into the disease. The Society has the benefit of both medical and welfare advisory panels, but the crucial elements in our work are those of self-help and mutual support.

The Parkinson's Disease Society, 36 Portland Place, London, W1N 3DG. Tel: 01-323 1174. A range of leaflets and booklets is available free to patients. *Parkinson's disease: information for patients* is supplied free for distribution by GPs.

Scanner

Treating heart disease ...

The long-delayed Welsh medical committee report (see *CHC NEWS 77 page 3*) on services for heart patients in Wales has now been published, along with a further Welsh Office study costing the report's recommendations. The report says that in Wales coronary surgery is available only to the fortunate few, and that half the patients having surgery — three-quarters of the children — have to be transferred to English centres because of inadequate resources in Wales. Yet the prevelance of heart disease is higher in Wales than anywhere else in the world other than Scotland, where a similar report in 1977 led to a considerable improvement in resources. The Welsh Office study accepts that facilities for cardiology and cardiothoracic surgery should be doubled — the report recommends this as phase one of needed improvements — but there will be a further appraisal of costs before any action is taken. *Report of the working party on cardiothoracic services in Wales* and *The study team's report* on the above will be circulated to Welsh CHCs. Extra copies from HPB1 Division, Welsh Office, Cathays Park, Cardiff. Tel: Cardiff 923484.

... and preventing it

Meanwhile, a report from the Office of Health Economics criticises the level of coronary deaths in Wales *and* England. The OHE claims that over 9000 deaths among men of working age would have been avoided yearly, had death rates improved during the 1970s to the same extent as they did in the US. The report blames bad habits — smoking, high-cholesterol diets and lack of exercise — and ignorance of risk factors, pointing out that many people believe incorrectly that "stress" is the major factor in heart disease. As is usual in studies of heart disease, most of the startling statistics refer to men, yet 7400 women under 65 die from heart disease each year. *Coronary heart disease — the scope for prevention* by Nicholas Wells. Price £1 from OHE, 12 Whitehall, London, SW1.

Disabled in Tyneside

A survey commissioned by North Tyneside social services department, aiming to contact every handicapped person in its borough, drew responses from 87.1% of the borough's households, showing a handicap prevalence rate of 3.7%. Of 5867 people interviewed in detail, 58% were elderly, and a total of 10,000 disorders was reported, with arthritis and rheumatism topping the list of disabling conditions. Unmet needs related mainly to housing, advice and health care. A valuable example of how to identify needs in your borough, the survey was carried out by Outset. *The handicapped in the community* by Karen Buck and Andrew Hibberd. Price £4 (plus p&p) from John Foster, N Tyneside Social Services Department, Citadel East, Killingworth, Tyne and Wear. Tel: 0632 682567.

Who does what in prevention?

is the self-explanatory title of a paper listing over 100 organisations, mainly non-governmental, working in the field of prevention. Based on a survey of their activities, details of the organisations are given in eleven subject areas ranging from alcohol to road safety, and a separate section describes their funding. By David R Cohen and Anne Moir, price £2 (payable to University of Aberdeen) from Mrs I Tudhope, Health Economics Research Unit, Medical School, Foresterhill, Aberdeen, AB9 2ZD.

Disability is no handicap ...

says the National and Local Government Officers Association (NALGO). Very few employers in the public *or* private sectors meet the 3% employment quota for disabled people. This booklet aims to improve that by giving negotiation advice to trades unionists, along with recommendations for improved work opportunities. Printed in large type for the benefit of people with poor sight, it includes lists of information sources and advice on the law. Free with an sae from NALGO Press Office, 1 Mabledon Place, London, WC1

... but life could be easier

Advice to staff caring for visually disabled patients in hospital is reprinted from a series of lectures given to medical workers last year. *How to make life easier for visually disabled patients — and the people who look after them,* supplement 1 from the Inter-regional review. Price 60p (inc post) from the Southern and Western Regional Association for the Blind, 55 Eton Avenue, London, NW3 Tel: 586 5655.

Concern for children

The final preventative medicine report from the Royal College of GPs is sharply critical of preventative care for children. While acknowledging that the major problems are "environmental ... in its broadest sense" — regional and class variations in death rates, for instance — the report blames GPs for poor premises, inadequate record-keeping, especially of immunisation, and inaccessibility. It claims that "an unknown number" of children are not registered with any GP, and says there is evidence of "continuing failure" of GPs to prevent some avoidable major handicaps. The report says that since implementation of the 1976 Court report was impeded, the ball is now in the medical profession's court. It gives detailed proposals for locating preventative child health services firmly within the primary care team. *Healthier children — thinking prevention.* Report of a working party appointed by the Council of the RCGP. Price £5.50 (inc post) from the Publication Sales Department, RCGP, 14 Princes Gate, Hyde Park, London, SW7 1PU.

Health circulars

HC(82)12: asks DHAs to review fire precautions in light of recommendations arising from the Warlingham Park hospital fire.

PM(82)21: lists medical and dental practitioners who are prohibited from handling controlled drugs.

Other publications

CVS in action — No 3 working with volunteers and *No 4 supporting neighbourhood groups.* Price £1.75 each (inc post) from Councils for Voluntary Service — National Association, 26 Bedford Square, London, WC1.

Self certification and employers' statutory sick pay. Price £3 from the Society of Occupational Medicine, 11 St Andrew's Place, Regent's Park, London NW1.

The sickle-cell society annual report 1981-2. From the society — c/o Brent CHC.

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: South Tees CHC The Lodge, 1A Acklam Road, Middlesborough, Cleveland, TS5 5AY. Tel: Middlesborough 828470

Page 3: Beverley CHC has changed its name to **East Yorkshire CHC**

Page 4: Wakefield Western CHC has changed its name to **Wakefield CHC.**

Page 4: Wakefield Eastern CHC has changed its name to **Pontefract CHC**

Page 4: North Nottingham CHC has merged with **South Nottingham CHC** to form **Nottingham CHC**, with address, phone number and Secretary as for South Nottingham. Chair: Mrs J Radford.

Page 5: Doncaster CHC Secretary: Miss B Langton

Page 5: Barnsley CHC Chair: Cllr Roy Barron

Page 5: Sheffield Northern CHC has merged with **Sheffield Southern** to form **Sheffield CHC**, with address and phone number the same. Chair: TW Shipstone. Secretary: Harry Trent

Page 5: Cambridge CHC Chair: Cllr Bill Sloman

Page 5: Kings Lynn CHC has changed its name to **West Norfolk and Wisbech CHC.**

Page 5: Ipswich CHC has changed its name to **East Suffolk CHC**

Page 6: North West District CHC has changed its name to **Paddington and North Kensington CHC**

Continued on next page

News from CHCs

☐**North Western** CHCs are calling on CHCs in other regions to support them in opposition to the decision — reported in *CHC NEWS* 72 page 3 — to turn Family Practitioner Committees into independent health authorities. A delegation of the region's CHCs travelled to London recently to lobby MPs, and held three hour-long meetings for the North West groupings of Conservative, Labour and SDP MPs. They argued that the decision represents a reversal of Government intentions as expressed in *Patients first* — the consultative paper on reorganisation — and would mean greater administrative costs and duplication of functions. MPs agreed — Labour and SDP MPs saw the move as unnecessary tinkering which would harm the integration of health services, while Tory MPs were worried that family practitioner authorities would become just another administrative tier. The CHC doubt that independent FPCs would aid patient welfare, and want the Government to take a second look at the plans before legislating to implement them.

☐ A report by **South East Cumbria CHC** on transport problems for patients in country areas has led to an experimental scheme funded with £10,000 from the Development Commission, which represents rural England. Patients in five GP practices with a round trip of more than 50 miles to their district general hospital will be able to claim travel expenses — at 11 pence per mile — if they have no medical need for an ambulance. At present help with travel costs is on a means-tested scheme for low-income patients only. A later phase of the new scheme will provide help with costs for certain essential visitors — parents of children in hospitals, and spouse, nearest relative or friend of elderly patients. Strangely enough, expectant fathers visiting maternity units will be excluded from the scheme. The new **South Cumbria CHC** will administer the experiment, which should start by the autumn, and will monitor take-up to provide ammunition for the Development Commission when it makes its case for the DHSS to take over and extend the scheme nationally.

Photo : South West Picture Agency

☐*Why did the patient cross the road? to get to the operating theatre, of course. Paulson Memorial GP hospital has developed on a hill either side of a B-road. Every day kitchen porters dodge the traffic with their food trolleys, but after emergency treatment was seriously delayed one day the League of Friends recruited* **Bath CHC's** *help to get a zebra crossing. They contacted Avon county council –which decided the volume of traffic is below the minimum criteria for a crossing. Yet the road carries local shift workers who travel at all hours and soon come to disregard warning signs. Local MP Paul Dean has agreed to help and now Avon County will be asked to think again.*

☐**Cardiff CHC** is disappointed that the local council has refused its request to inform residents of the effects of nuclear war by sending out details with the rates bills. CHC members were so disturbed by a talk and exhibition from the Medical Campaign Against Nuclear Weapons that they wanted the facts to be widely distributed, but South Glamorgan council said their idea was ruled out by mechanical packing of the bills. Coincidentally the council had recently refused a similar request to inform householders of what to do in a nuclear war — from the Home Office.

☐The Pharmaceutical Services Negotiating Committee has adapted **North Sefton CHC's** leaflet *You and your chemist* as a guide to the role of community pharmacy in primary health care. CHCs can produce local versions of the leaflet using artwork supplied by the PSNC, and so far over 100 CHCs have taken up the offer.

☐**North Tyneside CHC's** *Coping with cancer information bulletin* — so well received while still in draft form — is now out. Aiming to dispel the "mystique and horror" of cancer, it includes addresses of national and Northumbrian groups, guidance on practical and financial needs, sources of religious support and information on bereavement, research and alternative medicine. Free from the CHC.

CHC Directory: Changes continued

page 7: North Camden CHC has changed its name to **Hampstead CHC**
Page 7: Bloomsbury CHC Chair: Dr Alan Berson
Page 7: City and Hackney CHC Chair: Erica Davis
Page 8: Canterbury and Thanet CHC Chair: Keith Burbidge
Page 9: St Thomas's CHC has changed its name to **West Lambeth CHC**
Page 9: King's CHC has changed its name to **Camberwell CHC**
Page 9: Guy's CHC has merged with **Lewisham CHC** to form **Lewisham and North Southwark CHC**, address, phone number, Chair and Secretary as for Lewisham
Page 9: Cuckfield and Crawley CHC has changed its name to **Mid Downs CHC**
Page 10: Kingston, Richmond and Esher CHC has changed its name to **Kingston and Esher CHC**
Page 10: Roehampton, Putney and Barnes CHC has changed its name to **Richmond, Twickenham and Roehampton CHC**
Page 10: Sutton and West Merton CHC has changed its name to **Merton and Sutton CHC**. Chair: Mrs J Woolley
Page 10: Basingstoke and north Hampshire CHC Hackwood Road Hospital, Hackwood Road, Basingstoke, Hampshire. Chair: Susanne Dean
Page 14: Halton CHC Chair: Mrs Ann Entwistle
Page 14: Wirral Southern CHC has merged with **Wirral Northern CHC** to form **Wirral CHC**, with address and phone number as for Wirral Northern, and Chair and Secretary as for Wirral Southern.
Page 16: Rhymney Valley CHC Chair: Mr A James
Page 16: Swansea/Lliw Valley CHC 42 High Street, Swansea, West Glamorgan. Tel: same as before
Page 17: North Gwent CHC Chair: Cllr I Nash

CHC surveys and publications

The care of children in hospital (**N Bedfordshire CHC**). Report of a study of consumer experience of health services for children (**Cambridge CHC**). Survey of the views of outpatients attending Bishop Auckland hospital (**SW Durham CHC**). Survey of family practitioner and community health services (**Harrogate CHC**). Drug abuse in Hillingdon (**Hillingdon CHC**). Good practices in mental health (**Kensington, Chelsea and Westminster CHC** — now called **Victoria CHC** — with their local Mental Health Association).