News from CHCs

☐ Private hospital developments are worrying CHCs around the country and several have found that opposition on planning permission grounds is more effective than pleas based on the consequences for NHS services. **Central Manchester CHC** drew support from DHA members and local doctors when it mounted a campaign against a US-backed application to build a private psychiatric hospital within a ¼ mile of the Cheadle Royal, which is run by a charitable trust and takes long-stay NHS psychiatric patients on contract from the RHA. Cheadle Royal hospital is unique in that it trains staff for the NHS. Campaigners believed the private hospital would divert these trainees away from the NHS and, more importantly, it would take the charity's profitable acute business which subsidises its long-stay NHS work. But at local authority level objections were raised because the chosen site was on green belt land. The CHC decided on strategic grounds to emphasise this point and eventually the company withdrew its application.

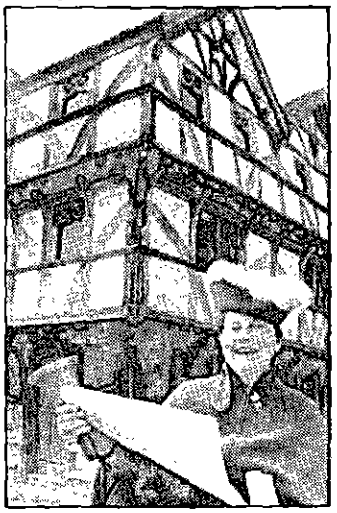
Canterbury and Thanet CHC already has its private hospital and is facing the consequences of a £400,000 district deficit when pay-bed business transfers to the AMI-owned Chaucer hospital, built in less than a year and already recruiting NHS nurses. The hospital director claims his business will lighten the NHS work-load, but CHC members are worried about the drain on resources, and the DHA treasurer has a tough job balancing the books in a year when DHSS-demanded efficiency savings and pay awards are costing the district £1 million.

Green belt considerations also caused Redbridge council to reject a private hospital planning application from a consortium of local investors, but **Redbridge CHC** was disturbed by reports that the consortium — called Third Independent Hospital Ltd — includes doctors, nurses and other NHS staff, and claims to have raised up to £½ million. The CHC felt that DHA members and staff should declare any financial interests in the scheme but was told by the district administrator that where no contract with the NHS is considered, no declaration of interests is required. Important planning decisions could be taken by those who favour private medicine, says the CHC, and now **North East Thames CHCs** have written to the Secretary of State to clarify the point.

☐ Mixed sex wards are causing a stir in some districts as DHAs combine wards to save running costs. After **Bromley CHC** lost a battle to prevent two male and female wards merging in Orpington hospital, it decided to concentrate instead on establishing a policy to safeguard patients from distress on the mixed ward. Many medical cases are admitted as emergencies — which rules out prior choice — but the DHA has agreed to move people who object, and at the CHC's prompting has worked out a nursing policy to remedy design problems on the purpose-built ward. Now the CHC will monitor progress to ensure the policy is not forgotten when the novelty wears off.

Meanwhile nearby **Tunbridge Wells CHC** — alerted by Bromley's problems — has conducted a coupon poll in the local paper. Of 429 replies, 413 were against mixing the sexes, although people with experience of the wards were less likely to object.

And **Salford CHC** members on hospital visits found patients in mixed sex wards had few complaints. The DHA has promised to include details of the wards in information booklets and admission letters, but good ward design means that privacy is assured.



☐ *Yvonne Chamberlain — possibly the only woman town crier in England — was recruited by* **Weston CHC** *to call residents of Axbridge to a meeting on the future of an unwanted administration block at the local hospital. The public turned out in force to contribute their ideas and now the former workhouse, in a designated area of historical interest, could provide employment for local people in conversion plans which include space for a new library.*

☐ Out of eight ideas submitted for funding by Liverpool DHA to the inner city partnership scheme two were contributed by **Liverpool Central and Southern CHC** — but all were turned down. The CHC is concerned about facilities for the 40,000 black people in Liverpool. It wanted a clinic for disorders such as sickle cell anaemia and a two-year survey into health needs of minority groups in the city, which its hard-pressed DHA is unable to fund. Inner city partnership money has gone to similar projects in London, so after the rejection the CHC mobilised its MPs to put pressure on Environment Secretary Michael Heseltine, whose department controls the grants. The tactic seems to have worked, because the DHA has been advised by unofficial sources to resubmit the schemes.

☐ Well-women clinics are facing opposition from doctors who fear a duplication of services. **Norwich CHC's** plans, supported by over 900 letters from local women and organisations, were put to the DHA in June but the local medical committee (LMC) raised a strong lobby against the proposal, saying the service should be provided by GPs. The DHA backed away from making a decision and instead invited CHC members to a seminar later in the year to discuss the issue.

Barnsley CHC's plans for a trial clinic have been accepted in principle by the DHA but while waiting for detailed costings of the scheme the CHC has heard rumblings of dissatisfaction from its LMC. It believes the LMC has "got the wrong end of the stick" on the clinic's service, so it has sent copies of its plans to the committee in the hope of dispelling doctors' fears of a duplicate service.

Havering CHC believes the need for well-women services is demonstrated by the fact that its district's trial clinic usually has a six-week waiting list. The CHC has found no opposition from GPs, and now members want to see more clinics in other parts of the district.

Photo: Barton Photography

continued from page 9

prepared to encourage public discussion on the distribution of resources between different categories of medical services.

The way forward DHSS, HMSO 1977 — followed the *Priorities* document and set out the previous Government's plans for the NHS. Gives summaries of the main comments received on *Priorities* and examples of how NHS resources can be used more effectively.

Inequalities in health — the Black report DHSS 1980 — provides a wealth of data on inequalities in access to and receipt of health services, with particular reference to social class. The current Government has shown little support for the report's main recommendations but this is still an important book to read — and is now published in Pelican paperback (see *CHC NEWS* 79 page 8).

Care in action DHSS, HMSO 1981 — sets out this Government's policies and priorites for health and personal social services in England.

Facts and statistics

A wealth of useful information is contained in annual reports from the DHSS, the Health Advisory Service, Health Service Commisioner and Chief Medical Officer of the DHSS. Good statistics are given in publications such as *Health and personal social service statistics for England, Social trends* and the *General household survey.*

This list shows only a very small proportion of the Government and DHSS publications which may be of value to CHC members, and concentrates on England. A full list of recent Government publications is carried in *Government publications — sectional list 11, DHSS*, free from the Government Bookshop, PO Box 569, London SE1 9NH.

Scanner

Hear it on the grapevine

Ten years of an advice project established by the Family Planning Association for young people are assessed in an independent review which concludes that the community project provides a unique and valuable service. Run by trained volunteers with guidance from qualified staff, Grapevine provides help with sex and relationship problems. The review includes recommendations for setting up similar projects elsewhere. *Grapevine* by Fiona Richardson. Price £1.50 (inc post) from the FPA, 27-35 Mortimer Street, London W1N 7RJ.

Making the best of birth

The Caesarian support group of Cambridge has produced a handbook for parents based on their experiences of planned and emergency caesarian births. Chapters describe the medical procedures, the choice of local or general anaesthetic, postoperative care, exercises and breastfeeding in the early days when sitting up to feed may be difficult. *Caesarian birth – a handbook for parents* price £1.50 (inc post) from Ann Watson, 7 Green Street, Willingham, Cambs.

The Association of Radical Midwives has published the proceedings of its first annual conference in booklet form. Sessions were held on the midwife's role, breast feeding, perineal shaving, independent midwives and overseas practice. Workshops included discussions of alternative positions for labour. *The role of the midwife – ARM first annual conference Sheffield 1981* price £1.50 from ARM, Lakefield, 8A The Drive, Wimbledon, London, SW19.

What's accessible?

Disabled visitors to London can now get up-to-date information on the arts and entertainment scene, with advice on access to events and venues. For details of the what, the where and the what-to-beware-of phone *Artsline* on 01-625 5666 from 12am to 4pm Tuesdays to Fridays and 10am to 2pm Saturdays — or write to Artsline, 48 Boundary Road, London, NW8 OHJ

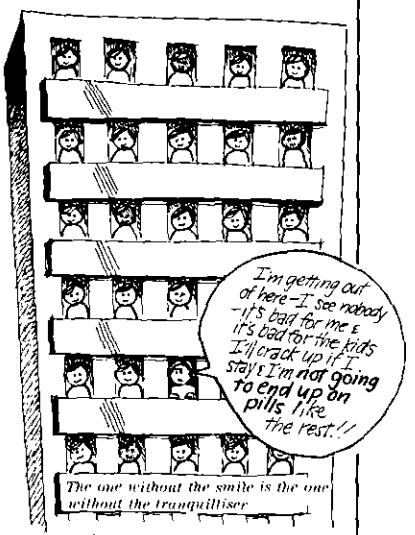
Picture the facts

Workplace safety is the subject of four broadsheets in poster form from the independent Labour Research Department. Covering noise, accidents, dangerous substances and safety policies, each poster carries further details on the back. *Health and safety broadsheets* cost £1.50 inc post for a minimum of four — cheaper bulk rates — from LRD, 78 Blackfriars Road, London SE1 8HF Tel: 01-928 3649.

The See Red women's poster collective have three new posters in their women's health series, dealing with contraception, sexually transmitted diseases and female repreoductive organs. Price £1.40 each inc post from See Red Women's Workshop, 16A Iliffe Yard, off Crampton Street, London SE1 Tel: 01-701 8314.

Action for the elderly

Better funding for CHCs, an increase in voluntary organisation representation and abolition of the age limit are called for in Age Concern England's 312-point national policy, now published in a handbook covering the needs of the elderly throughout society. The fruits of some forty years of experience are described for the first time in one publication, along with details of the structure and membership of the Age Concern movement. *The Age Concern England handbook* price 50p inc post from the Marketing Department, Age Concern England, 60 Pitcairn Road, Mitcham, Surrey, CR4 3LL.



A new booklet written for people who want to give up tranquillisers says that doctors often do not recognise that these drugs can be highly addictive to some users. The booklet advises gradual withdrawal and includes a 12-point plan to help escape the pill bottle. Trouble with tranquillisers *costs 40p (inc post) from Release Publications, 1 Elgin Avenue, London, W9. Release are hoping to set up a national self-help network for "tranx" users. Tel: 01-405 5742.*

Keep the facts

A passport-sized, hard-cover record book has been produced by the National Pharmaceutical Association for parents to use in keeping track of their children's medical histories. Called *Medicard*, it includes space for details of allergies, medication, vaccinations, x-rays, hospital visits and illnesses — and should be equally useful for adults. On sale at local chemists for £1.99.

Health circulars

HN(82)25: contains arrangements to phase in mental health review tribunals for patients whose detention in hospital has not been reviewed in three years.

HN(82)28: accompanies a letter from the Health and Safety Executive reminding DHAs of their responsibilities under the Health and Safety at Work Act.

HN(FP)(82)14: details conditions for payments under the essential small pharmacies scheme and arrangements for FPCs to administer the scheme.

PM(82)29: A consultant giving a second opinion under the complaints procedure on clinical judgement (HC(81)5) earns a fee of £34 daily.

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: North West Durham CHC Secretary: David Woodhead
Page 4: Worksop and Retford CHC has changed its name to **Bassetlaw CHC**
Page 4: Central Derbyshire CHC has merged with **South Derbyshire CHC** to form **Southern Derbyshire CHC.** Secretary: Mrs Jean Holden. Chair: Mrs SM Henry. Address and telephone temporarily as for South Derbyshire CHC
Page 5: Cambridge CHC Tel: Cambridge 387655
Page 5:South Bedfordshire CHC Acting Secretary: John Barclay
Page 6: Hounslow CHC has merged with **North Surrey CHC** to form **Hounslow and Spelthorne CHC.** The CHC is operating from both addresses until further notice. Acting Secretary: Michael Mannall
Page 8: Redbridge CHC Chair: Mrs Eileen Bramwell
Page 9: North Surrey CHC has merged with **Hounslow CHC** to form **Hounslow and Spelthorne CHC**
Page 9: Bromley CHC Chair: Mrs VM Burton
Page 10: Wandsworth and East Merton CHC has changed its name to **Wandsworth CHC.** Chair: Mrs Kay Sonneborn
Page 11: Wycombe CHC Chair: Mr RN Lines
Page 11: Aylesbury and Milton Keynes CHC has changed its name to **Aylesbury Vale CHC.** A new CHC has been created called **Milton Keynes CHC** The David Baxter Centre, 63 North Seventh Street, Central Milton Keynes
Page 12: Plymouth CHC Chair: Mrs P Hocken
Page 12: Torbay CHC Chair: Mr Ronald Wilman
Page 12: Macclesfield CHC Chair: Mr DG Higgins
Page 14: Blackpool CHC has changed its name to **Blackpool, Wyre and Fylde CHC** Chair: Cllr JM Lane
Page 17: Arfon-Dwyfor CHC Chair: Mr Eurwyn Jones
Page 22: East Lothian District LHC Chair: Mr J Baptie.

Book reviews

Lead poison

by Rick Rogers, £1.95 inc post from New Statesman, 10 Great Turnstile, London WC1V 7HJ.

It is fitting that a former editor of this magazine should have written the first book for lay readers specifically about the health hazards of lead pollution. Since its first article about lead in December 1977, *CHC NEWS* has regularly reported the increasingly bad news about lead, and can claim much of the credit for alerting CHCs to the problem. What in 1977 might have been thought by some to be a "fringe" subject for CHCs can now be seen as a central issue for everyone concerned about the health of the nation.

Lead poison is a succinct, blow-by-blow account of the way the lead story has developed over the last few years. At its core is a dissection of the many errors and omissions of the DHSS's 1980 report *Lead and health*, and a critique of the inadequate measures to reduce lead in petrol announced by the Government last year. The book concludes with suggestions for campaigning against lead, for protecting yourself and your children against it and for further reading.

For me, the main points to grasp in this complex tale are as follows: there is probably no "safe" level for lead, so the less human beings get of it the better; although food is the main source of lead intake for humans, most of the lead in food gets there from air; almost all the lead in air comes from lead in petrol; and technically speaking there is no need to put lead into petrol — it just happens to be convenient for the oil and car industries.

Another point that comes out strongly in *Lead poison* is the tendency for public authorities at all levels to minimise or conceal the truth about environmental health hazards, to avoid "creating panic". If it is true that the number of mentally retarded children in our society is considerably larger than it might otherwise have been because of lead, perhaps a bit more well-organised panic might be a good thing.

Dave Bradney, Ex-editor, CHC NEWS.

Learning to live with MS

by Robin Dowie, Robert Povey and Gillian Whitley, Multiple Sclerosis Society, 286 Munster Road, London, SW6 6AP, £2.50 inc post

It is impossible to take the shock out of a diagnosis of multiple sclerosis, but reliable information can do much to reassure. I was told I had the disease some seven years ago, and had to make my own way through the largely depressing and unhelpful literature to discover exactly what the disease was, and to get some idea of what I could look forward to.

This book recognises that the newly diagnosed need to know the facts if they are to make sense of what has happened to them, and it is bound to help in the painful process of re-adjustment that often follows a diagnosis — helping both those with MS and those around them.

Everything from psychological problems to shopping to current research to what to tell the children is covered, and it is made clear that the course of MS varies greatly from person to person — sufferers have to define for themselves what they can and cannot do.

Given all this straight talking it is therefore surprising to find the medical profession given an easy ride. Many people with MS — especially women — are told initially that their symptoms are psychosomatic or hysterical. This can be horribly undermining and needs to be explicitly challenged. Instead the problem is fudged throughout, with diagnosis described as coming when the doctor "decides to take the patient into his (sic) confidence". Whatever the moral and emotional problems faced by doctors, they will not be resolved by a reinforcement of paternalistic attitudes.

It is an unfortunate stance within an otherwise positive and helpful book, which will give many of those newly diagnosed the first opportunity to understand their situation and become better able to cope with it.

Rose Shapiro

A difference in the family

by Helen Featherstone, Harper and Row, £7.95

"A child's handicap attacks the fabric of a marriage... it excites powerful emotions in both parents... creates fertile ground for conflict."

Helen Featherstone's powerful analysis of handicapped children within the family brings into sharp focus the many struggles that parents have to face. The conflict in the above quotation from the book, whilst linked with the relationships of the parents, occurs too with outside influences — doctors, teachers, social workers and so on.

Mrs Feathersone writes about her son Jody (born with many handicaps caused by *toxoplasmosis* — he is blind, has cerebral palsy, suffers from fits) in the context of many other families whom she met through various groups.

She tackles in a spirited way the research publications and books by other parents of handicapped children, drawing out information which gives the reader further insights into the problems of families.

This book is very good value for money. Some books by American writers give you the feeling that they can only serve an American readership — that is not true of this book.

I strongly recommend this book for all those wishing to gain a deeper understanding of the handicapped person within the family.

Alf Boom, Member, West Berkshire CHC

The world of Nigel Hunt — the diary of a mongoloid youth

by Nigel Hunt, Asset Recycling Ltd., Olney, Bucks. Price £2.50 plus 25p post

When Nigel Hunt's publishers launched their new edition of his book earlier this year the daily press failed to report that the book had been first published in 1966 and that Profesor Lionel Penrose, who wrote the foreword, was, alas, no longer alive. It matters to this reviewer because it was the first book to lead the way to a better understanding of mental handicap in general and Down's syndrome in particular.

Nigel learned to read and write. He is a published author. Nigel's record of his daily life when he was 13 or 14 years old makes fascinating reading. His walks around London — St James' Park, Buckingham Palace, Hampton Court — are all very well, but when he tells us that he sings German songs and when he describes his holiday in the Austrian Tyrol, it is then that we really understand his world.

I look forward to Nigel's new book, which his publishers tell us is on the way.

Alf Boom, Member, West Berkshire CHC

CHC News back numbers

Browsing through back numbers will introduce you to the scope and breadth of CHC work. As a taster here are some examples of articles from past years.

The day care boom — units for adults by Carol Edwards *CHC NEWS No 79 Aug/Sept 1982.*
Hospital as workplace — is it safe Francis Cox *No 76 May 82.*
The receptionist's dilemma Sara Arber *No 74 March 82.*
The unemployment epidemic Steve Parry *No 73 Jan/Feb 82.*
Reform of mental health law — will it be enough Larry Gostin *No 72 December 81.*
Campaigning for better health John Dennis, Peter Draper and Linda Marks *No 70 October 81.*
A countryside survival kit Stephen Woollett *No 69 Aug/Sept 81.*
Institutions don't have to be this bad Ann Shearer *No 68 July 81.*
Background to the NHS Sir George Godber *No 67 June 81.*
Are there enough nurses? Jillian MacGuire *No 66 May 81.*
CHCs at work Christine Farrell and Jeff Adams *No 65 April 81.*
CHC publicity Beryl Sloan, Phil Topham and Nick Harris *No 64 March 81.*
Volunteers in the health service Ian Bruce and Sandy Duncan *No 63 February 81.*
Who runs the health service Andy Alaszewski and Stuart Haywood *No 62 January 81.*
What's in a name — generic prescribing Sue Jenkins *No 61 December 80.*
Obstetrics — whose baby? Peter Huntingford *No 60 November 80.*

Your CHC office probably keeps back issues of *CHC NEWS*, but additional copies are available from us at 50p each inc post.

and views. Managers welcome "objective" surveys, though sadly they do not always see the CHC as objective, nor have time to carry out surveys themselves — room for joint planning and co-operation here.

Another result of complaints may be the publication of information leaflets for patients by either management or the CHC. And an active management's use of the secret weapon: "The CHC will kick up a fuss about this" may result in faster policy changes than the CHC can achieve through its own powerful, but clumsy warhead —use of the press.

And what of the future? I reject the mechanistic model of medicine and would be the last to believe that it is often the doctor's fault when a patient unexpectedly deteriorates or dies. But I would be far tougher on doctors when they fail to communicate or explain, and when their manners are abrupt or off-putting. When patients have unrealistic expectations of post-operative improvements, the fault often seems to lie with the doctor, who has brought the subsequent complaint onto his own head.

Communicating means more than just talking — but also checking that the patient is listening and does understand. Perhaps if CHCs could contribute their skills in this to doctors in training we would be making a major contribution to the future NHS.

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also in considerable pain from gum inflammation caused by the bridging treatment.

He wrote a formal complaint to the FPC, thus setting in motion the official complaints procedure. Meanwhile he went to his GP for treatment of the gum infection, but when it failed to clear up he became extremely anxious that it might lead to loss of some or all of his teeth.

At this point the CHC drew attention, in spite of the FPC's comments, to the advice given in *CHC NEWS*. We advised him to ring the FPC to ask how the risk to his dental health might be avoided without jeopardising his case, and whether the delay before a necessary examination by the regional dental officer might be shortened.

The FPC at first said it was "up to the patient to decide" whether to have further treatment, but later agreed to speed up the RDO appointment. Meanwhile an attempt via his GP to obtain an appointment at a London teaching hospital failed — he was told to refer his problem to the FPC.

The RDO's report on his examination was sent to the patient nearly two months after his formal complaint was first made, and he was informed that the procedure would mean a further delay, perhaps of months, before the complaint hearing could occur.

Faced with the need to preserve his "evidence" intact until then, the patient abandoned his complaint.

This case surely demonstrates that there is an urgent need for thorough reform of the dental complaints procedure. Patients should not have to continue suffering in pursuit of a fair hearing.

* Details of the case have been altered to protect the identity of the complainant.

The official word

*by Susan Clayton**

It is often difficult for new CHC members to absorb the many ideas debated by Government on specific health topics. There are many Government and DHSS publications which might be useful to read but it is hard for newcomers to know where to begin.

So here is an introductory guide to some of the more important policy documents, consultative papers, white papers and reports published in recent years which are relevant to current debates in the NHS.

Children and maternity services

Fit for the future — the Court report Cmnd 6684 DHSS, HMSO 1976 — reports on child health services and proposes a number of ways in which they might be improved. While many of these proposals have been rejected it is still worth reading.
Perinatal and neonatal mortality — the Short report House of Commons Paper 663, Session 1979-80 — the select committee on social services made a detailed enquiry into baby deaths around the time of birth and produced many proposals for change. The Government's reply is in Cmnd 8084, 1980.

Community and primary care

Collaboration in community care — a discussion document Central Health Services Council DHSS, HMSO 1978 — the report of a working party to study collaboration by the NHS and local authorities in the provision of community care. Stress is laid on ways to improve this joint action.
Care in the community DHSS 1981 — a consultative document outlining seven ways in which resources might be shifted from hospital to community services.

Elderly people

A happier old age — a discussion document on elderly people in our society DHSS, HMSO 1978 — a brief resumé of services for the elderly, it raises a number of important questions on choices which may have to be made as the number of elderly people in the community increases.
Growing older Cmnd 8173, HMSO 1981 —a review of issues which determine the well-being of older people.

Health promotion

Prevention and health — everybody's business DHSS, HMSO 1976 — a very readable booklet outlining some of the main issues which must be considered in any debate on preventative health services. It was followed by several booklets on specific issues — *Reducing the risk — safer pregnancy and childbirth* 1977, *Eating for health* 1979, *Avoiding heart attacks* 1981 and *Drinking sensibly* 1981.

Hospital services

Organisation of the inpatient's day Central Health Services Council, HMSO 1976 — a well-prepared, readable book discussing ways to improve the quality of daily life on a hospital ward.
Hospital services — the future pattern of hospital provision in England DHSS, HMSO 1980 — a consultative document on the size, location and usage of hospitals.

Mental handicap

Better services for the mentally handicapped Cmnd 4683 DHSS and Welsh Office, HMSO 1971 — sets out the 1971 Government's recommended strategies for caring for the mentally handicapped. Rather an old document, but many of the issues are relevant today.
Report of the committee of enquiry into mental handicap nursing and care — the Jay report Cmnd 7468 DHSS, HMSO 1979 — While some of the main recommendations have been rejected, this is still worth reading.

Mental illness

Better services for the mentally ill Cmnd 6233 DHSS, HMSO 1975 — sets out the 1975 Government's strategies for supporting the mentally ill in hospital and the community. A useful introduction to the needs of mentally ill people.

NHS organisation

Royal commisssion on the NHS — the Merrison report Cmnd 7615 HMSO 1979 — despite its formidable title this gives an excellent resume of the current strengths and weaknesses of the NHS together with recommendations for change. Surprisingly readable, it provides a good introduction to most health service debates.
Patients first — consultative document on the structure and management of the NHS in England and Wales DHSS and Welsh Office HMSO 1979 — laid out this Government's proposals for NHS reorganisation. Details of the new structure are in health circular HC(80)8.
CHCs in England DHSS 1981 and *CHCs in Wales* Welsh Office 1981 — the most recent consultative document on the future of CHCs, focusing in particular on role and membership. The new CHC structure comes in health circular HC (81)15 and WHC(82)3.

Physical handicap

Chronically sick and disabled person's Act 1970 HMSO — worth looking at to see what provision *should* be made for handicapped people as a result of this legislation.

Priorities and resource allocation

Sharing resources for health in England — a report of the resources allocation working party DHSS, HMSO 1976 — the RAWP formula derived from this report is being used to share resources more equitably across the country. Difficult to read but important in its implications.
Priorities for health and personal social services in England DHSS, HMSO 1976 —

continued on page 12

**Susan Clayton is Lecturer in Social Policy at Lancaster University and a member of Lancaster CHC*

WAKE UP - changing the inpatients day

*By Barbara Stocking**

The NHS has the reputation of being a large, bureaucratic organisation in which inertia impedes change. But scratch beneath the surface and you find lots of innovators trying out new ideas. So what are the factors that allow some innovations to diffuse rapidly while other get blocked?

I am currently looking at 23 different innovations in patient care, some which have diffused widely and others hardly at all, to try to see what makes change possible. From these examples it should be possible to draw some conclusions about how to accomplish change.

Early waking and lack of sleep make up one of the major complaints of patients in hospital, so I decided to ask CHCs whether attempts at change had been made and the reasons for success or failure.

My initial letter and follow-up questionnaire to the 228 CHCs then existing in England and Wales produced a total of 206 replies — a 90% response rate. This was very gratifying as the survey was done at a time when CHCs were suffering restructuring.

I first asked whether there had been any investigations of patient waking times in their districts. 69 CHCs said there had been — sometimes a formal survey of inpatient satisfaction, sometimes a survey carried out by the health authority, and sometimes simply CHCs asking questions about it on their visits. 126 answered "no" and 11 gave no information, but answers to subsequent questions showed that CHCs had clearly sought some information, since they had a good idea of what patient waking times were.

Several CHCs said they would now take up the matter with health authorities and another four said they would start asking about waking times during visits.

The next question asked whether CHCs had tried to change patient waking times. 42 said yes, 152 said no and 12 gave no information. Many CHCs which had not attempted change commented that there was no need, because waking times had already been changed — perhaps after publication of the Government report on the inpatient day (see page 9) — or because in surveys patients seemed satisfied.

Of the 42 CHCs attempting change, six said their attempts were very successful, 32 reported partial success, three had no success at all and one was currently investigating what had happened to its suggestions.

The successful ones made various comments. One said change had happened because the district management team also felt it was needed, and another said the change had been achieved by staff initiative. One success was based only on a particular ward and one CHC had gained later waking times in arrangements for a new district general hospital and hoped other hospitals in the district would follow. Another CHC commented that its success could be measured by the fact that patients were now awakened by the day staff rather than the night staff.

Partial success sometimes meant one ward or specialty rather than general change and more than one CHC commented that partial success had been achieved only by repeated discussions continuing after the change was supposed to have been made.

A major reason for the difficulties seems to be that altering waking times effectively alters all the arrangements for the day. Catering and domestic staff are affected, some tasks have to be switched from night to day nursing shifts, doctors' rounds may be affected and theatre and other treatment staff may have to adapt.

There are just too many people whose routines may have to be reorganised and whose best interests lie in maintaining the status quo.

A CHC secretary who had just been in hospital himself remarked:

"I came to the conclusion that the reason (for 6am waking) was really a matter of routine that was more to the liking of the staff, and which the patient was expected to accept without comment... I was left with the feeling that hospital routine exists for the benefit of everyone except the patient whose bad luck it is to be so incarcerated."

Patients do tend to accept the hospital "drill" and make no complaints, so CHCs may feel it is not necessary to enquire about the matter. The comments of another CHC secretary were illuminating. She said:

"Hospital routine was created many years ago for good reasons which still stand. As an ex-nurse and many times patient I can see no reason for change — nor have we had comment and since we now deal with around 100 patients per week there seem to be no problems."

Even where it has been decided to make waking times later and more flexible for individuals this is hard to achieve, especially in Nightingale wards, because of the "one awake — all awake" syndrome. Some patients may be woken early for treatment or preparation for surgery and so the rest of the ward is woken by the noise.

One CHC had tried to overcome this by recommending the grouping together of patients so that those convalescing were as far from the areas of heavy work and noise as possible.

But the *need* to wake patients early could also be disputed — few patients at home are likely to set the alarm for 6am simply to take their medication.

When CHCs or others have been successful in changing waking times it is sometimes because Government reports on the inpatient day have given them the power to keep raising the issue. Change also seems to be most likely where there have been alliances between particular groups — CHCs and nurses, for instance — and sometimes ward staff have brought up the problem with health authority members on their visits.

Perhaps the most fundamental requirement for change is just grim determination to find out what is taking place — not always easy unless early or night visits are made — and to keep raising the problem.

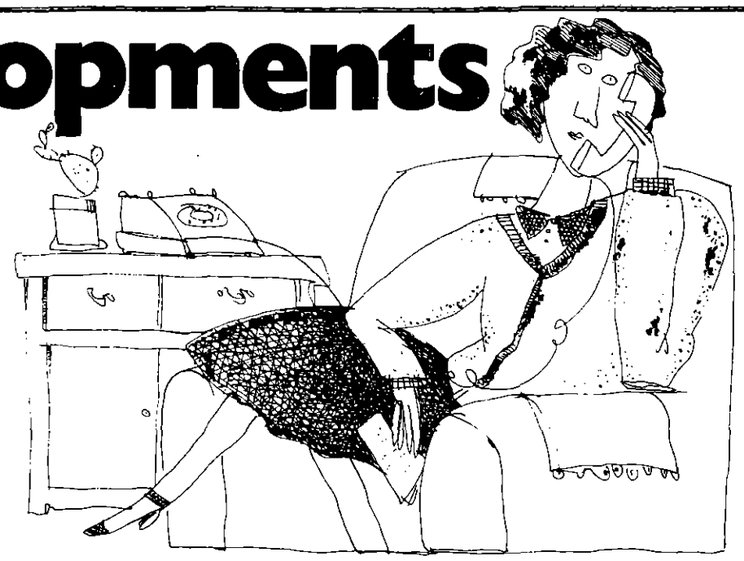
Now CHCs have seen my survey results I would be delighted to hear further thoughts or information from them. I shall be contacting some of you who have tried to achieve change to find out more about your experiences.

Finally, good luck to those CHCs which said they have been spurred on to investigate waking times or to try to change them. I should be interested to hear what success you have.

Photo: Liz Heron

Barbara Stocking is Senior Nuffield Research Fellow at the London School of Hygiene and Tropical Medicine.

Keeping up with developments in the NHS



The challenges currently facing the NHS are perhaps greater than at any time during its history. The combination of tight financial controls, a series of attempts to increase the efficiency and accountability of health authorities, and a growing private health care sector present a formidable set of demands to health planners and policy makers.

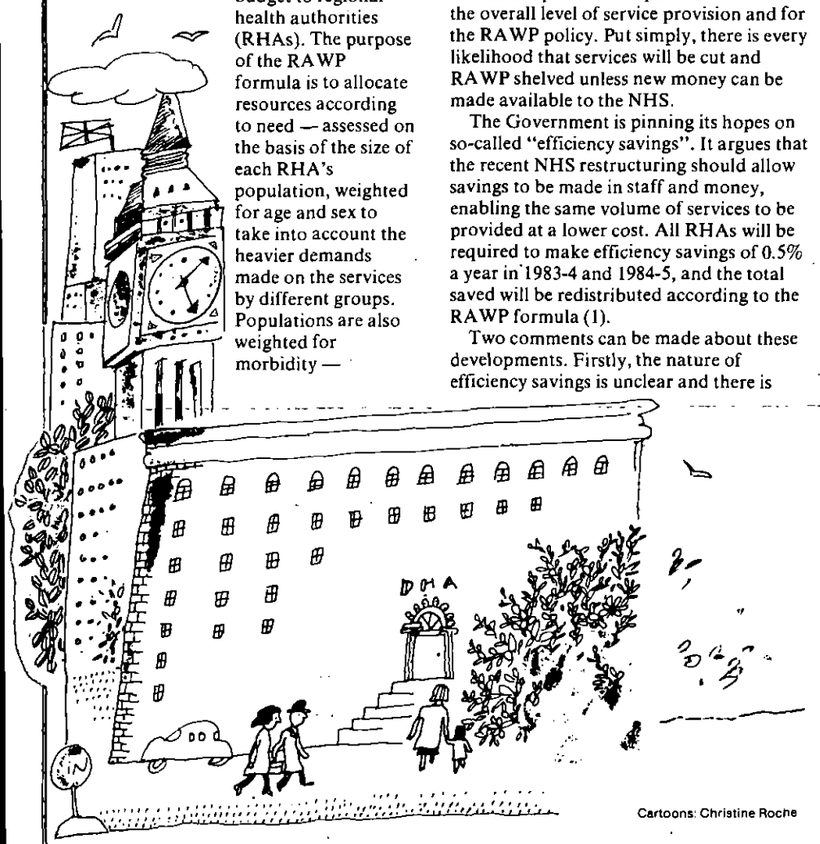
To point to these demands is not to argue, as many are wont to do, that the NHS is on the point of collapse. Rather it is to draw attention to some of the key issues confronting health authorities in the 1980s, and to the context in which CHCs will have to operate. This article examines the nature of these issues and identifies the implications for CHCs.

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

Finance

National growth rates in the NHS budget in recent years have been around 2% per annum. This increase in resources has enabled some new developments to go ahead. It has also allowed progress to be made in implementing the policy of evening up the allocation of resources to different parts of England — the RAWP policy.

RAWP is the acronym for the resource allocation working party — a committee drawn from the DHSS and the NHS — which in 1976 devised a formula for distributing the NHS budget to regional health authorities (RHAs). The purpose of the RAWP formula is to allocate resources according to need — assessed on the basis of the size of each RHA's population, weighted for age and sex to take into account the heavier demands made on the services by different groups. Populations are also weighted for morbidity — experience of ill health — and mortality rates are used as a proxy for morbidity.



Cartoons: Christine Roche

Using the RAWP formula a target revenue allocation is calculated for each RHA. Successive ministers have decided that the targets should be worked towards over a period of years. In practice this has meant a gradual process of levelling up, with well-provided regions such as the Thames RHAs receiving virtually no growth money while deprived regions such as Trent RHA receive rather more than the amount of money available for growth nationally. There have also been moves to achieve a fairer distribution within regions.

Expenditure projections for the NHS as a whole for the period up to 1984-85 indicate that there will be real growth of only 1% in the current financial year and no growth at all in subsequent years.

This has profound implications both for the overall level of service provision and for the RAWP policy. Put simply, there is every likelihood that services will be cut and RAWP shelved unless new money can be made available to the NHS.

The Government is pinning its hopes on so-called "efficiency savings". It argues that the recent NHS restructuring should allow savings to be made in staff and money, enabling the same volume of services to be provided at a lower cost. All RHAs will be required to make efficiency savings of 0.5% a year in 1983-4 and 1984-5, and the total saved will be redistributed according to the RAWP formula (1).

Two comments can be made about these developments. Firstly, the nature of efficiency savings is unclear and there is reason to doubt whether health authorities can make savings and maintain existing levels of service provision.

As the House of Commons social services committee comments in a recent report: "There is some suspicion that *efficiency savings* are becoming a regular euphemism for *expenditure cuts*"(2). The committee also points out that "savings" will be a false economy if capital schemes designed to save future revenue costs are deferred in order to save money in the short term.

Secondly, the continuation of the RAWP policy at a time when the only money available for growth comes from efficiency savings marks an important shift away from equalising allocations through levelling up to a policy of robbing Peter to pay Paul.

RAWP may yet have to be put on one side if prices and wages increase at a faster rate than that allowed for in the Government's cash limits. This has already happened to some extent this year, when Ministers required RHAs gaining most under RAWP to contribute a higher proportion of pay increases from their own allocations than other regions.

It is difficult to see how a similar move can be avoided if the same situation should arise in future years.

Efficiency and accountability

The concern to improve efficiency in the NHS is manifested not only in the concept of efficiency savings, but also in a number of specific innovations introduced in recent months. Four of these are particularly interesting.

Rayner scrutinies will be applied to the NHS along the lines of those carried out in the civil service by Sir Derek Rayner, who is on loan to the Government from Marks and Spencer (details in *CHC NEWS 79*).

Management Advisory Service (MAS) trials will test out different ways of improving the quality and efficiency of service provision. Three trials started on 1 April and will extend over two years in the Wessex and North Western RHAs and jointly in the Oxford and South Western RHAs. The MAS is being evaluated by a research team with a view to establishing it on a national basis at the end of the trial period.

Performance indicators are being developed by the DHSS as a way of assessing the efficiency of health authorities. Certain key indicators will be used — average cost per inpatient case, average length of inpatient stay, average number of outpatients seen in a clinic session, for instance — in order to compare the performance of health authorities. These comparisons will highlight those authorities which appear to be performing well or badly in the hope that action will be taken to improve the efficiency of the poor performers.

Regional reviews are potentially the most important development. They will involve meetings between civil servants and the officers of RHAs, leading up to a meeting in each region between a Minister and the RHA Chairman. So far regional reviews have been carried out in Trent, Mersey, Oxford, South Western, Yorkshire and East Anglia regions, and others are in progress.

The purpose of the reviews is for Ministers to discuss with RHA Chairmen future plans for service development and past performance. Each review is followed by a letter from the Minister to the Chairman, setting out the key points discussed and identifying what the Minister sees as the main areas for action, including a timetable for implementation.

Ministers intend that the meetings should be held annually and RHA Chairmen should be held accountable for carrying out agreements reached at previous reviews. In turn, RHAs are responsible for holding annual review meetings with their district health authorities (DHAs).

The DHSS has argued that in this way the delegation downwards to DHAs caused by NHS restructuring will be matched by appropriate lines of accountability to Ministers.

These developments suggest a much greater involvement in health planning by the DHSS than has hitherto been the case. They are significant in signalling a shift away from planning by circular and consultative document — the method which has predominated since the introduction of the planning system in 1976 — to planning by dialogue.

It remains to be seen whether this dialogue will result in changes to Government policies rather than action to ensure local compliance with those policies.

Privatisation

Of all challenges facing the NHS, the growth of private health care is arguably the most important. Since coming to office in 1979 the Conservative Government has encouraged the development of private health care, and to this end a working party has been examining alternative methods of financing health services.

Region's distances from rawp target

Distances from target expressed as a percentage of each Region's allocation

RHA	1982-83
Northern	-5
Yorkshire	-4
Trent	-5
East Anglian	-6
NW Thames	+12
NE Thames	+8
SE Thames	+8
SW Thames	+6
Wessex	-5
Oxford	-2
South-Western	-4
West Midlands	-4
Mersey	-1
North-Western	-5

The working party submitted its report to the Secretary of State in January 1982, and although it was never published, it is believed to have made various suggestions for increasing private health insurance.

Recently however the Government announced that it had no plans to change the present system of financing the NHS largely from taxation, and this appears to mean that there will be no radical changes in the system of health financing.

Instead health authorities have been encouraged to contract out services such as catering and laundry to private companies, and to co-operate with private hospitals in the provision of services to patients.

Considerable uncertainty exists about the desirability of these developments. While some commentators have argued that £300 millions would be saved immediately through contracting out (3), others question whether the private sector is any more efficient than the NHS. Health service staff are also understandably concerned at the effect of contracting out on their jobs.

Doubts also exist over co-operation or "partnership" between the NHS and private hospitals. Although it has been suggested that health authorities could reduce waiting lists and improve standards by making use of facilities in private hospitals, there is a danger of unnecessary duplication, competition for staff and the development of a two-class system of health care.

The ability of health authorities to make use of private hospitals varies between areas and types of service. In areas such as London and the major conurbations where the private sector is strong the possibilities of partnership are much greater than in rural areas. Equally, the concentration by private hospitals on certain types of acute care known as "cold surgery" — such as treatment for varicose veins — means there is more scope for partnership in this area of service provision than in relation to the elderly, mentally ill and mentally handicapped, which the private sector tends to ignore.

The establishment by the Government of a further working party to suggest ways of increasing co-operation between the private and public sectors indicates that these uncertainties will not disappear, and there is a need to ensure that the benefits to patients and the community of partnership outweigh the costs.

Coping with change

What are the implications of these developments for CHCs? Three points seem to be of particular interest.

Firstly, at a time when cuts in services rather than growth are likely to predominate, CHCs have a key role in monitoring where the cuts fall and which services are most affected. From the community's point of view it is vital that the needs of priority groups and services are not neglected in the struggle for scarce resources.

In this respect it is interesting that reports of the first review meetings between Ministers and RHA Chairmen indicate that Ministers have emphasised to RHAs the need to give priority to groups such as the mentally ill and handicapped.

Secondly, the review meetings have introduced an important new element into the health planning system. CHCs which want to have an influence on planning would be well advised to keep a careful eye on the progress of the reviews — between the DHSS and RHAs *and* between RHAs and DHAs — and on the outcome.

Finally, the future development of private health care will continue to be an issue of importance. Again, there would seem to be a role for CHCs in monitoring the activities of the private sector at district level and in ensuring that the overall interests of the community are not ignored.

Here indeed is a formidable agenda for CHCs in the 1980s.

References

1. Health circular HC(82)14 — *Resource assumptions and planning guidelines: 1982-3 to 1984-5.*

2. *Second report from the social services committee session 1981-2 – 1982 White Paper: public expenditure on the social services* Vol 1 — Report HMSO.

3. *Reservising health* by M B Forsyth. Adam Smith Institute, 50 Westminster Mansions, Little Smith Street, London SW1.

Learning from complaints

PATIENTS' COMPLAINTS

by Sue Jenkins, Secretary, Leeds Western CHC

"You can't put things right for me, but maybe you can prevent the same thing happening to someone else."

Those are words with which every CHC secretary is familiar since — despite what many doctors think — legal action is far from most complainants' minds. Because many would be put off by a defensively aggressive hospital administrator, the CHC plays a useful listening role — and can encourage "feedback" into the system.

Those who argue that CHCs are unnecessary and merely provoke complaints perhaps forget the complexity of the system. A single complaint can involve several official bodies — the district health authority, the family practitioner committee, the regional health authority where regional services are at issue, and often the social services department as well.

Perhaps a complainant simply needs names and addresses to write to, but there are others who require more help. If a CHC secretary has spent half an hour listening to an elderly patient's sad tale of slip-ups and tactlessness is it fair to ask the patient to put it in writing? And once it is off his chest, will he bother? Yet his story may be exactly the kind which could be useful in teaching inexperienced staff.

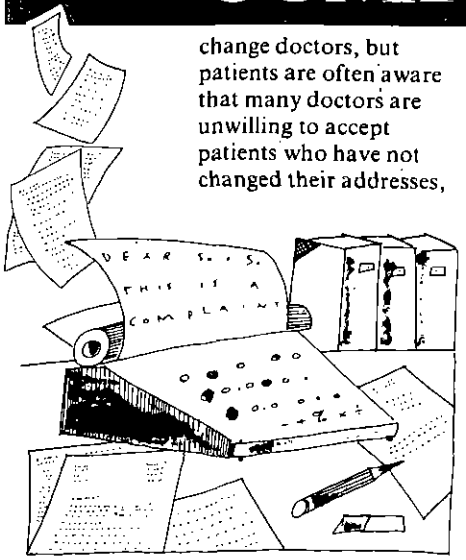
It is more comfortable to learn from others' mistakes, and so in the last year my CHC has been urging the DHA to receive regular anonymous summaries of complaints received by its officers in the same way that I provide this for CHC members.

Similarly I always mention specific complaints when participating in student nurse and medical student training sessions. They infallibly promote eager discussion.

But how can the CHC help the individual patient? Often the patient will be satisfied with a letter of explanation or apology from an NHS administrator. But sometimes he will firmly dispute a doctor's clinical judgement, and until recently there was nothing that could be done about this without taking legal action. Since September 1981, however, it has been possible to ask the regional medical officer to consider the case and give an opinion (see *CHC NEWS* 67 page 3).

The status of GPs as independent contractors needs much explanation to aggrieved patients, who may be astonished to find they can be crossed off their GP's list without any reason given. This prevents many patients from daring to question the infallibility of their GP, let alone suggesting that an appointment system could run better or a receptionist be more helpful.

Patients are generally surprised to find they have no means of complaint against the way a practice is run, and can make a complaint only if they feel the GP has not provided an average standard of medical care. The "quality control" of GPs is supposed to lie in the patients' freedom to change doctors, but patients are often aware that many doctors are unwilling to accept patients who have not changed their addresses, suspecting them of being "difficult".



Cartoon: Christine Roche

Many GPs are as worried by these problems as are CHCs, so perhaps the CHC's irritant role as patient's friend can be put to constructive use in discussions with local doctors, in GPs' training, and in assistance to patient participation groups — set up in several practices to encourage dialogue between patients and the primary care team.

Although the CHC may not always be able to help an individual patient — in getting a speedier hospital admission, for instance — it learns from the enquiries and complaints it receives and will use this experience when next consulted by management on future plans.

CHCs may wish to find out more about the size of particular problems and will organise surveys on patients' experiences

The dental dodge

by Gavin Ross, Chairman of the Primary Care Group, North West Herts CHC

A patient with pain following dental treatment faces a dilemma if he or she wishes to complain about that treatment. Further treatment to remedy the discomfort may jeopardise the case because professional members of the dental service committee have a right to examine the physical evidence — the patient's mouth — at the case hearing.

After a patient in our district was obliged to wait over a year in discomfort to preserve proof of bad treatment, we were pleased to see the advice, published in *CHC NEWS* 50 page 10, of a senior lecturer in community dentistry who had been consulted by the *CHC NEWS* Information Service.

He suggested a referral to a consultant at the nearest dental hospital. "The hospital dentist will then be able to report ... at a later date ... on the state of the patient's teeth before treatment was completed."

There is no specific reference to this topic in the *NHS (service committees and tribunals) regulations 1974* so we wrote to the Herts family practitioner committee (FPC) for confirmation that the advice was correct.

The FPC replied that it was not "a question of the advice being inaccurate or misleading, more a question of being inappropriate.

There is no provision in the regulations for the opinion of a hospital consultant to override the jurisdiction or opinion of the professional members of a dental service committee.

There is further no requirement on a doctor to refer a patient to a dental consultant in the circumstance quoted, finally no requirement on the dental consultant to write a report to the FPC."

The practical test came when Mr A*,an actor, brought his case to the CHC.

The case was not simple. There were several grievances — some due to misunderstanding the nature and cost of the treatment — but there was also a possible breach of terms of service.

During bridge work a front tooth was accidentally chipped, and the extra crown needed to remedy this was mismatched for colour.

This angered Mr A, as his profession made appearance important, but he was

Health News

Who are CHCs — what the surveys say

The proportion of CHC members in the South West Thames region who are women has risen from 51% in 1974 to 59% early this year, according to the University of Surrey's survey (1), but the predominance of people in professional or managerial occupations has not changed since a 1974 survey shortly after CHCs' establishment. Younger adults are still underrepresented while nearly a quarter of members are over 65 — compared with 11% originally. Over half are members of political parties and show a broad range of political opinion. The survey goes on to analyse members' perception of their own activities and their views on a spectrum of controversial issues.

"Sensible" and "helpful" were the two words most frequently chosen from a list of adjectives by administrators in the four Thames regions to describe CHCs' suggestions and ideas. CHCs' independence was particularly valued and district administrators said CHCs saved them time in sifting complaints. CHCs are having a significant and beneficial impact on district management teams, concludes the survey.

The picture on district planning teams throughout England is not so rosy. The University of Birmingham's study (3) found wide regional variations in district policy on CHC participation in planning teams, including an unexplained geographical division — district policies in the northern regions are markedly less favourable towards CHC representation than in the southern regions. CHCs were worried about the ambiguity of their role on planning teams — as were district officers — but the overwhelming majority of CHCs wished to be represented on the teams.

Over half of CHCs and LHCs which replied to the Labour Research Department's survey (4) would like more trade union involvement — though the LRD says replies are more likely to be from CHCs sympathetic towards trades unions. CHCs have had a poor response in trying to contact unions yet the interests of CHCs and health service unions coincide, says the LRD, since what affects the staff affects the patients too.

Of the 24 Greater London CHCs which had discussed health service planning for nuclear war, five had held public meetings on the topic and 12 had also discussed the transport of nuclear waste (5).

1. *CHCs in the South West Thames region — a survey of members* project supervisor Sara Arber, Department of Sociology, University of Surrey, Guildford, Surrey.
2. *Can the public's voice influence bureaucracy? — the case of CHCs* by Erica Bates in *Public administration* Spring 1982, the journal of the Royal Institute of Public Administration.
3. *CHC involvement in district planning teams — policy, politics and practice* by Penelope Mullen, Kate Murray-Sykes and William Kearns. Research report 15 price £2 inc post from the Health Services Management Centre, University of Birmingham, Park House, 40 Edgbaston Park Road, Birmingham, B15 2RT.
4. *Labour Research* July 1982. Price 85p inc post from the LRD, 78 Blackfriars Road, London, SE1 8HF.
5. Unpublished survey by Graham Rich as part of his BSc in sociology of medicine from King's College Hospital, London.

Current thinking in community care

The long-awaited Government decision to press ahead with plans to move long-stay hospital patients into the community — reported in *CHC NEWS* 79 — will make care in the community an issue of growing importance to CHCs in the future.

Less than a month after the Government's announcement the North East Thames RHA has released three consultative documents on services for psychiatric, geriatric and mental handicap patients, detailing plans for a "radical shift" from hospital to community. The move would be partly financed by the closure of three large hospitals, but the RHA has warned that local authority grant cuts could jeopardise support systems for its patients.

Meanwhile a letter to the Guardian from two professional workers at the Stonham Housing Association — which manages homes and hostels for the mentally ill in Southampton — claims that community care is a "figment in the minds of the policy-makers". They say the most able patients have already been "creamed off" by community projects in the 1970s, and those more vulnerable patients now being transferred from hospitals are already putting an "unacceptable burden" on voluntary and statutory bodies.

CHCs will have to be vigilant if the community is not to become a dumping ground for refugees from the closing institutions. So for newcomers, here is a round-up of some recent reports — many in response to the consultative paper which preceded the Government's decision — on various aspects of care in the community.

A good starting point is **Care in the community — recent research and current projects** edited by Frank Glendenning — a collection of papers on care of the elderly which covers many broader issues of support for the vulnerable and for those — usually women, say the authors — who care for them. *Beth Johnson Foundation Publications, price £3.95 inc post from Age Concern England, Marketing Dept, 60 Pitcairn Road, Mitcham, Surrey, CR4 3LL.*

A handbook of good neighbour schemes in England by Philip Abrams, Sheila Abrams, Robin Humphrey and Ray Snaith describes nearly 200 schemes for a range of client groups and is arranged alphabetically by county. *Price £2.95 inc post from the Volunteer Centre, 29 Lower King's Road, Berkhamsted, Herts, HP4 2AB.*

Housing and community care by Andrew Purkis and Paul Hodson argues that care policies are based on a misunderstanding of the needs of vulnerable groups — the majority need not *sheltered* but *ordinary* housing, which is currently in short supply — and calls for a long-term strategy combining normal housing and specialised support services. *Bedford Square Press (NCVO), price £3.95 from bookshops, or £4.45 by post from Macdonald and Evans Distribution Services, Estover Road, Plymouth, PL6 7PZ.*

One vital form of support comes in for critical examination in **Home help — key issues in service provision** by Robin Hedley and Alison Norman. *Price £3.50 from the Centre for Policy on Ageing, Nuffield Lodge, Regent's Park, London, NW1 4RS.* And **The elderly consumer** — a survey for the National Consumer Council — found that nearly a quarter of elderly women questioned who said they needed a home help had been unsuccessful in applying for one, whereas 98% of the elderly men questioned who wanted a home help had got one. *Price £1 inc post from the NCC, 18 Queen Anne's Gate, London, SW1H 9AA.*

Crisis or challenge — family care, elderly people and social policy by Chris Rossiter and Malcolm Wicks warns that employment patterns, geographical mobility and divorce may erode the family structure which at present "provides the great bulk of personal care" for the elderly. *Price £4 inc post from the Study Commission on the Family, 3 Park Road, London, NW1 6XN.*

Finally, a series of reports from the Equal Opportunities Commission (EOC) exposes the often desperate plight of those women who labour unpaid in the home to ensure their elderly or handicapped relatives need not enter institutions. **Family care of the elderly handicapped — who pays?** by Muriel Nissel and Lucy Bonnerjea and partly funded by the EOC found that "none of the husbands (in the families studied) contributed substantial direct care". *Price £3.50 from the Policy Studies Institute, 1-2 Castle Lane, London, SW1E 6DR.*

Behind closed doors is a report on the public response to an advertising campaign about discrimination against married women in certain social security benefits (see *CHC NEWS 78 Comment* page 2). **The experience of caring for elderly and handicapped dependants** (survey report), **Caring for the elderly and handicapped — community care policies and women's lives** (research report) and **Who cares for the carers? — opportunities for those caring for the elderly and handicapped** (recommendations) together chronicle the emotional and physical strain, poverty, isolation, accomodation problems and loss of employment prospects suffered by women who provide this, the cheapest form of community care. *Free from the Publicity Section, EOC, Overseas House, Quay Street, Manchester, M3 3HN.*

Comment

Wexham Park Hospital psychiatric unit in Slough has been the scene of an extraordinary train of events since the suspension in August of senior nursing officer Paul Walsh — apparently for refusing to co-operate in the forcible treatment of a patient.

Within a month suspensions of four more nursing staff demonstrated a complete breakdown in relationships between doctors and management on the one hand and nurses on the other. Midnight incursions onto the wards by police accompanying district officers were followed by police-supervised transfers of patients from one of three wards in the unit onto an ENT ward in the main hospital.

The picture became more confused with the "strictly confidential" but much-leaked report of an inquiry into events already a year old at the time of the first suspension.

The inquiry was set up after doctors complained to the regional medical officer about the behaviour of nurses in the unit. Nurses had already complained about doctors' behaviour, and now they claim their side of the story was ignored.

If Paul Walsh is to be believed — he has been extensively interviewed in the nursing press — doctors had scant regard for the rights of patients and ran the unit on autocratic lines.

The inquiry, on the other hand, is reported as accusing Paul Walsh of "disrespect" towards consultants, and of encouraging his staff to meddle in therapies beyond the normal scope of nursing duties.

But it also accuses doctors of "cavalier" interpretations of the Mental Health Act and of signing section 30 forms in advance. It appears that routine forcible detainment was countered by nurses in a campaign of sabotage against treatment prescribed by doctors.

The patients themselves seem to know what they want — after being transferred off the ward in the "discreet presence" of the police, some moved themselves back in again later the same day. And the patient championed by Paul Walsh before his suspension has secured her freedom after an appeal to a mental health review tribunal.

The nursing press has taken up the crucial points of principle in the "Walsh affair". They are worried about questions of the detainment and forcible treatment of the mentally ill. Do nurses have a right to refuse to participate in forcible treatment? If so, how do they exercise that right within a hierarchical structure?

These issues are clearly of critical importance for patients too — and for those CHCs which have taken an interest in the revision of our mental health laws currently wending its leisurely but controversial way through Parliament.

Health News

Labouring for justice

After many unsuccessful attempts through orthodox channels to establish a woman's right to refuse unnecessary treatment in childbirth, campaigners have set up a maternity defence fund to raise money for a test court case.

The Association for Improvements in the Maternity Services (AIMS), the Society to Support Home Confinements and the Birth Centre are respresented on a committee which "more in sorrow than in anger" is pledged to raise the £60,000 needed to take a case as far as the European Court of Human Rights.

Donations are flowing in from the public — especially pensioners who remember birth as a natural event — and some doctors, as well as an anonymous $4,000 contribution from the US.

Writing in the *Nursing mirror* Leicester University sub-dean of law John Finch — author of the Association of CHC's legal update service — says a "routine" episiotomy performed against a woman's wishes is "no different in law from a knife wound delivered in a fight". AIMS agrees, and believes such abuses must be challenged in court.

Donations to The Maternity Defence Fund, 33 Castle Close, Henley in Arden, Warwickshire.

● Striking regional variations in provision of pregnancy screening and counselling services have been identified by the Maternity Alliance in a survey which found facilities within regions also vary considerably from district to district.

The Alliance says screening for congenital abnormalities is "largely dependent on the attitudes of individual consultants", and a considerable number of DHAs question the value of routine antenatal screening to spot central nervous system disorders.

It all depends on where you live contains the survey results listed by district. Price £1.70 inc post from the Maternity Alliance, 309 Kentish Town Road, London, NW5 2TJ. Tel: 01-267 3255.

Deliver us from doctors

It is the clear duty of medical and dental staff to ensure the safety of patients is not threatened when a doctor is suspected of incapacity due to addiction or illness.

So says health circular HC(82)13, issued by the DHSS after concern within the professions over the so-called "three wise men" procedure previously used to control doctors thought unfit to practice.

The circular places responsibility for unfit doctors squarely on the shoulders of the professions themselves. It recommends for each DHA a special professional panel (SPP) consisting of senior staff who will form three-member sub-committees for each case to be considered. If urgency requires it, panel members can take informal action individually.

Where a threat to patients is thought likely the regional and district medical officers should be informed of the case and if a doctor's physical or mental condition seriously impairs fitness to practice the General Medical Council can be informed.

GPs who hold no DHA appointments are unaffected by these provisions.

The previous procedure involved three eminent members of the same discipline appointed as needed by health authority administrators — but it was unpopular in the professions.

Death by anaesthesia

Recommendations made over thirty years ago to reduce poor practice in anaesthesia are not being followed and patients are still dying from the same avoidable factors identified by an Association of Anaesthetists study in 1949.

The association's new study estimates that some 280 deaths a year are caused solely by anaesthesia and most of these could be avoided.

Anaesthesia plays some part in a further 1800 deaths and again these show avoidable factors, but the report stresses that these cases are a tiny fraction of those who safely undergo anaesthesia every year.

The study covered Wales, Scotland and the North Western, West Midlands and Trent regions. Deaths amongst inpatients within six days of operation were assessed for factors including pre- and post-operative care relevant to anaesthesia, but the authors point out that co-operation with surgical specialties was achieved only after a promise to avoid considering surgical factors.

All grades of anaesthetists are blamed for mistakes. Trainees are left unsupervised even in emergencies and pre-operative assessment is omitted in 10% of cases. Clinical record-keeping is poor and hospital records department staff are sometimes unco-operative. The provision of monitoring equipment is inadequate and many hospitals have no recovery room.

The Association hopes these standards of care will be improved now poor practice has been exposed by the study.

Mortality associated with anaesthesia by J N Lunn and W W Mushin. Published by the Nuffield Provincial Hospitals Trust, 3 Prince Albert Road, London NW1 7SP.

Your letters

AGM activity

Dr C E Davies, Chairman, Stockport CHC

I am writing in the wake of what I found to be a frustrating and irritating annual general meeting of the Association of CHCs at Coventry. My comments are not intended as gratuitous criticism of those who clearly put in a great deal work organising the meeting. Rather I hope that some of my suggestions might lead to more stimulating and worthwhile AGMs in the future.

My main concern is the disproportionate number of hours spent in formal debate. I would not want to reduce the number of motions on the agenda but would have liked to see other activities organised in parallel with the main debates. After all, only one delegate from each CHC held a voting card, so many of those at the debates were passive observers.

The organised activities could include

- More workshops — formal sessions organised in advance or ad hoc groupings convened at the conference itself. An information exchange board could enable CHC members with particular interests to get together.
- Consultancy sessions — covering areas such as legal advice, publicity, public relations and advice on specific medical topics. Consultants would have to be paid and CHCs would have to book sessions in advance.
- Films, slide shows and lectures — topics might be research projects undertaken by CHCs, videos on health matters and so on.

These suggestions of course would involve additional organisation. The need for extra rooms might indicate a university setting and a local committee might be needed to assist the overworked ACHCEW staff. But these are minor problems compared with the advantage of holding an AGM that functioned as a worthwhile information exchange as well as a forum for debate.

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GILL KENT (EDITOR)

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If CHCs feel these ideas are worth pursuing then Stockport CHC would be more than willing to join with other CHCs in Greater Manchester to host an AGM on these lines — perhaps in 1984.

Paranoia or positive thinking?

Dag Saunders, Secretary, Salop CHC

Surely it cannot be in the long-term interests of CHCs for there to be continued reference to the possible reconsideration of CHC's future existence. The more discussion there is on this, the more politicians will feel they have to do something about it.

Foremost amongst the questioners of CHC's future have regrettably been ACHCEW and CHC NEWS, which seem to have developed some sort of hysterical paranoia on the subject. CHCs will guarantee their future and developing effectiveness if they continue to work in a responsible, honest, open and independent way.

If the job is done well and is seen to be necessary — not a hand-in-glove operation with the health authority nor a state of perpetual confrontation — none of us need have any worries on what the future may hold.

Secretary of the Association of CHCs Mike Gerrard replies:

I entirely agree with Dag Saunders' final sentence, providing the assessment of CHCs is made objectively and without any presuppositions. It was not ACHCEW but health ministers who said there would need to be another performance review, having earlier questioned whether there would be a need for CHCs. It is certainly right to think positively now, but it is prudent to remember that the Secretary of State may need some convincing when the time comes.

Indicating our role?

Linda Stapleton, Secretary, North Devon CHC

My CHC is very interested in recent statements from the DHSS about accountability in the NHS and "performance indicators" for measuring efficiency, so in May we wrote to the Secretary of State to ask how CHCs will be involved in providing information to help assess local services.

CHCs may be interested in the reply we received in August from junior Health Minister Lord Trefgarne. He said:

> "Performance indicators are still at an early stage of development. They will be given their first test during the annual regional reviews in the coming months and no doubt they will need to be modified in the light of how useful they prove there.
>
> They are primarily tools to help look at the management and use of clinical, financial and manpower resources from an "objective" standpoint rather than guides to the quality of service in a given locality, or to consumer satisfaction. A health authority's admission rate per 1000 of the population or its cost per case for various specialties are examples of the sort of thing we have in mind. *I would not see the views of the consumer as being in themselves performance indicators.*
>
> We envisage such indicators being used primarily in the dialogues between Government and regional authorities and in their turn between regional authorities and district authorities.
>
> The aim in developing them is not to provide answers about authorities' performance but rather to raise questions. These *may* need to be explored by authorities at ground level to see whether what cannot be readily explained from the "objective" standpoint is justifiable because of particular local factors, or whether remedial action is called for.
>
> *I would certainly expect CHCs to become involved at this stage* in looking at the local implications of applying performance indicators."

- Our italics. See pages 6 and 7 for the facts on the accountability scene.

Teeth for life

Michael Silver, Dental Surgeon, London

It is strange that Whitehall allows lead to be pumped into the atmosphere, where it damages the brains of babies and young children, and gives a thumbs up to sucrose which damages teeth and adds to the problems of obesity and diabetes.

Whitehall also makes available tobacco and alcohol which cause untold suffering and keep the health workers busy.

The one really useful project which has been researched since the 1920s remains free for more "democracy". This is fluoridation.

A society which does not value its teeth will not respond to the idea of teeth for life — easily attainable with modern research.

Maybe it is the lead our brains absorbed when we were children that prevents better decisions on fluoride being made now.

Apology

The last issue of *CHC NEWS* carried a letter from Tegwen Wivell of South Gwent CHC criticising Martyn Smith of West Birmingham CHC for making his political views known in the magazine. She also criticised *CHC NEWS* for publishing his views.

Mr Smith has asked us to point out that his letter, published in *CHC NEWS* 78, was written from his home address in his capacity as Chairman of the Liberal Party health panel. Pressure of work on the editorial office meant that Mr Smith's position as Secretary of West Birmingham CHC was quoted alongside his position on the health panel, and the distinction which he intended was lost.

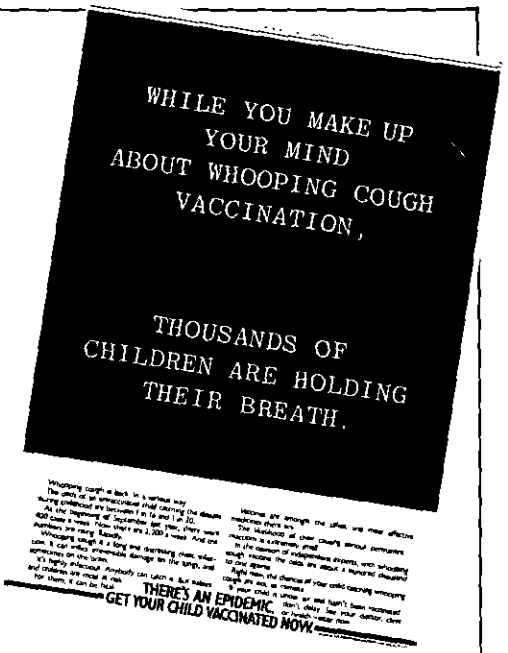
We apologise to Mr Smith for any distress caused by our mistake in confusing his roles. We also apologise to Ms Wivell for causing her to gain a mistaken impression of the facts.

CHC NEWS

For Community Health Councils

October 1982 No 80

THE WHOOP RETURNS



As weekly whooping cough notifications continue at epidemic levels controversy still rages over the balance of risks and benefits from the pertussis vaccine.

Early last month the DHSS launched a £230,000 press and TV campaign to persuade parents to have their children vaccinated. Clinics and GPs' surgeries were flooded with worried parents after harrowing TV adverts featured a black screen carrying the words "There's an epidemic. Vaccinate now" over the sound of a child coughing with the typical heart-rending "whoop".

The DHSS has also acted on the advice of the joint committee on vaccination and immunisation (JCVI) to raise the age limit for vaccination to six years — despite the JCVI's previous advice issued in May that the vaccine "should not normally be given after the age of three years". The aim is to catch the children who went unvaccinated during the years of low vaccine uptake.

Pertussis — the medical name for whooping cough — is easily caught from older children by small babies and most deaths occur in children under one year.

But high uptake rates following the launch in 1957 of the mass vaccination programme began to fall in 1974 when the Association of Parents of Vaccine-damaged Children was formed.

Chief critic of the vaccine is Professor Gordon Stewart of Glasgow University. He blames the present epidemic on the recession and says worsening economic conditions tend to accompany increasing infectious disease. He insists that the risk-benefit equation will vary according to the circumstances of each child and recommends vaccination only for children at high risk of catching the disease.

But after an article in the Times by Professor Stewart the Chairman of the JCVI John Badenoch wrote to the Times accusing the Professor of having "done more than anybody in the UK to bring the vaccine into disrepute".

Two facts are no longer disputed. Firstly, the vaccine cannot give complete protection from pertussis — though it lessens the likely severity in vaccinated children who catch the disease. Secondly, the vaccine *can* cause severe complications — but only in a tiny number of cases.

The JCVI's own estimate is one case in every 110,000 children vaccinated, but disablement campaigner Jack Ashley says vaccine damage compensation payments suggest a figure of one in 28,000.

This must be set against brain and lung damage and deaths from the disease. The figure quoted by the Secretary of State of one death in 3,000 cases amongst children may be an overestimate but the nine known deaths this year suggest that an epidemic of the present severity tips the risk/benefit balance in favour of vaccination.

Who are the CHCs - what are they?

Perhaps they are not as "holy, wise and fair" as Shakespeare's Sylvia, but several recent surveys show CHCs to have a healthy diversity of attitudes towards their role in the health service and their relationships with other bodies, inside and outside the NHS.

South West Thames region's CHCs come under the microscope in a survey of their structure and function by the University of Surrey's sociology department, which made some revealing findings on the sort of people who become CHC members.

All four Thames regions were studied for a paper by Erica Bates, now of the University of New South Wales, who looked at how NHS administrators view CHCs and what impact CHCs have on decision-making.

CHCs in the Greater London area were quizzed on their attitudes to the controversial issue of NHS war planning by a student at King's College Medical School in London, who found that two-thirds of the CHCs he asked had discussed planning for nuclear war on at least one occasion.

Two surveys looked further afield than the South East. The independent Labour Research Department drew on replies from 79 CHCs in England and Wales, as well as ten of the Scottish local health councils (LHCs) to examine their involvement in health and safety at work.

Finally, a major research report from the University of Birmingham's Health Services Management Centre explores the role and effectiveness of CHCS in England by looking at their involvement in district planning teams.

● Details of the surveys are on page 4.

INSIDE.... The changing NHS

page 6/7

Patients' complaints

page 8/9

Welcome to new members

You are joining a national network of patients' watchdogs which has survived a severe organisational shake-up. Your skills and enthusiasm are needed at this testing time for the NHS. We hope this issue of *CHC NEWS* will help you find your feet in the wide and varied world of CHCs.