CHC NEWS

For Community Health Councils

March 1980 No 52

Jenkin tells special meeting

CHCs have a "formidable case"

The arguments in favour of CHCs add up to a "formidable case", Secretary of State Patrick Jenkin told a special general meeting of the Association of CHCs on 15 February. But he also set out the case for abolishing CHCs and warned that opinions against them are being "fairly widely expressed".

Stressing that the Government has "an open mind", Mr Jenkin first put the case *for* CHCs:

- Health authorities should *manage* and the consumer role should be kept quite separate;
- CHCs can make a "sensible reconciliation of conflicting consumer viewpoints";
- CHC members become aware of the constraints on health authrities and can defend the NHS against ill-informed criticism;
- CHC hospital visiting provides an effective monitor — especially for long-stay patients;
- CHCs provide a critical voice, independent of the professions;
- There is an important role for CHCs in educating users of the NHS and promoting good health.

Mr Jenkin listed the views ranged *against* CHCs as:

- The money could be better spent on direct patient care, and CHCs cost "substantially" more than £4m;
- CHCs call for more and better services without heed to resources to pay for them;

Photo: Don Price

- With more local representation on district health authorities (DHAs), there will be no need for CHCs;
- CHCs unnecessarily complicate consultation — local authorities would do as well;
- Some CHC members merely seek to promote their own public images;
- Some CHCs insist on involving themselves in national policies as well as local issues.

The Health Services Bill gives the Government no powers to abolish CHCs and further legislation would be needed to do this. Mr Jenkin said that if CHCs stayed, he would want them to be "essentially local forums for local discussions of local health care".

DHAs would find CHCs a valuable field of recruitment, Mr Jenkin believed. He rejected the view that "competition for good people" would harm CHCs, and said that vacancies on councils would be easily filled.

As well as summarising the thinking behind *Patients first*, Mr Jenkin expressed concern about the "recent spate of temporary closures". He assured the Association that he would take its views into account when reviewing closure procedures later this year.

CHCs can also expect to be consulted about the shift in Government policy on hospitals. There will be fewer huge district general hospitals and more small, local hospital will be retained.

In answer to questions from the floor Mr Jenkin explained why the Government has rejected the Royal Commission's advice that FPCs should be integrated with health authorities. He said there would have been "one hell of a row" and that the advantages were not worth the major upheaval.

After Mr Jenkin's speech delegates turned their attention to recommendations for the future of CHCs as set out in *Patients first and foremost*, a paper prepared by ACHCEW's working group on the role and development of CHCs. The twelve recommendations summarise the case for CHCs in the restructured NHS and provide concrete proposals on their future role and operation. They call for CHCs to be given the right, in the new structure, to be consulted by RHAs and DHAs, to attend and speak at DHA and FPC meetings, to receive all necessary information on a regular basis, and to assist complainants at FPC service committee hearings. Other recommendations cover changes in regulations governing membership, CHC staff appointments and use of budgets, and absence from work on CHC business. The only recommendation rejected was no.6, asking that CHCs be allowed to employ an additional member of staff. ACHCEW's Standing Committee was asked simply to call for "realistic" pay and staffing levels.

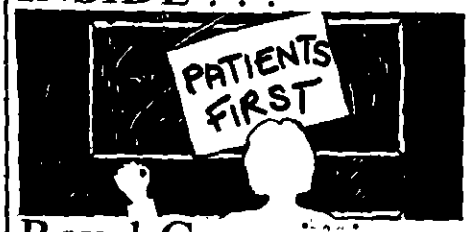
During the debate on *Patients first*, delegates agreed that the fight for the survival of CHCs should be seen as part of the struggle for more democracy and accountability in the NHS, and voted for this to be accepted by the Standing Committee as the view of the meeting.

Many speakers expressed concern about the hospital orientation of *Patients first*. And several from single-district areas warned that their experience offered little hope that the new DHAs would be any closer to the community than present AHAs. The meeting carried a resolution supporting the retention of CHCs in the new structure.

Judge rules "emergency" invalid

Mr Justice Woolf ruled in the High Court on 25 February that the Secretary of State misdirected himself when he took emergency powers under Section 86 of the NHS Act 1977 to suspend the Lambeth, Southwark and Lewisham AHA(T) and replace it with a commission. Mr Jenkin was wrong in not specifying the period of the emergency, and also in resorting to emergency powers rather than using Section 17 of the Act to impose a specific direction on the AHA(T) to keep within its cash limit. If this had been ignored, the authority could then have been declared in default (under Section 85) and replaced. The Judge recommended that the commission should remain pending a probable appeal.

INSIDE . . .



Your letters

Patients: first or last?

Colin Clews, Secretary, Salford CHC

Patients first or patients last: this would seem to be the option that the public and the health service are being asked to comment on by the recent consultative document. In distributing a letter about the proposals of *Patients first* to local authority members, voluntary bodies and other individuals and groups interested in health care, this CHC has been impressed by the strength of support that we are receiving, even from amongst AHA members, for the rights of the public to be adequately represented in the future NHS.

The present fight to remain in existence surely gives CHCs an ideal opportunity of ensuring, once and for all, that everyone knows who we are, what we are and what we do. When we still hear MPs referring to the removal of CHCs as "deleting a tier in the NHS", as they did during the debate on the Health Services Bill in December, it would seem that CHCs still have a lot to do in this respect.

Lining up with CHCs

Juliet Mattinson, Secretary, East Berkshire CHC

Support for retaining CHCs is emerging in quarters which have certainly surprised me. Chief officers in the medical, nursing and administrative hierarchies respectively of three different health authorities have personally said we should stay. They cannot be three lone voices.

At a recent meeting of administrators in the region who met to discuss *Patients first*, what surprised me even more was the total lack of disagreement with this viewpoint from the large audience which I had joined with some qualms!

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Hospital building: circles save energy?

Isabel Whitworth, Member, East Herts CHC

I read with interest the article on NHS hospital building in *CHC NEWS* (January 1980). In the interests of daylight availability, distance walked by staff, and economy, may I ask that the design of curved, semi-circular and circular buildings may also be considered. And for the future, we should be thinking about solar panels in hospitals.

CHC members' term of office

Pat Keep, Secretary, High Wycombe CHC

Because of the regulations concerning the maximum period a CHC member may serve, many members will not be eligible for reappointment this year. They will be deemed to have served two terms. The DHSS is interpreting the two term regulation to mean anything in excess of one term. This means that a member appointed at any time before December 1976 cannot be reappointed this year.

After the local authority elections in May 1976 many district councils changed their nominations to CHCs. These people will not be eligible for reappointment this year although they have only served a total of four and a half years. Not only will some local authorities experience great difficulty in replacing all their nominations but continuity of CHC membership will also suffer. We shall be interested to hear the views of other CHCs.

Health centres

John Holden, Secretary, King's Lynn CHC

We would be interested to receive information from other CHCs about health centres which incorporate pharmacies, opticians and dental surgeries. We would be interested to know the number of general practitioners in practice at the health centre and the terms of the contracts for the services of the dentists, opticians and pharmacists.

Infertility group

Dorothy Bull, Chairman, CHILD, Farthings, Gaunts Road, Pawlett, Somerset

Readers may find it useful to know about CHILD, an organisation for infertile people in Britain. We are a registered charity raising funds for infertility research, but we are also concerned with education and counselling. We publish a quarterly newsletter called *Childchat* — the current issue, No 7 contains articles on the induction of ovulation and adoption, plus members' letters. The information we have collected on infertility is available both to members and to the general public. Membership costs £4 per year.

Artificial insemination by donor

Gillian Jakobson, 2 Meadowfield, Oxenhope, Keighley, West Yorkshire

I must write in support of Maggie Waker's comments in *CHC NEWS 45*. I too am amazed at the attitude of Mrs A J Barrett (*CHC NEWS 43*). As a member of the National Association for the Childless, and as someone who has been receiving infertility treatment for the last ten years, I am horrified at the total lack of knowledge shown by Mrs Barrett on the subject of AID.

I had many inseminations with my husband's sperm (AIH) before I conceived, and then our baby was stillborn because of my diabetes. Only after five years and some 150 inseminations by AIH was I offered AID — and then some 50 inseminations led to *no* conception. During my 2½ years of donor inseminations, which I had in London, my husband and I had to live apart so that I could be on the spot for treatment. I hope this will sweep away once and for all Mrs Barrett's total misconception about "instant gratification".

AID is not readily available on demand, and many of us have to pay privately for it and travel miles into the bargain. I should be only too happy to meet Mrs Barrett, or any other CHC member, so that they may know the traumas that infertile couples go through.

Rehabilitation ideas

Dr R C Orsborn, Chairman, East Birmingham CHC

I have been asked to contribute a chapter in a forthcoming book on rehabilitation in the community. Rehabilitation is to be understood in its broadest sense, including care of the mentally ill and mentally handicapped. My contribution is to deal with the role of the GP in providing such care as a member of a health care team. If any reader of *CHC NEWS* could provide me with useful ideas and information, I should be extremely grateful.

Maternity research

Beverley Beech, Chairman of AIMS, 21 Iver Lane, Iver, Bucks.

AIMS, the Association for Improvements in the Maternity Services, now ha[illegible] [illegible]search correspondent. She will keep a check [illegible] the kind of research projects being done on maternity care and childbirth. If people have details of current or projected research, we would be very grateful if they could write to Yvonne Kyndt, 3 Pelham Road, South Woodford, London, E18.

Incontinence

Irene Watson, Secretary, Hull CHC

I was pleased to see Sue Nattrass' article on incontinence (*CHC NEWS 51*). In Hull, the CHC approached one of our consultant geriatricians and now, through cooperation between the urology and geriatrics departments, patients can be referred for tests to see whether their condition is treatable. The Hull CHC commends the Health Education Council booklet, *Incontinence: a very common complaint*. This should be made widely available.

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

Comment

The medical profession is in conflict with itself. On the one hand the British Medical Association's new secretary, Dr John Havard, has declared that doctors are "anxious to get rid of the mystique attached to medicine". On the other hand the firm message from the BMA's guide to medical ethics is still that doctors are the ultimate decision-makers in health matters, even though they admit they don't have all the answers.

For the first time the BMA has made public its ethical guide for members*. At a press conference to launch the ethics handbook Dr Mike Thomas, chairman of the BMA's central ethical committee, said it was important that "patients understand the rules by which doctors play the game". This is fine although it is disturbing that a book which discusses topics such as research on human subjects, and the doctor and the state, should be compared to a book of rules for a game.

A doctor is expected to "preserve secrecy on all he knows" about a patient though there are exceptions to this, such as when a patient consents to the breaking of confidentiality or when the law requires the doctor to tell what he knows. Confidential information can also be divulged by doctors who think it is their overriding duty to society to do this, but they must be able to justify the disclosure of information. Last year the BMA warned its members not to cooperate with police attempts to discover details about patients.

Doctors' ethics require them always to be the leaders of health care teams. The guidance on multidisciplinary teams is hazy, but implies that doctors should lead those too, though they can expect challenges to their traditional unquestioned supremacy.

There are some issues on which the BMA cannot provide clear answers — doctors are as divided as the public. These ethical dilemmas include screening, abortion, genetic counselling, brain death, forcible feeding, and tissue transplants. Another is protest action by doctors about reduced services for patients. The guide says, "The desire not to harm patients by direct action may then result in harming them by doing nothing". An insanitary operating theatre or unreliable supply of drugs might be examples of this dilemma.

The handbook is already out of date and a revised edition is promised within a year. In a vote last year the BMA decided that it should "unequivocally condemn" industrial action "which increases the sum of human suffering", so the next edition of the handbook will reflect this view.

The changing technology of medicine and the shortage of NHS resources affect the ethical problems which doctors face. The BMA wants to hear patients' views of its ethical guidance, yet the medical profession still clearly sees its ethical code mainly as a protection against the patient. * *Handbook of medical ethics* (£3 to non-members, £1 to members) from BMA Tavistock Square, London, WC1H 9JP.

Health News

Liberal support for CHCs

CHCs must be retained and their powers should be strengthened, the Liberal Party's Health Panel has decided.

In a draft response to *Patients first*, the panel comments that "The work done by CHCs varies, and some could be encouraged to do more, but many are already finding that their work is limited by a lack of resources ... Health authority members have a totally different job to do, and will not be able to give time both to that and to the activities currently undertaken by CHC members".

On other aspects of *Patients first*, the panel agrees that in general a switch to single-district areas would improve efficiency, but cautions that "a handful of multi-district areas" may still be needed. Also it might sometimes be best to retain the sector tier — for instance "it would not be sensible to impose a structure which might require ... fifty unit administrators to report to district level".

The draft Liberal response upholds the principle of staff representation on health authorities, and argues that the proportion of local authority appointees should not be reduced. It speculates that "by 1983/4 there will be comparatively few local authorities under Conservative control, and the Government may wish to reduce their influence for that reason". On costs, it predicts that the *Patients first* proposals will produce "little or no saving" overall.

The Conservative and Labour parties both say they will not be responding to *Patients first*, though the Labour Party has already expressed its support for the retention of CHCs.

Other organisations which have spoken out in favour of CHCs — or intend to do so — include: the BMA's General Medical Services Committee (see page one of last month's *CHC NEWS*), the Health Advisory Service, the Royal College of Nursing, the National Council of Social Service, the International Hospitals Federation, the National Federation of Leagues of Friends, the Standing Conference of Councils of Voluntary Service, the South Western and Mersey RHAs, the Social Priorities Alliance, the Association of Local Councils, the National Council of Women and *New Society* magazine.

The list above was compiled early in February, and is growing steadily.

Primary care in London

Photo: Raissa Page

Evidence about the problems of delivering primary health care services in London has been invited by the London Health Planning Consortium. The DHSS-sponsored study group is to consider relatively short-term measures for improving primary care in London and is to report by the end of the year. Evidence should be sent, before the end of April, to London Health Planning Consortium, Primary Health Care Study Group, Room 1922, Euston Tower, 286 Euston Road, London, NW1 3DN.

Reports that the Consortium is among the quangos shortly to be axed have been denied by the DHSS, although the long-term future is uncertain.

"A respectable case" for abolishing CHCs?

In an analysis of the dilemma of reconciling central responsibility for the NHS with local autonomy and responsiveness, Professor Rudolf Klein offers a solution in which CHCs would be redundant. He argues, in an article in the *British Medical Journal* (9 February p 420) that the reorganisation proposed in *Patients first*, with district health authorities (DHAs) being more responsive to local needs, would justify the reintegration of the managerial and the representative role. This could involve the disappearance of CHCs, on the ground that there would be an excessive overlap of function between CHCs and DHAs.

In trying to make "a respectable case" for abolition Professor Klein examines three functions of CHCs and suggests how these might be taken on by other bodies. The role of informing the public, he says, could be given to the Citizens' Advice Bureaux. This solution entirely ignores the fact that informing the public does not just mean providing advice and help with complaints. It should, as Professor Klein himself admits, be a two-way process, allowing the public to channel its ideas back to the health service managers. CHCs also take on the task of informing the public at large, and not just individuals.

The second function Professor Klein looks at is representing public opinion. He maintains that CHCs are unrepresentative and their surveys unreliable, and suggests that DHAs could do surveys just as well. Voluntary organisations could continue to nominate some members to DHAs, in order to ensure that the interests of the most vulnerable health service consumers were

Continued on next page

Health News

Continued from page three

protected. The value of CHCs as an *independent* voice for patients is not considered. The same attitude is apparent when Professor Klein discusses CHCs' third function, monitoring, which he dismisses as "an invocatory, vogue word", empty of meaning. He claims that the monitoring function of CHCs is merely a duplication of the monitoring carried out by DHSS and health authorities, thus choosing to ignore the fact that there is a vital difference between monitoring by NHS management and by CHCs.

In short, Professor Klein makes no attempt in this article to justify his assumption that representation in the new NHS structure could be absorbed by DHAs without jeopardising the interests of patients. Indeed, his scheme only hangs together by squeezing out opportunities for the patients to have their say, and he fails in any case to explore the resource implications of transferring the CHCs' functions to other bodies.

Health and racial equality

Merton, Sutton and Wandsworth AHA has adopted a policy statement on race, affirming its commitment "to ensuring equality of access to services by all sections of the community".

The AHA is approaching the DHSS for funds to help with adapting its services to meet the needs of a multi-racial community, which the Secretary of State can provide through Section 11 of the Local Government Act 1966. The area is also suggesting that the criteria for joint financing should be widened to include projects "which directly contribute to improving the health of ethnic minorities".

These initiatives stem from a detailed report on *Ethnic minorities and the health service*, prepared by Wandsworth and East Merton Health District. The report's 64 recommendations — including proposals for the appointment of an interpreter, a community health worker and a dietician, using Section 11 funding — have now all been adopted by the AHA.

The report draws heavily on local research and on two useful publications: *Religions and cultures*, a pamphlet produced by the Lothian Community Relations Council, and *Asian patients at hospital and at home*, by Alix Henley (see *CHC NEWS 50*, page seven). A final version of the report is being prepared for publication — details from Mrs Shirley Hardy, Grosvenor Wing, St George's Hospital, Blackshaw Road, London SW17.

Broadmoor and ECT

Patrick Jenkin has decided that a management inquiry into Broadmoor Special Hospital would not be justified on the grounds of allegations made by two nurses at the hospital of ill-treatment of patients, including physical assault and the use of "unmodified" ECT and of tranquillisers for control purposes (for details see *MIND OUT* November/December 1979). Mr Jenkin gave his decision in a written answer to the House of Commons on 25 January, but he supported it by a letter of explanation giving special attention to the allegations about ECT. This states that the DHSS is satisfied that the use of ECT at Broadmoor is in line with current practice. The use of unmodified ECT — ie, without muscle relaxant and anaesthetic (the anaesthetic being given to counteract the unpleasant effects of the muscle relaxant) — may, Mr Jenkin says, be justified in exceptional circumstances where, in the clinical judgement of the doctor, this is the best course.

The memorandum on ECT issued by the Royal College of Psychiatrists in 1977 made no mention of unmodified ECT, since it was assumed that in all normal circumstances anaesthetic and muscle-relaxant would be used. But further guidance issued recently by the College (see *British Medical Journal* 9 February p 403) states that in certain situations — for example, where there are medical contra-indications to the use of anaesthetic and muscle-relaxant drugs but an urgent need to control the patient's behaviour with ECT, or where no anaesthetist is available — the doctor could be right to proceed with unmodified ECT. However, Mr Jenkin's use of this guidance to support his decision on Broadmoor has been challenged in a letter to the *Guardian* (2 February) from Dr Anthony Clare of the Institute of Psychiatry and Larry Gostin of MIND.

Promising proposals for mental illness hospitals

The spate of public inquiries into mental illness hospitals in recent years was both a symptom and a cause of demoralisation among staff working in them. The report* of a DHSS working group set up in response to the general unease pinpoints some of the other factors that are still contributing to low morale — the piecemeal and slow development of community psychiatric services, and recurring threats of hospital closure; the continuing isolation of mental illness hospitals and the increasing numbers of patients with intractable problems concentrated there; and the large size of hospital catchment populations and the remoteness of management. At first glance the report may seem as uninspiring as its title, but in fact it provides a lucid analysis of present difficulties and some imaginative solutions to them.

The main recommendations for change include detailed proposals on setting objectives and policies for each hospital. Standards of care relating primarily to the quality of patients' lives — on such things as accessibility to toilets, levels of noise, and privacy — should be written down, with target dates for their achievement and a checklist for monitoring progress. Standards documents and checklists should be available to patients, relatives, leagues of friends and CHCs, and should be drawn up and regularly reviewed in consultation with CHCs and patients' organisations. Models are provided in appendices to the report. Hospitals should also record their progress in an annual report.

The working group recommends that the simplification and rationalisation of hospital catchment responsibilities should be taken on board in strategic planning. A more radical management proposal is for the setting up of a psychiatric services management team (PSMT), answerable to the DMT, in each district — whether or not there is a mental illness hospital or an existing district psychiatric service. The PSMT would not be an extra administrative tier but would consist of key senior staff, and would undertake the general management and planning of all psychiatric services.

* *Organisational and management problems of mental illness hospitals: report of a DHSS working group (with HN(80)1)*

New procedure for resolving local disputes in the NHS

A procedure for handling local disputes has been agreed by the NHS General Whitley Council. Disputes which have not been resolved at officer or employing authority level should go to a locally convened conciliation panel consisting of an independent chairperson acceptable to both sides, two members appointed by the employing authority and two by the staff organisation(s) involved.

People directly involved in the dispute should not be members of the panel, and each side should include only one member or employee of the bodies concerned. If both sides on the panel agree it can make recommendations, or refer the dispute to the Government's Advisory, Conciliation and Arbitration Service for arbitration. If there is no agreement, either side can refer the dispute to ACAS for conciliation. Disputes should be resolved within two months.

The Staff Side of the Whitley Council has also asked Patrick Jenkin to withdraw his recent circular on industrial relations (see *CHC NEWS 50*, page three). It describes the circular as "provocative" and "likely to have a serious impact on the vast amount of goodwill on which the service relies". Mr Jenkin has refused this request.

• Also see *Books*, page seven.

Counting cuts

Patients' welfare is the main consideration in health service cuts, say the health authorities. An informal survey of its members by the National Association of Health Authorities (NAHA) shows that savings are being made by more efficient use of resources, such as supplies centralisation and more efficient heating systems. In some cases this has released money for use elsewhere — opening wards and day centres. But NAHA warns the Government that if the pressure of public spending cuts continues on the NHS, this source of money will soon dry up. NAHA News (December 1979) appeals for greater support from the Government against public campaigns opposing "efforts to rationalise services". NAHA, Park House, 40 Edgbaston Road, Birmingham B15 2RT.

by Priscilla Alderson, Member, Tunbridge Wells CHC

CHILDREN IN HOSPITAL

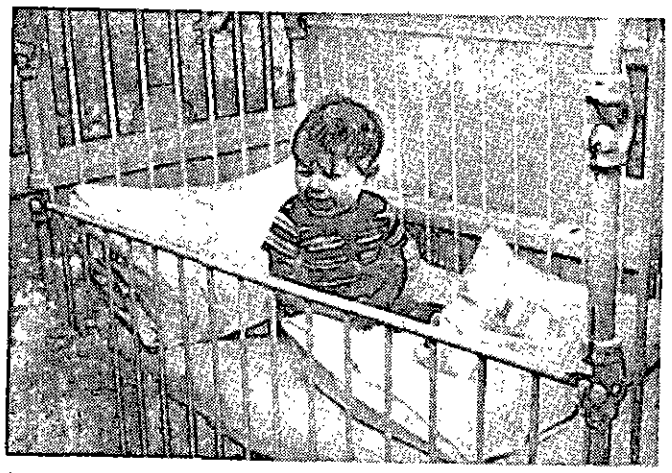
Children are especially vulnerable to hospital policy. A rule may forbid a mother from carrying her young child into the anaesthetic room before an operation. She must watch him leave the ward on a porter's trolley and for many children a small rule such as this may mean unnecessary misery at the time and broken nights for the child's family for weeks afterwards. Doing away with a rule like this may make all the difference and lead to a happy time in hospital.

Every other child under seven spends at least one night ill in hospital. Children have a much higher than average admission rate. They have special mental and physical needs and tend to be more easily frightened and confused than adults. Their opinions tend to be ignored even when clearly or forcibly expressed. Their welfare depends more than that of most patients on the specialised care, knowledge, and decisions of all the hospital staff. CHCs can greatly affect children's welfare in surgical wards, special care baby units, and accident and emergency departments, as well as in children's wards.

A year ago our CHC child health group visited a pleasant children's ward. We were worried about a notice on the treatment room door: "No parents allowed in here". Knowing DHSS policy, we were able to get the notice removed. Recently I stayed in that ward with my five year old son and he was very pleased that I could be with him in the anaesthetic and recovery rooms. But the moments he needed me most were in the treatment room and I was relieved to be able to go in quietly with him without having to argue the point.

Old fashioned rules persist in many hospitals, although child care has changed radically in homes, schools, and other hospitals. It is extremely difficult for children and parents in the ward to criticise, suggest improvements, or prompt staff to revise policies. I believe that the policies laid down 20 years ago by the *Platt report on the welfare of children in hospital* are both realistic and beneficial, as the following selected quotes show:

"An adult ward is no place in which to nurse sick children... The emotional needs of children in hospital require constant consideration.



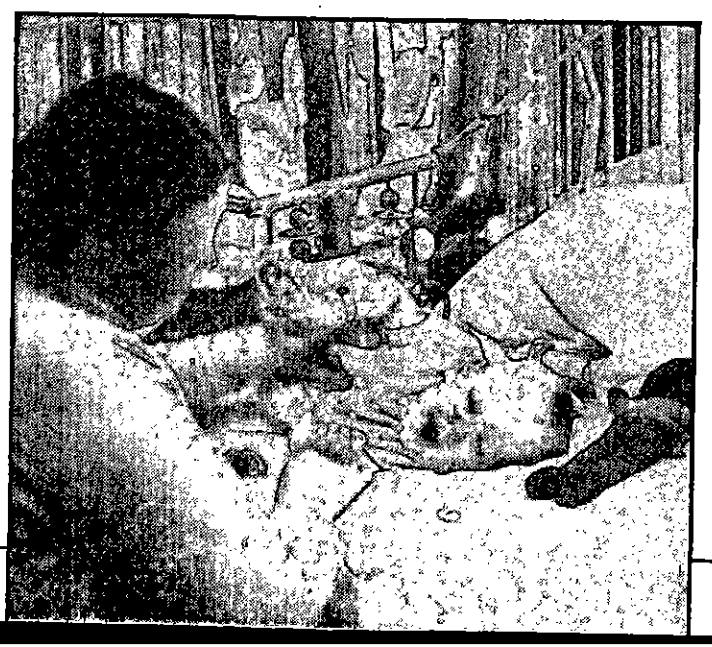
• Visiting without restriction is essential ... Parents should not be denied access to their child in hospital ... We should like to see restrictions lifted on visiting on operating days. If parents are properly prepared and willing to help, they can be present both immediately before and when the child is recovering from the anaesthetic ... The same arrangements should apply to children admitted for tonsil and adenoid operations.

• More harm than good is done by allowing parents to see their children only through a glass partition ... since we know of hospitals which are able to dispense with it we hope it will disappear altogether.

• The mother should help in looking after the child, including feeding, washing, keeping him entertained and putting him to bed and getting him up; as well as comforting him during painful or unfamiliar medical or nursing procedures.

• Those hospitals that do admit mothers have been able to find accommodation by simple adaptations. When the need has been appreciated the accommodation has usually been found.

• Canteens and a supervised playroom for visiting children are valuable; we hope that as soon as possible all hospitals dealing with children will make every effort to provide these essential facilities.



• Every effort should be made by hospitals to preserve continuity with the home during the time the child is in hospital.

• Children should not be admitted to hospital if it can possibly be avoided."

Since 1959 these have been official government policies for children in hospital, repeated over decades in reports and circulars urging hospitals to care for all children in children's wards; to ensure that staff are "thoroughly familiar with the developmental and especially the emotional needs of children in hospital"; and to welcome and involve parents at all times.

It is unfortunate that official reports look so dull and weighty, for they are readable, humane and biased towards the patient, and are a valuable source of quotations for anyone who hopes to persuade hospital staff to improve patients' care. Besides describing good practice, they explain the need for it: the *Platt report* clearly describes the child's grief, fear and need for mothering care. The reports have many ideas for CHC members to remember when making hospital visits.

Because few CHC members have time to read the papers listed at the end of this article, the National Association for the Welfare of Children in Hospital (NAWCH) has published a short summary of the main points on the care of sick children. There are suggestions on questions CHC visitors might ask about staffing, play, education, planning, volunteers, parents, visiting, routine, and safety. A copy of *What is a children's ward?* is being given to each CHC. Further copies are available from NAWCH, 7 Exton Street, London SE1. Please send 50p and a large, stamped addressed envelope.

Further reading

The welfare of children in hospital: report of the Platt Committee, HMSO 1959

Organisation of the in-patient's day; HMSO 1976

Report of the expert group on play for children in hospital, HMSO 1976

Fit for the future (the Court report), HMSO 1976

Visiting of children in hospital, DHSS circular HM(66)18.

Hospital facilities for children, DHSS circular HM(71)22.

Planning of hospital children's departments (the Swift Report), British Paediatric Association, 1974.

Photos: Camilla Jessel

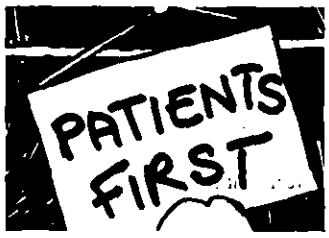
Which patients first?

*by Kay Richards**

For those with critical concern about the future of our NHS, recent pronouncements do not at first sight appear to augur well. Similarly, for those with critical concern about the quality of general practice—particularly in inner city areas — the recommendations of *Patients first* do not show much awareness of the difficulties to be surmounted, or the ways in which these might be tackled.

The report of the Royal Commission on the NHS noted that "When we seek health care or medical aid we look in the first place to services available in the community, and usually that is as far as we need to go". It is timely to reflect that in any one year less than 10% of all patients seen by the NHS are likely to be admitted to hospital. *Patients first* claims that it is "fundamental to making a national health system work well in response to patients' needs that the structure and management of the service should be right", yet it chooses to dismiss the Royal Commission's clear recommendation that Family Practitioner Committees should be "abolished and their functions assumed by health authorities as a step towards integration".

The commission believed that this step would allow health authorities "to influence more positively than they can at present the distribution and



Cartoon: Diana Heeks

quality of surgeries and other practice premises, the balance and relationship between hospital and community care, the movement of staff across institutional boundaries, and deputising services" (paragraph 20.57).

Rejection of this recommendation is serious in itself, since *Patients first* may be setting a pattern of NHS organisation for the next twenty years. Of even more concern is the fact that *Patients first* takes no opportunity to endorse many of the Royal Commission's other recommendations concerning practice, attitudes, skills, patient involvement, and audit and peer reviews. These recommendations challenge the power of the professionals and ask them clearly to put the patient first—without infringing in any way the jealously guarded, though at times over-protective, concepts of clinical judgement and clinical freedom.

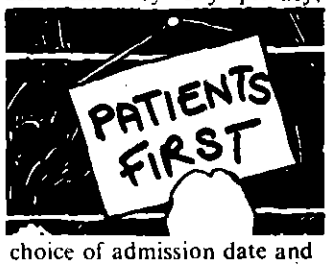
The commission's report deliberately considered philosophy, objectives and practice before discussing structure, because structure should enable the achievement of good practice and sound objectives. The question must be posed — can the recommendations of *Patients first* be properly evaluated without some indication from Government of the objectives and purposes which it wishes to see the NHS achieve?

Without such an indication, local discussions taking place now — both about *Patients first* and about the likely boundaries and catchment areas of the new health authorities — will run the danger of being over-influenced by past practice and by powerfully entrenched interests. An opportunity will be lost to think positively about what the NHS locally should be seeking to achieve, and about how its services are received and perceived by the patient.

Perhaps by not identifying these issues clearly in its document the Government is being honest, and is saying that it really isn't sure what role and purpose it wants the NHS to achieve. If that is so then it is up to CHCs and others with concern for the patient to tell Government. As a "cross- bench" member of the Royal Commission, I can say that I am alarmed and dismayed by the Government's present actions and attitudes towards the NHS.

The commission's objective assessment and review provided a base from which to develop the service by enhancing its strengths and alleviating its weaknesses. The NHS remains greatly admired as one of Britain's finest social institutions, despite some of the more acute problems which it has faced in the past few years. But we confirmed that it is under-funded and over-bureaucratic, with too complex an organisational structure. Many of its practices are not aimed at meeting patients' needs.

When we were in session, between 1976 and 1979, private practice was not at a level to influence the NHS for good or ill, but we noted the reasons why people choose private medicine. They "buy" privacy,



choice of admission date and choice of consultant. "In our view", we said, "it should not be necessary to seek private treatment to obtain these advantages .... the NHS should make more effort to meet reasonable requirements of this kind" (paras 18.10 and 18.41).

Present Government policies are aimed at reducing public expenditure, at withholding the additional resources which the NHS particularly needs to assist with the problems of our rising number of elderly patients, and at encouraging the further development of private practice. I don't know by what strange alchemy such policies are meant to improve NHS staff morale and widen the range and quality of services developed to meet patient need. Such a mixture can only depress further and make second class a service which should command our confidence and respect.

One important but neglected area of NHS activity is that of influencing social policies to alleviate the causes of ill-health. Also neglected is the practice of involving patients in their own treatment, encouraging them in self-help and self-care. The commission did not say "the patient shouldn't attend the doctor so often". We recognised that the health service has a responsibility to help him not to need to do so.

We saw a real need for

more skills to be available in general practice, for counselling and for the identification and early treatment of emotional stress and tension. More time should be spent with patients. The counselling aspects of the primary care team must be strengthened, and liaison between hospital and community based NHS personnel must be improved, in order to achieve effective communication and treatment in the interests of the patient.

Will the new structures suggested in *Patients first* help us to achieve this, or will the gap between hospital and community-based NHS still be too wide? Many inner-city areas suffer from too few doctors with over-large lists, from isolated doctors practising in deplorable premises, and from too many elderly doctors out of touch with new thinking and developments. As an incentive to young doctors to become established in these areas, the commission recommended the provision of adequate premises and the introduction of a salaried employment option for GPs. Now fears are being expressed that the new health authorities may become hospital-dominated again. If the committee responsible for family practitioner services was clearly linked to and identified with the local health authority,

* *Kay Richards is Assistant Director (Residential Services) with the Hertfordshire Social Services Department, and was a Member of the Royal Commission on the NHS.*

the authority would be in a much stronger position to resist such pressures and to implement positive recommendations.

When commenting on *Patients first*, CHCs should try to ensure that these wider issues are considered in their localities, and that all comments are submitted against this wider background of debate. Of equal importance, however, is to ensure that CHCs themselves continue to have a part to play in the new service. Bringing member management of the service in at a more local level in no way diminishes the need for a consumer or public voice at local level too. When resources are scarce and political tensions high, it is all too easy for appointed or elected members to become so aware of the management dilemmas and the resource allocation problems that they cease to be open to the possibilities for change and reallocation. Requests for new services are met with "No", rather than with a questioning of the current need for established services.

CHCs, by keeping in touch with local concerns, by providing an objective voice, and by acting as the "patient's friend", freed of the direct responsibility of management, have shown that they bring an important new dimension to NHS policies and practice. Not only did the Royal Commission

support CHCs and wish to see their position strengthened, it also made it clear that even if authorities become smaller CHCs should continue to be available in at least as many localities as they are at present.

Patients first is valuable as much for what is not said as for what is said, as a stimulus for discussion. It clearly sets out to streamline the structure. It also affords an opportunity to those with a wider concern for the NHS, and for primary care in particular, to raise other issues which they see as important. It will be a very long time before such an opportunity occurs again, so this is a chance not to be missed. *Patients first* does suggest that the Government will consider and judge other proposals of the Royal Commission "in their proper time". Make it now!

Book reviews

Alcohol and alcoholism

Tavistock Publications, £1.95

This report of a special committee of the Royal College of Psychiatrists is deliberately written in non-technical language. It explains clearly, quoting figures but not overwhelming the reader with them, the frightening growth in the nation's drinking. It examines the multiple causes, which lead an individual to become a heavy drinker, and the astonishing diversity of the disabilities which can result.

In one way or another, heavy drinkers can damage every organ and system in the body, and the danger of dependence is very real: no-one has a guaranteed immunity. The public should be aware that every aspect of community life is affected by excessive drinking.

The report decries the pitifully inadequate attention given to prevention, notes the unused records of research which could help with the understanding of why people drink harmfully, and points to the need for a national plan. Above all it calls for more concern, since "people with drinking problems are very much of us — they are not to be put aside as a strange, abhorrent and disgraced minority".

Margaret Campbell
Oxfordshire CHC

Asbestos, killer dust

by Alan Dalton, £2.25 inc post from BSSRS Publications, 9 Poland Street, London, W1.

This righteously angry and biased book deserves to be read. Subtitled: *A worker/community guide: how to fight the hazards of asbestos and its substitutes*, it marshals the scientific and medical facts — and the human anguish — into a compelling case.

It points the finger at the slowness of Government agencies to act on asbestos, at the "red herrings" spread about by the asbestos industry, at the myth that only blue asbestos is dangerous, and at the tendency of most "independent experts" to moderate their criticisms when offered research funds by the industry.

There is a deadly legacy of asbestos still to be dealt with in a variety of non-industrial settings — including schools and houses — and the chapter on "The hospitals scandal" contains several alarming case-histories, suggesting that there is still much asbestos to be eliminated from hospital wards, basements, kitchens and laundries.

The book accuses "most" hospital managements of obstructing attempts by NHS trade unionists to protect themselves *and patients* against asbestos hazards. Perhaps this is an overstatement—but even if it is that should not deter CHC members from finding out what's happening locally.

Industrial relations in the NHS: the search for a system

edited by Nick Bosanquet, King Edward's Hospital Fund for London (distributed by Pitman Medical), £6.

How long does it take to be overtaken by events? Not long, it seems, in the industrial relations field, for the ink was scarcely dry on *The search for a system* before the Government had published its December circular *If industrial relations break down.*

Industrial relations problems in the NHS have been gathering momentum for some years, and while no serious observer could look on with equanimity for ever it might have been hoped that the Government's advisers would have stopped to read this book before plunging into intervention. It covers the subject very thoroughly, and while it does not offer all the answers it sheds comprehensive light on the questions.

Few of the protagonists escape its analysis unscathed. Health authorities, the professions, trade unions and the Whitley Council system all take their share of responsibility. The development of NHS consultative and negotiating machinery (and its shortcomings) is traced from the days of paternalistic management and an unquestioning staff right through the ancillary workers', nurses' and doctors' actions of the early to mid-1970s, to the mass unionisation of recent years. The book shows how the intractable coincidence of insistent union demands with determined Government restriction on the growth of the service produced the 1979 industrial relations breakdown.

The increasing adoption of union attitudes and techniques by professionals of all kinds is documented, and interestingly the authors explain the inevitability of this shift in terms of the lack of any alternative practical course of action for those concerned.

The change that has befallen the NHS as budgets have been squeezed and traditional attitudes have proved inadequate is plainly set out. It is made clear that dramatic and disturbing change such as this should be recognised for what it is, and approached thoughtfully and with foresight.

The contribution by Roger Dyson and Kathleen Spary is particularly useful, giving details of the many NHS professional associations, their membership and their status as trade unions or otherwise. Much of this will be new to CHC members. Medical and nursing matters are given special attention, but for general information the first four chapters must be regarded as obligatory reading. Brian Edwards' thoughtful assessment of the performance of managers in industrial relations matters; and their failure to produce a coordinated national and local strategy, also deserves to be read.

The recent circular will displease many who have worked at industrial relations in the NHS—including, I suspect, a number of the contributors to this book. But looking on the bright side, the book will still be around when the circular has been superseded, and CHC members, NHS trade unionists, managers and civil servants would do well to draw on its lessons for the time when they can be put into effect. In a world that sometimes seems to become hysterical over every point of difference in the industrial relations arena, this book is an informative, readable and unemotional contribution to the debate.

Mike Gerrard
Association of CHCs

by JACK HALLAS,
Nuffield Centre for Health Service Studies,
University of Leeds

Photos: Liz Heron

PATIENTS FIRST -or looking forward to the past?

The question is not "Can CHCs survive?", but "would CHC members want to continue to operate within, and cooperate with, a National Health Service which might well be vastly different by the latter part of the 1980s?". This is just another way of saying that consideration of the Government's consultative paper, *Patients first*, should not be carried out in isolation from other developments which, taken together, add up to a very different agenda for the future NHS.

New directions for the NHS

At the very least, CHC members and secretaries should make themselves familiar with the debates consequent upon the passage through Parliament of the Health Services Bill 1979. And they should try to keep up with the pronouncements of Ministers and publications which represent the views of politicians, such as, to take one example, the book *Equality*, published in 1979*.

To use a somewhat inappropriate term, this "Kremlinology" is necessary to create a vision or model in which the mind takes account of significant changes of philosophy about, and new directions in funding of, state health services. Perhaps it is ironic that, some years ago, Sir Keith Joseph should use a CHC dinner as a platform to extol the health system in France, where some 30% of the total resources employed in providing health services comes from the private sector. Present Ministers have been somewhat reluctant to make similar estimates of the amount of private practice—both inside and outside the NHS—they would like to see developing in the UK. But there is no doubt that an acceptable upper limit might well be in the region of one-tenth of total activity.

In his December 1979 article in *The Director* the Secretary of State for Social Services Patrick Jenkin had a vision of a National Health Service funded from a state insurance fund, with hospitals largely self-financing. Ministerial comment on *Patients first*, especially by Gerard Vaughan, has emphasised that the most important feature of that paper is the strengthening of management at hospital level. I hope I have already said enough to sketch in the context in which *Patients first* should be debated. Whether the picture conjures up rosy visions or nightmares for the future will depend on which side of the bed readers sleep.

* Equality *by Sir Keith Joseph and Jonathan Sumption, John Murray (Publishers), £4.95*

Implications for CHCs

There are three features in the consultative paper which have a direct bearing on the future of CHCs: the role of the region, the membership of the new district health authorities, and the emphasis on strong unit management. At the time of writing, not enough evidence is forthcoming to suggest that RHAs welcome the role which is envisaged for them in the document. Their members and officers are being required to be massively involved in carrying out managerial "adjustments" which could affect a significant proportion of the senior officers working within their purview. They are then supposed to recede gradually into the distance..

In the seven years of their existence, the 14 RHAs have individually developed differing broad approaches to organisational changes and planning procedures, resulting in a continuum of decisions or non-decisions that runs from "creeping incrementalism" right through to "root and branch" interventionism. Tinkering with boundary changes at the margins of existing areas may be a useful, social geographic luxury — but one which a fairly tight Government timetable will prevent RHAs from adopting. In that case, the axe-grinding currently to be heard will be only a prelude to the execution of whole districts, allied to a spate of shotgun weddings.

Experience would also argue that organisations of the size of most regions would find great difficulty in gradually fading away. Of course, their activities will have a considerable bearing on the future of community health councils, should it be decided that CHCs are to continue. If the evidence of the recent report prepared by a working party of the South Western RHA is anything to go by, some regions still have a lot to learn about the intricate relationships built up between communities and some CHCs during the last six years.

If it is agreed, after consultation, that membership of the district health authorities (DHAs) should be of the order suggested, then large questions must be asked as to whether such a size of membership could manage to deal with the organisational problems of the present time, which look likely to continue — for instance, crucial decisions on restricted or alternative methods of funding, industrial relations matters, and restructuring of the planning system. These problems are likely to bulk large on any DHA's agenda, thus creating a considerable amount of doubt as to whether matters of public representation could be satisfactorily coped with by such authorities. If that were to be the case, it could be said that the consultative paper should have been called *Professionals first*.

The emphasis in the document on strong management at hospital level is, of course, an instance of this Government's general dislike of "wetness" or "sogginess" in management, and its desire to see efficient managers making brisk decisions in moments of crisis. It can be argued that this is a return to a manner of management which often did go on in hospitals in the 1950s and early 1960s. There is small relevance to the way in which such organisations, if they are of any size, are managed today. It is a matter of certain fact that the district general hospital of 750 beds upwards, now a commonplace in the NHS, is a very different type of organisation from the smaller and more cosy units of yesteryear, which could appear to respond to direct managerial control.

Another new Government policy will hark back to an even earlier mythical "golden age". The Health Services Bill, when it becomes law, will empower authorities to engage in fund-raising activities to increase their resources over and above their allocations. The body scanner and hospice fund-raising activities of recent times demonstrate the willingness of the public to fund drama. Members of councils might like to ask themselves whether they and the public would be as prepared to assist, say, a geriatric hospital of not too high repute in such fund-raising endeavours.

Photo: Raissa Page

The NHS see-saw

So, taking stock of the future, we see a picture of a National Health Service that has a large private practice element built into it, with a considerable private sector outside of it, moving towards a state insurance fund with doctors and hospitals making an "item for service" charge to patients, who would then seek reimbursement from an insurance fund. These various "adjustments" in the future working of the NHS can be seen in academic terms as the normal struggle that goes on in all widely spread organisations between propagating the benefits of centralism and, on the other hand, making deliberate moves to shift power to the periphery.

The almost unique feature of the current period of ferment in the NHS is the speed with which contrasting solutions are being proposed and implemented. If power be devolved from a DHSS centre, and the regions have a self-denying ordinance imposed on them, the NHS then begins to seem susceptible to problems arising from fragmentation and, in the case of certain hospitals, considerable isolation. Naturally, it is not all bad. There are a number of features of these proposed changes which merit admiration for political courage and nettles grasped. The reduction of the clumsy advisory machinery, and the removal of bands of management which have proved to be unnecessary, will make considerable savings for the NHS. It is unfortunate that it may well be that the winds of political change will sweep away some of the benefits that have been obtained as a result of the existence of CHCs.

The community and the consumer

In the mid-1970s it was encouraging to see that the word "community" had become respectable enough to appear in councils' titles. The emphasis on strong hospital management must reduce the amount of resources and interest provided for services taking place in the community, and disadvantage them even more than they are at present. This is clearly detrimental to good management, which should be concerned with preventing problems from presenting themselves. It can also be seen as a disservice to the tax-payer or insurance fund contributor, who will have to bear the weight of a service concentrating on hospital technology and its adaptation to a growing hospital population that could have been served by means of strengthened community services.

It is also unfortunate that the Health Services Bill, Ministerial pronouncements and the consultative paper all assume that people who use the health service are clever and knowledgeable consumers who know the market and the ways in which they can insure themselves against disaster, both by their life-styles and by the speed with which they present themselves for treatment. CHCs will known from their own experience that this is very far from the case.

It will be impossible to lose sight of the work and experience built up by CHCs during their seven years of endeavour. And if, as a consequence of the consultation period, CHCs do disappear, it is only right that a considerable proportion of the membership of DHAs should be drawn from their number. But most commentators on *Patients first* seem so far to be in broad agreement that DHAs, even with a large injection of ex-CHC members, could not reasonably be expected to cope with the representation of the views of the population served in any sense other than dealing with crises as they arose; and that, in some modified form, perhaps allowing for a larger element of voluntary organisation membership, CHCs should continue.

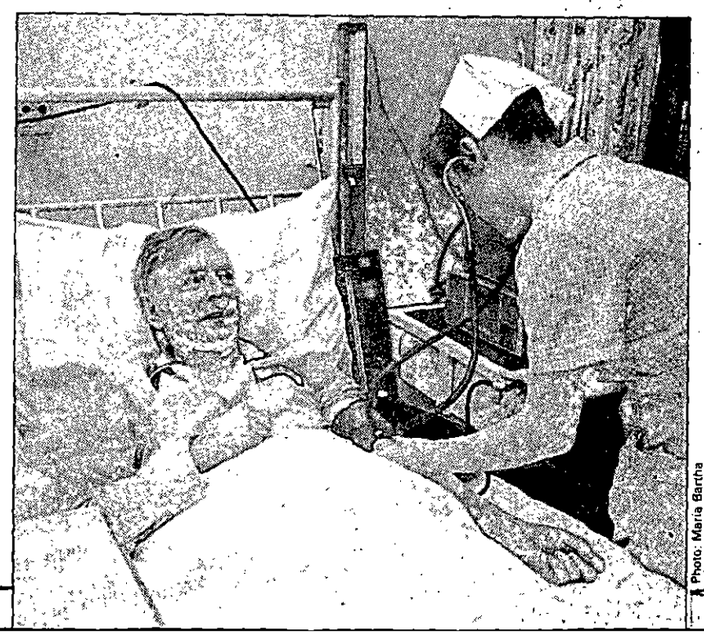


Photo: Maria Bartha

Turning back the clock?

If we go back to the start of this article and look at that question again, it would seem that, even if CHCs did continue, they might well find themselves in a very different sort of NHS, constricted by a much narrower remit than they enjoy at present, having lost the broad interpretation of their terms of reference which they have worked to have accepted and now so confidently use. The only justification for ferment in the NHS is that change is beneficial, that the process can be viewed as an upward spiral of learning from experience and improving the service provided. What is to be feared is that what we are engaged in is a circular process — that we are retracing our steps to a past which, in some ways, never existed, and which can never be recaptured.

Healthline

Leaving hospital

Our CHC is interested in investigating the problems faced by elderly people when discharged home from hospital. Can you suggest any sources of information to help us?

Several CHCs have done surveys on how elderly people cope at home when they leave hospital, including Redbridge, Kensington, Chelsea and Westminster (South); Roehampton and Manchester Central. Among other CHCs which have also investigated the problem in various ways are: West Birmingham, Darlington, Grimsby, South Hammersmith, Haringey, East Hertfordshire, High Wycombe, Hull, Kettering, Rochdale, and Sutton and West Merton.

You could also get in touch with the Continuing Care Project, which was set up in 1977 to look specifically at the aftercare problems of elderly discharged patients. The project has published *Organising aftercare* (£1 + 25p post) and *Going home?* (50p + 20p post), and can also provide book lists reading lists, conference papers and speakers for seminars. The address is: 20 Westfield Road, Edgbaston, Birmingham B15 3QG (021-454 7894).

The county connection

How is the number of county council appointees on a CHC decided?

The Regulations on this are all in Statutory Instrument 1973 No 2217. When CHCs were being set up, the RHAs as "establishing authorities" first decided how many members each should have (paragraph 4 (3)). Half these had to be appointed by the "relevant local authorities" (LAs)—those covering all or part of each CHC's health district (4 (4)). Each LA had a right to at least one CHC appointment (4(4)). But a typical CHC might have 15 LA seats and be involved with perhaps 4 LAs — so the "additional" appointments were to be split up between the LAs by mutual agreement, failing which the RHA would decide (6(1)). In general the arrangements made in 1974/5 have remained unaltered, though it is open to RHAs to vary the total membership of a CHC — and hence the number of LA seats — at any time (4(3)).

Because some CHCs have more members than others, and because the "additional" LA seats were split up by local agreement between the LAs concerned, some CHCs have ended up with more county council (CC) appointees than others. **Swindon**, for instance, has 4 CC members out of 22, and **Blackburn** has 3 out of 30. **West Berkshire**, which has an overlap into Oxfordshire, has 4 CC members out of 30 — 3 from Berkshire CC and one from Oxfordshire CC.

How many nurses?

Are there any national requirements for nurse staffing establishments?

No. Each area health authority sets its own staffing levels. But various approaches have been made to working out minimum or optimum nurse: patient ratios. The most complex involves assessing workload according to the degree of patient dependence.

But most existing nursing establishments are estimated on a nurses to beds ratio, and were originally based on a formula called the revenue consequences of capital spending (RCCS). However, the actual nursing budget may be based on nurses per bed *occupied*, and the number of nurses needed is obviously affected by developments such as shorter working hours, shift systems, longer holidays, new training requirements, and increased bed use and patient throughput, and is also related to the balance of trained to untrained staff and the availability of auxiliary staff. There are DHSS recommendations on minimum nurse: patient ratios for some kinds of hospital care, though these date back to 1971 and 1972. They are: 1:4.4 available beds in hospitals for the mentally handicapped; 1:3 in hospitals for the mentally ill; and 1:1.9 in geriatric wards with 30 or more available beds (extra staff are required in smaller wards).

Who signs the certificate?

Who is responsible for signing a medical certificate for National Insurance purposes for a patient who has been discharged from hospital but continues to be treated as an outpatient and is unfit for work?

Where the clinical responsibility for treatment rests with the hospital doctor, the hospital doctor and not the GP signs the certificate for a patient attending for outpatient treatment.

MAKING CONTACT

Rod Griffiths, chairman of the Association of CHCs for England and Wales and of Central Birmingham CHC, describes the preliminary results of a survey of CHCs, contact with the public, which is being carried out at the Health Service Research Centre, University of Birmingham.

CHCs are under the microscope at the moment, and one important aspect of their work that is bound to be examined is how far they are successful in involving the public in discussion on the health service and in keeping the public informed about local developments and CHC activities. CHCs will remember receiving, towards the end of last year, a survey questionnaire about the extent to which they involve the public in their work. So far 160 completed forms have been received, and those CHCs which have not yet returned them will be receiving a reminder any day now. But the 160 replies available are enough to provide an encouraging picture of CHCs' contact with the public.

Surveys

We asked CHCs about the surveys they had done, what methods were used, and who the targets were. The grand total was impressive: we found that the 160 respondents have between them carried out 147 surveys in the last year. In fact, over one-third of the surveys ever carried out by these CHCs have been in the year immediately preceding receipt of our questionnaire, so clearly surveys are an activity that is on the increase.

The most popular method of surveying the general public in the community was by postal survey, but other methods—on-street interview, house-to-house interview and newspaper ballot— were also used quite extensively. Surveys about hospital services were not surprisingly most frequently carried out among inpatients and outpatients. But CHC surveys have also covered ex-hospital patients, hospital visitors, staff, and patients on waiting lists. We will be going back to CHCs to ask them about their surveys in further detail.

Direct contact with the public

134 out of the 160 councils replying allow the public an opportunity to speak at regular CHC meetings. 78 councils reported that members of the public actually participate in the discussion. Members of the public do not always avail themselves of the opportunity to speak, but about half of the positive respondents recorded the public speaking at 50% or more of their meetings.

26 of the 160 CHCs hold surgeries in the community. 123 use their powers of co-option onto CHC committees, and these CHCs have each coopted an average of six people in the past year.

We asked how many public meetings (other than regular council meetings) CHCs had held in the last year, and got the astonishing total of 378 from the 160 who have replied. This activity is also increasing.

Contact with organisations

The general public is notoriously difficult to pin down as a group, but within the community CHCs also have contact with many specific organisations with interests in the health service. We asked CHCs if they sent speakers to such organisations, and all but one said they did. In total staff and members of CHCs had spoken on about 3000 occasions in the last year. Even more massive is the contact established by post. Some 19,000 organisations get *regular* mailings of information from CHCs, on average six times a year, and a further 30,000 get information on a less regular basis from the 160 respondents.

CHCs do involve the public

It is clear that CHCs are carrying out a vast amount of work in seeking to inform and involve the public in the workings of the NHS. The information here is an underestimate of the real activity because 68 CHCs have so far not replied. Obviously we would like a 100% response so that we can present a complete picture in time for the deadline on consultation over *Patients first*.

Weighing in for the Consumer: a management viewpoint

by Alasdair Liddell, Area General Administrator, Kensington-Chelsea-Westminster AHA (T)

The debate about the role of CHCs has been simmering ever since they were introduced as part of the packaging of the 1974 reorganisation. Assessments of their worth from within the service have ranged from quite moderate statements such as "politically inspired interference" and "totally ineffectual" to more extreme views, but until now the debate has been denied any real momentum by the political reality of their existence. *Patients first* changes all that, and a more thoughtful discussion is now required, since I would guess that Secretary of State Patrick Jenkin is genuinely undecided about their future.

The role of CHCs has generally been understood to be threefold:

- representing local views
- representing the interests of the consumer of health services
- communicating and explaining health authority policies to the public.

The third role is extremely difficult and most CHCs have not attempted it. Where they have tried to explain health authority policies they have often effectively undermined their own credibility by becoming too closely allied to the health authority in the public mind. The other two roles have been more straightforward, although they too can be in conflict.

For instance, when Tower Hamlets district management team decided to close acute beds at Bethnal Green Hospital, so allowing space for geriatric beds from St Matthew's Hospital in Hackney, the CHC had to resolve such a dilemma. The local view was unequivocal — "Save Bethnal Green!" — but the CHC had continually been pressing the need to improve hospital facilities for the district's elderly, more than half of whom were cared for outside the district boundaries. The CHC recognised the dilemma, agonised briefly, and decided not to oppose the change of use.

This had an interesting consequence. Representing the *interest* of the consumer involves the responsibility of making a judgement about that interest. When the issues are complex, a dialogue with the health professionals is essential if the choice is to be informed. Such a dialogue helped Tower Hamlets CHC decide about the interests of their consumers but because of it they were for a time isolated from the community while the local authority and the trades councils led the campaign to save the acute beds. Subsequently the CHC, its membership spiced by some new local authority nominees, reversed its decision, but this new opposition came too late to stop the change of use.

The conflict between the two roles is unavoidable — and healthy if it gives an edge to CHC debate. Merely to pass on the views of the consumer would be sterile and unimpressive, yet to make judgements about the interest of consumers without also reflecting local views would deprive CHCs of their legitimacy.

How have CHCs performed, despite the tension between these primary roles? The quality of CHC advice and comment has varied considerably. Some CHCs have produced reports of very high quality, while others have had a more general influence within the NHS planning process. It appears that CHCs have performed better in areas which have sound operational planning and therefore provide better information flows. On the other hand, local authority membership of CHCs has not, generally, produced the anticipated gains. Local councillors are busy people whose first priority is the job for which they were elected, and those who can give their time to health see AHA membership as more important than CHC membership. This problem will increase as the number of health authorities doubles.

One difficulty in assessing CHC performance is that the centralised nature of the NHS allows them minimal influence over decisions which have far-reaching effects on local services — for example, allocation of resources (RAWP), medical manpower planning, priorities for major capital schemes. More fundamental perhaps is the difficulty of actually measuring performance — but in the complex, multidimensional world of the NHS how many planning teams, management teams or medical committees would claim full responsibility for a particular achievement?

The picture is further clouded by our tendency to be coy about the precise impact of a CHC on a particular decision — although sometimes of course it is politically expedient to

allocate more credit than may be deserved. In my view, the real achievement of CHCs must be measured not by individual notches on the minute book, but by the general background influence exerted on planners, management teams, and administrators in the early stages of formulating policy.

Whether we like it or not the NHS is involved in politics, and the public wants to be informed about its decision making. It is also in the interests of the NHS that the public *are* genuinely informed. The NHS is professionalised and centralised and needs an effective counterbalance, free from organisational pressures. This could not be provided by district health authority members — even if they will be less remote than present AHA members — because their primary function will still be to make a judgement about the most effective use of resources, not simply to reflect local views. There are also more pragmatic reasons for retaining a separate consumer voice. The NHS must develop by changing what we do and how we do it — in the current economic climate this is the only way forward. Inevitably these changes must be undertaken in a public arena in which local (sometimes parochial) interests abound. Occasional conflict with the local community is probably unavoidable.

Without a CHC, some DHAs would at times have to deal with a number of activist or politically motivated groups simultaneously. In some areas uno[illegible] is would be set up, but without the responsibility to represent the range of community opinion. On the other hand, districts where there was *no* motivation for such unofficial groups might be exactly the ones where there was the most need for consumer representation.

CHCs can also be helpful in a ginger-group role. For instance the debate about the balance of resources between acute hospital medicine and the non-acute and community services can be difficult to conduct rationally in an environment where the vastly superior fire-power of the acute hospital specialists can be difficult to resist. CHCs can help by keeping the debate on the agenda.

The argument about £4m is irrelevant, and insulting to CHCs. This sum is only 0.5% of the NHS budget, and a lot less than even unimaginative companies spend on market research.

CHCs must stay, with their role of reflecting local views and representing the interest of the consumer — particularly those who cannot speak for themselves — reaffirmed. They must learn to cope with the tension between these roles, and become more politically adept at retaining public confidence when they make unpopular decisions. In relation to the consultation procedure they can be extremely disruptive and time-consuming, and most administrators feel the procedure should be streamlined, without necessarily removing CHCs' ability to involve ministers. CHCs have a public platform and access to the health authority, and they *need* no other powers. We should dispense once and for all with the "toothless watchdog" cliché. A watchdog needs no teeth; it should simply be about and make the right noise at the right time.

X-rays in cottage hospitals: a local low cost service

by Brian Sherlock, Secretary, Hereford CHC

Until 1 April 1979, anyone suffering a minor injury in the Hereford health district could obtain immediate X-ray examination at their nearest cottage hospital. This was of benefit to the patients in that their injuries were accurately assessed and treatment was given at once, and they and their relatives were spared the worry and uncertainty of a long wait to establish the seriousness of the injury.

All this was possible because for many years these X-rays of minor injuries to limbs had been carried out by nurses at the cottage hospitals. These nurses were fully trained at the radiography department of Hereford County Hospital under the supervision of the consultant. They were fully trained, too, in X-ray safety procedures and received regular refresher courses. Every X-ray was subsequently examined by the consultant.

This system worked to everyone's satisfaction. The public received an excellent service which was available near their homes, twenty-four hours a day and seven days a week. The workload at the central X-ray departments in Hereford was lessened. And the nurses in the cottage hospitals got a great deal of satisfaction from the work.

Two years ago, the practice of using nurses to take X-rays was questioned by the Society of Radiographers. The DHSS was persuaded that it contravened the Professions Supplementary to Medicine Act 1960. The AHA was instructed to cease employing nurses in this way, and after having stalled for almost two years, the AHA was reluctantly forced to withdraw a service which had operated so well.

To provide an emergency X-ray service at the cottage hospitals, the AHA had to employ one additional radiographer. The new service was based on a one-hour-a-day session, Monday to Friday, at two of the cottage hospitals (Leominster and Ross), with an on-call system from Hereford County Hospital to the remaining cottage hospitals when there was staff available, and only in normal working hours: 9am-5pm, Monday to Friday.

In consequence, people in Hereford health district have either to travel to Hereford County Hospital—journeys of up to 25 miles each way at expensive ambulance mileage rates or at their own expense. Or they may have to wait until the following day for their injury to be X-rayed. In time, no doubt, people will arrange their accidents to fit in with the X-ray sessions at the hospitals! Thus we have a very restricted service which costs the AHA about £20,000 more to provide, and what could we not do with that revenue today?

It must be said that the Hereford DMT and the AHA wished to continue the former system. The CHC mobilised public opinion to press for the retention of the service. Our MPs succeeded in obtaining an adjournment debate in the House of Commons. The GPs and hospital staff — including local radiographers — supported the CHC's efforts. The CHC met the then Minister of Health, Roland Moyle, and put the case to him that the regulations under the Professions Supplementary to Medicine Act, 1960, were not designed to meet the particular circumstances of rural sparsely populated districts such as Hereford. The Minister brushed aside this argument with a comment about obeying the law of the land.

The DHSS, in insisting that a valuable service to the public be withdrawn, seemed to be guided solely by their interpretation of the regulations under the Act. It is somewhat ironic that within three months of the introduction of the new restricted service, the solicitor to the West Midlands RHA was able to inform the DHSS that his interpretation of that Act was that while an unqualified person may not be employed as a radiographer, this was not an impediment to nurses using X-ray equipment. He further said, "If a person attending a hospital is not afforded X-ray facilities when they should have been afforded X-ray facilities, simply because there is no radiographer present, then the AHA will be liable in negligence for the failure to provide the service, not the radiographer."

The new arrangements have been in force for nine months. Monitoring by the DMT and the CHC has shown that it does work fairly well. However, the fact remains that a valuable around-the-clock service which had been available for many years, has been replaced by a very restricted service which is extremely costly both to the NHS and to the patients. Nurses are denied the additional satisfaction they obtained from operating the original service and sometimes patients have to wait for their injuries to be X-rayed. Perhaps the saddest thing about all this is that the DHSS forced the AHA to comply with a questionable interpretation of the regulations when the AHA had been prepared to listen to the wishes of the community as expressed through the CHC. If CHCs are to disappear, who will speak for the interests of the public on matters such as this?

FOCUS ON FARES

by Mary Smith, Secretary, Liverpool Central and Southern CHC

The cost of travelling to and from hospital for poorer patients and visitors should be paid by the National Health Service. This is the main recommendation of a report initiated and partly conducted by our CHC*.

Access to the NHS should be made as easy as possible. Most people are very willing to pay their own fares to hospital, even those who cannot afford the extra expense. Many people in financial hardship are not claiming fares, because they feel stigmatised by the present fares system.

This CHC's concern about the problems of reclaiming fares to hospital was shared by the Merseyside Child Poverty Action Group and the local branch of the British Association of Social Workers. The survey was a joint venture and we were fortunate to have two social work students doing placements. They carried out the survey, talking to patients and staff from eight local hospitals and to DHSS officers who had experience of dealing with claims for fares.

Our researchers contacted 22 local charities and five voluntary organisations to assess what contribution these groups could make to patients trying to reclaim fares to hospital. They found enormous variations in the use of voluntary organisations and charities and the amount of help these were able to offer.

Typical comments made by hospital staff on the advisability of publicising benefits were: "We'd be overwhelmed", and "It's not our job really". Patients' experiences and attitudes were typically: "I didn't know you could claim", "I'm just grateful for the treatment", and "Too much red tape and aggravation".

Even though the NHS has a responsibility to pay fares for patients it will only pay certain income groups, and our research showed that the method of application varies widely between hospitals. In the few hospitals which actually displayed information, this was found to be inaccurate and largely ignored the official guidance.

Claiming fares is not a simple matter of income, fare costs and eligibility. It is complicated by difficulties at home, lack of information, attitudes to claiming and problems such as finding the right office in the hospital. The current trend towards centralising services in one hospital and the development of regional specialties will cause hardship for more people.

There is no statutory help with fares for visitors to hospital. The DHSS may help if the applicant is on supplementary benefit. In

Community health workers for Hackney

by Helen Rosenthal, Vice-Chairwoman, and Fedelma Winkler, Secretary, City and Hackney CHC

City and Hackney CHC seems likely to get funding from the Hackney and Islington Inner-City Partnership for community health workers for two projects from April. One is a multi-ethnic health education project amongst non-English-speaking women, which has been proposed jointly by the CHC and Hackney Council for Racial Equality. The other is a community health project based on a new housing estate in Hackney. The two projects have been accepted for funding by the Inner-City Partnership, and are now awaiting approval by the Department of the Environment.

Multi-ethnic health education project. Hackney has the highest infant mortality rate in England and Wales, and is also one of the most racially mixed areas in the country. It has been estimated that the perinatal mortality rate amongst Hackney's Asian women is 30 per thousand — higher than that in many third world countries. Many women who come from rural areas and speak no English lead isolated and often poverty-stricken lives in the inner city. They and their children may have inadequate diets. They have great difficulty in using the health service and communicating with health workers. Even when children or husbands act as interpreters, women are inhibited from using the health service because of embarrassment.

The project will employ two community health workers who will be based at a community centre. They will set up and support groups and classes for Asian women, to help break down social isolation and to teach skills in both language and communication, and in health care. Time will also be spent teaching and advising individual families in their own homes, and in health service institutions, especially about nutrition and hygiene. This will involve close liaison with health visitors, GPs and child health services. The education of health workers in the NHS on the cross-cultural problems of non-English-speaking people will also be part of their work.

The community health workers will also be involved in developing translation and interpretation services in hospitals (especially maternity units), health centres and clinics. There is a great need both for assisting individuals in their dealings with health workers, and for designing written material in ethnic minority languages, and other visual aids on health matters. Interpreters and translators must be able to

act as advocates for non-English-speaking patients so that their rights are ensured. Through this work, the CHC and HCRE aim to improve the health and life chances of some of the most deprived and vulnerable women in Hackney.

Community health project. The community health project will employ initially one, and subsequently two, community workers, who will work to raise health issues with groups and individuals on a new Hackney housing estate. The aim of the project is to stimulate greater awareness of the meaning of health, and of how the causes of ill-health are rooted in society and the environment. The purpose is to encourage people in the community to play a more positive part in determining their own health, to make better use of the health services, and to engage more easily in dialogue with the CHC and health services to change and improve them to suit local needs.

The initiative for this project came from the concern of the CHC that its staff and resources did not permit the regular and sustained "grass-roots" community work felt to be needed around health issues in the community. "Look after yourself", urges the Health Education Council. In a deprived inner-city area with some of the worst health statistics in the country, this approach is ineffective. The community workers will develop collective ways of working to raise consciousness about health, through groups for isolated young mothers, pensioners, at schools, adult education centres and work-places.

The estate has a well-established tenants' association which has wanted to be involved from the outset. A new health centre on the edge of the estate has several sympathetic health workers. Other ideas for the project include exploring the possibility of setting up a patients' association and developing the health centre as a community resource.

An important feature of both projects is that they will employ lay workers, rather than health professionals. We hope that this will help to break down the barriers that exist between professionals and the community. People in the community can also be helped to realise that professional views of need may be at odds with those perceived by the community.

The projects will work closely together, and will be able to share resources. Both projects will additionally feed into the work of the CHC, which should then be better placed in its claim to speak for the community.

Photo: Raissa Page

TO HOSPITAL

general visitors have to rely on social workers applying to charities for help.

The DHSS staff are confused about the rules and regulations. And each hospital has a different approach to the problem. In some, social workers deal with fares and in others the job falls to the hospital administrator. Yet hospital social workers and administrators feel they are doing a job for the DHSS. Our joint report made the following suggestions with national implications:

1 The provision of transport and the reimbursement of travelling expenses for patients and visitors should be accepted as the responsibility of the NHS.

2 The procedure for claiming fares should be standardised between hospitals, with one person in each hospital responsible for dealing with claims.

3 Since the NHS recognises the principle that having visitors plays an important part in the recovery and well being of patients, the person appointed should deal not only with patients' claims, but should also help and advise visiting relatives and close firends. This applies to adults, not only children.

4 The present income level below which people are eligible for claiming should be raised and should be the same for patients and visitors.

5 There should be a fares office near the main entrance of the hospital.

6 Conspicuous, clear and accurate notices should be placed in all health buildings, GP surgeries, dental surgeries and opticians' and chemists' shops.

7 Claimants should have to produce the minimum of documentation before a claim is met.

8 The creation of regional specialist units increases the cost of patient travel. Some patients have to remain as in-patients during their treatment, because the journeys are too long. Free transport for patients to hospital from central pick-up points may result in both relief for patients and net savings for the NHS.

9 Patients attending regularly for a course of treatment, who would be entitled to ambulance transport but are encouraged to make their own travel arrangements, should not be financially penalised because of this.

The report includes a guide to claiming fares. It has been circulated to DHSS offices, hospitals, Citizens' Advice Bureaux and community groups on Merseyside, as well as to individuals who contact us for advice.

* *Fares to hospital: report of an investigation and guidelines to practice* £1 plus 26p postage, from Jacky Steeman, British Association of Social Workers, 16 Kent Street, Birmingham B5 6RD.

Parliament

Royal Commission debate

The House of Commons debate on the Royal Commission's report was very much a re-run of the well-known policies and views on the health service of the two main parties. Patrick Jenkin, Secretary of State for Social Services, reiterated the Government's plans for restructuring the NHS, and its conviction that more money for the service would have to wait until the economy recovered. The NHS simply could not attend to every ill, and the public had to be educated to limit its demands. Imposing realistic charges was one way of underlining the responsibility of individuals for their own health care.

Mr Jenkin warned that the more that was spent on pay, the less there was for services. But he admitted that the 0.5% growth allowed for the health service in 1980/81 was not enough to cope with the ageing population, keep up with medical advance, or maintain standards. It was therefore reasonable to develop voluntary effort and the private sector, and to explore, as the Government was doing, the possibility of a shift to greater reliance on insurance schemes, despite the Royal Commission's rejection of this option.

The Government also disagreed with the commission's call for an inquiry into London's health services (which Mr Jenkin called a recipe for delay), and for legislation on fluoridation of water (on which the Government wishes to proceed by persuasion). The DHSS had carried out a review of hospital policy and would issue a discussion document, which would stress the value of small, human-scale hospitals. On the question of CHCs, the Government's mind was genuinely open.

The Royal Commission's endorsement of the principle that the NHS should be free at the time of need and nationally financed was welcomed by both Labour and Liberal speakers. Stanley Orme said it was a Labour policy goal to phase out charges. Private practice was immoral, and an insurance system would create a further bureaucracy, and would discriminate against the old, the disabled, and the mentally ill and handicapped, who would be uninsurable. While giving a general welcome to the Government's plans for restructuring the NHS, he warned that democracy and local accountability would be diminished — and it was therefore ironic that CHCs should be under threat. The Opposition also criticised the Government for ignoring the Royal Commission's recommendations on reducing drug costs, abolishing FPCs, and improving primary care. Roland Moyle promised that the Government would be pressed for a debate on London (Hansard, 23 January, cols 454-579).

DHSS annual report

The DHSS has decided to discontinue preparation and publication of its annual report, in order to reduce the Department's workload and expenditure. Some of the material already prepared for the 1978 report may be made available in some other way (Laurie Pavitt MP, Brent South, 25 October).

School meals

Arrangements for monitoring the impact of the proposed alterations in the school meals system on the health of schoolchildren are being considered by the DHSS and the Department of Education and Science (Sir Brandon Rhys Williams MP, Kensington and Chelsea, 20 December).

Rubella

The DHSS intends to take no further action at this stage to identify women vaccinated by the faulty rubella vaccine supplied by Smith Kline and French.

Recall of the 91,197 doses of faulty vaccine is proceeding: 36,127 doses have been returned and 2830 are being returned. Doctors have been notified of the need to trace women vaccinated with the faulty vaccine, but will not be asked what action they have taken. Any possible question of compensation for a child born disabled as a result of the faulty vaccine would be for the courts to decide.

From 1 January to 12 August 1979, 291 terminations of pregnancy were carried out as a result of maternal rubella disease, 95 as a result of rubella contact, and 81 as a result of rubella immunisation. During the first 26 weeks of 1979, 1976 cases of rubella were reported in the UK and Republic of Ireland, compared with 529 cases for the same period in 1976, 342 in 1977, and 1924 in 1978 (Jack Ashley MP, Stoke on Trent, and Lewis Carter-Jones MP, Eccles, 20 December).

Fluoride in Europe

Five of the nine EEC countries at present permit artificial fluoridation of water supplies: Belgium, West Germany, Luxembourg, Republic of Ireland and the UK. The first three countries have not introduced it. Fluoridation was introduced in Holland but it had to cease because of a legal decision on a technicality, and not for any medical or dental reason. France, Denmark, and Italy do not permit fluoridation (David Stoddart MP, Swindon, and Ivan Laurence MP, Burton, 29 October and 9 November).

What is Huntington's chorea?

by Maureen Jones, Secretary, Association to Combat Huntington's Chorea

Huntington's chorea (HC) is an inherited, incurable disease passed on by either sex, which affects the patient both physically and mentally. About 6000 people have the disease in Britain today. Symptoms are subtle at first, but by the middle stages—after seven years or so—the patient can have pronounced jerky movements of the limbs and trunk, eating and talking can be difficult, and there may be mental and emotional difficulties. The disease generally begins in the late thirties or early forties, although it can start earlier or later.

HC can last between ten and twenty years, or more, and the presence of the illness in a family poses great strain on the caring spouse and the at-risk children of the family. The spouse has the problem of caring for a difficult patient for a long time, probably having seen an in-law deteriorate previously in the same way. The children watch their affected parent, and know that they have a one-in-two chance of "ending up like dad".

It can be a demoralising experience even for those children who will not eventually develop the disease. At present, there is no accurate test available to determine who will and who will not develop the disease in the future. It is just a case of wait and see—and of hoping that research in the meantime will find out more about the basic error in the brain that is thought to cause the disease. It is hoped that eventually a drug will be found to control the symptoms successfully, and although some drugs are already in use the ideal controlling drug has yet to be found.

Because of the many problems associated with the disease, the HC family needs a great deal of help from health professionals—family doctors, social workers, health visitors, hospital personnel etc. It is essential that these professionals are fully aware of the problems and symptoms of the disease, and of the best treatment known so far. This is where the Association to Combat HC can help— it can provide information booklets and leaflets, and its twice-yearly newsletter gives details of current research throughout the world. News of this research is important to HC families, who are accustomed to thinking that theirs is an extremely rare disease. To help both families and health professionals, the association recently appointed a full-time social worker to improve the welfare of patients and families.

A holiday home in Epping Forest, North London, was opened last summer to take HC patients, with or without their spouses, for a few weeks' break. Last year this home—the first of its kind in the world—helped to relieve the strain for over fifty HC families. And the home is not just an immediate service to families—specialised knowledge on how to care for HC patients is being gained there, and it is expected that this knowledge will help other HC patients and their families in the future.

For further details contact the Association to Combat Huntington's Chorea, at Lyndhurst, Lower Hampton Road, Sunbury on Thames, Middlesex, TW16 5PR. Tel: 01-979 5055 and 01-941 4523.

Scanner

Health and Safety

Farm accident figures are still "disappointing" says the Health and Safety Executive.

According to a report*, 105 people died from injury or occupational disease in agriculture in 1977.

Overturning tractors are still the greatest single cause of death.

• *Health and safety: agriculture 1977 (HMSO, £1.25).*

The medical branch of the Health and Safety Executive is the Employment Medical Advisory Service (EMAS), which gives advice about occupational health. In its report* for 1977-78, the agency expresses concern about health hazards such as lead, asbestos and asbestos substitutes, as well as hazards to laboratory workers.

• *Health and Safety: Employment Medical Advisory Service report 1977-78, (HMSO, £1).*

Jay report gets a warm welcome

The Campaign for the Mentally Handicapped has called the Jay committee report on mental handicap nursing a "fine, constructive report". The report described its objectives as "unashamedly idealistic" but CMH says that Jay's model of nursing care is a "highly realistic one, already tried and tested in Scandinavia and parts of the United States". *CMH responds to Jay* (30p plus 20p post) from CMH, 96 Portland Place, London W1N 4EX.

Restricted growth

The layman's guide to restricted growth describes why some people are very short. Not all growth disorders are inherited and it is important to diagnose what type of disorder is causing restricted growth. The leaflet costs 25p from Pamela Rutt, Association for Research into Restricted Growth, 24 Pinchfield, Maple Cross, Rickmansworth, Herts. The Association provides a medical advisory service.

New magazine for voluntary organisations

A new magazine about voluntary organisations has been launched by the National Council for Social Service. The attractive-looking first issue of *Voluntary action* (December 1979) contains articles about job creation, reclaiming urban wasteland, the "boat people", and Family Network, the phone-in service run by the National Children's Home. There is also an article about strikes, volunteers and trade unions by Ian Bradley. The magazine will be quarterly at first, costing £3 for a year's subscription or 75p for a single copy. Money to *Voluntary action*, 26 Bedford Square, London WC1B 3HU.

Health Education Council's new recruit

Is Superman, the cartoon character, who appears on the HEC's latest anti-smoking poster. The poster is aimed at children, who are invited to send for a copy. Requests to HEC Superman offer, PO Box 1, Sudbury, Suffolk C010 6SL. The offer closes on 30 April.

1980 disability benefits

The Disability Alliance's fourth handbook of rights has been published. It gives details of how to claim a wide range of benefits and services for which handicapped people may be eligible. New chapters include "How to use your CHC", "How to complain to the Ombudsman", and "Living in residential accommodation". *Disability Rights handbook for 1980* from Disability Alliance, 1 Cambridge Terrace, London NW1 4JL. (£1 including post, with special rates for voluntary organisations concerned with disabled people.)

Welfare benefits handbook

Child Poverty Action Group has published the ninth edition of its 120-page *National welfare benefits handbook*. This has a blue cover and is based on the November 1979 benefit uprating. It gives detailed information on basic supplementary benefit, and additions such as clothing and extra heating allowances.

Housing benefits, education benefits, family income supplement, and benefits for the disabled are also explained in plain language. The handbook gives guidance on how to claim and how to take claims to appeal. From CPAG, 1 Macklin Street, London WC2 (£1 including post).

Directory of CHCs: Changes

An updated version of the Directory of CHCs was last published in October 1978, and each CHC was sent a copy. This version is now out of print. Work on a 1980 version is now in progress, and an announcement will be published in *CHC NEWS* as soon as this is available. Meanwhile changes to the 1978 directory will continue to be published each month on this page. Please notify us of any alterations in address, telephone number, chairman or secretary.

Page 4: North West Leicestershire CHC Secretary: Zigurds Smits

Page 6: Harrow CHC 2nd Floor, Equitable House, Lyon Road, Harrow HA1 2EH. Chairman: Miss Olive Hawker; Secretary: Miss Ursula Walker. Tel: 01-863 6432.

Page 8: South Camden CHC Tel: 01-388 6789/0

Page 10: Guy's CHC Chairman: Cllr Mrs Coral Newell

Page 11: West Surrey and N E Hants CHC Chairman: H L Snowden

Page 13: Oxford CHC Chairman: Mrs Elizabeth Leyland

Page 14: North Devon CHC Secretary: Mrs Linda Stapleton

Page 15: South Birmingham CHC, 60 Northfield Road, Cotteridge, Birmingham B30. Tel: 021-459 8090

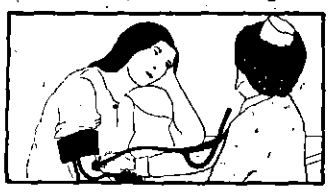
Page 16: Dudley CHC Chairman: Reverend E R Smart

Page 16: Macclesfield CHC, 19 Castle Street, Macclesfield SK11 6AF.

Page 22: Wessex Group of Chairmen of CHCs Chairman John Baker.

Mother tongue

For mothers with little or no knowledge of English, having a baby in a maternity ward in Britain is a doubly anxious occasion. Now the Commission for Racial Equality has produced a kit which aims to fill the gap in understanding between staff and non-English-



Drawing: Jan Farrell

speaking patients. It aims to teach some antenatal background as well as an outline of what to expect in hospital. It includes pictures and diagrams and could be used by any leader of antenatal classes.

Ante-natal language teaching kit *by Judith Nesbit, (£1 including post) from CRE Elliot House, 10/12 Allington Street, London SW1E 5EH.*

Child poverty

Is seriously underestimated and the cost of a child is far greater than is officially recognised in benefits and taxes, according to a recent pamphlet published by the Child Poverty Action Group. The author, David Piachaud, assessed the cost of providing a child aged two, five, eight and eleven with food, clothing and other basic requirements. His estimates substantially exceed supplementary benefit rates for children. *The cost of a child* 50p from CPAG, Street, London WC2.

Defective product liability

Laws on liability for defective products such as medicines come one step closer with the publication of a draft EEC directive. This will be discussed by a working party of all member states, and according to the DHSS Medicines Division, "there is no prospect of an early decision". A copy of the draft directive was sent to ACHCEW and to other bodies invited to comment on the DHSS' earlier consultative document (see page 3 *CHC NEWS* September 1979). *Draft EEC directive on liability for defective products*, Official Journal of the European Community No C271, 26 October 1979.

News from CHCs

☐ Humberside AHA has always allowed the official CHC observers to attend the "closed" committee sessions of the authority's meetings. Now the AHA has further demonstrated its trust in the CHCs' respect for confidentiality by allowing the secretaries of the four councils **Hull, Beverley, Grimsby** and **Scunthorpe**, who attend as members of the public, to stay for the closed sessions too.

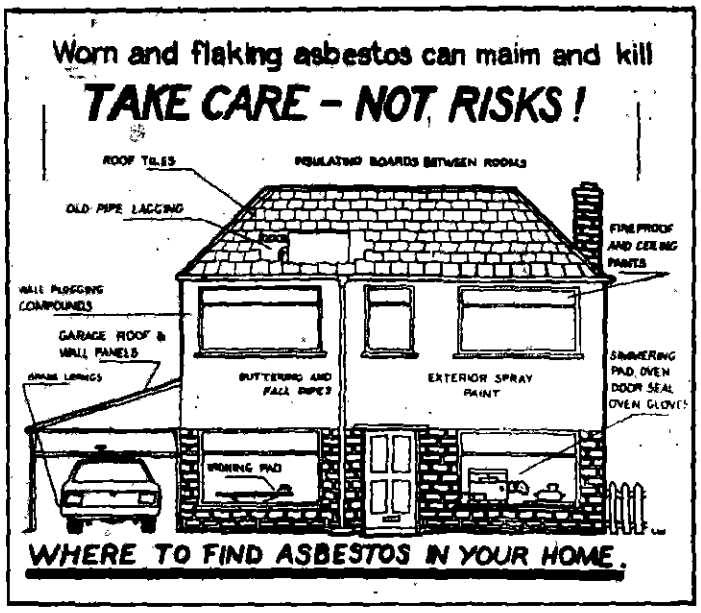
☐ Trent RHA has reversed its decision to receive a delegation from **South Lincolnshire CHC**, which wanted to discuss the district's underfunding. But the RHA chairman and some members agreed to meet both Lincolnshire CHCs to hear their views on disparity of funding between regions, areas and districts.

☐ A showcase report giving details of what CHCs in the SE Thames region see as their major "success stories" is being compiled by Sue Thorne, secretary of **St Thomas's CHC**. A copy is being sent to every CHC, with the aim of encouraging CHCs in other regions to repeat the exercise.

☐ In Birmingham the Family Practitioner Committee has condemned the practice of GPs charging for treatment which should have been provided free under the NHS. Allegations of such behaviour are extremely serious, says the FPC, in a statement to the press issued following **Central Birmingham CHC**'s exposé of charges for home visits to Asian patients. The FPC suggests that if a GP wants to charge for a service, patients should ask what the likely fee will be and get a receipt when payment is made. The CHC has issued a statement regretting that the FPC will not allow the full account of its deliberations to be published, particularly since "much of the discussion does them great credit". The CHC is pressing the FPC for further action — including multi-language posters about charges in GPs' waiting rooms and better liaison with the city's Asian communities.

☐ People in the **Worcester** health district could soon be discovering their CHC on the doorstep with their morning "pinta". The CHC is negotiating with the local Co-op for a joint leaflet, which would be delivered by Co-op milkmen to as many as 50,000 homes. The Co-op would pay half the printing costs and distribute free. The whole campaign would cost around £100 — far cheaper than a postal mailing shot.

☐ The three **Manchester CHCs** have set up a Well Woman Information Exchange. People on its mailing list will receive details of books and articles on women's health needs, reference documents, and news of CHC involvement in local well women campaigns. The CHCs' joint working party has held a public meeting attended by over 120 women, is planning a second such meeting, is surveying local women's experiences of existing facilities, and plans to present "comprehensive guidelines" to the AHA on well women services.



☐ *Flaking asbestos in your home can be deadly. This is the message of posters distributed throughout the London Borough of Barking by the CHC, following meetings with Nancy Tait of the Society for Protection against Asbestosis and Industrial Diseases, and with local MP Jo Richardson. Several thousand leaflets about asbestos were distributed in clinics and hospitals, and at the town show.*

☐ A formula for allocating CHC budgets under various expenditure heads has been agreed between the West Midlands RHA and a sub-committee of CHC secretaries appointed by their regional association. Each CHC is to receive an amount to cover the actual cost of staff in post, a fixed sum for information gathering and general expenses, a variable sum on top of this, pro rata to district population, representing need, and a sum to cover accommodation equalling the cost of the most expensive CHC offices in the region. Contingency reserves are held by the RHA. A letter to the 22 CHCs in the region from the regional treasurer points out that the accommodation element allows CHCs the choice between expensive offices and less ideal facilities, thus freeing money for activities that are given a higher priority. CHCs moving from cheap to expensive offices must find the money by reducing expenditure.

☐ In **Waltham Forest** the CHC and the Community Relations Council have formed a joint committee, which meets every six weeks to consider the special health needs of ethnic minorities in this part of NE London. The need for such a committee had become particularly apparent to members of the CHC's "0-18" sub-committee.

☐ Following the resignation of its secretary Drew Kimber, **Sunderland CHC** has decided to carry on with no full-time secretary until the summer. The CHC advertised the post twice, but was disappointed with the local knowledge of applicants. Finally it agreed with region that since it can take new secretaries six months to "find their feet", it would be better to wait for the Government's decision on CHCs before appointing.

☐ **Leeds Western CHC** has asked its AHA to appoint a salaried GP, to remedy inadequate medical cover in the city's three large hostels for the homeless. Reviewing its tenacious hostels campaign, which began in May 1977, the CHC concludes that no real improvements have yet been made. In two of the hostels, 63% and 73% respectively of the residents are not registered with a GP. Many are over 80, and some are chronically ill. The CHC's report recommends that the FPC should "immediately" arrange on-premises GP surgeries with nursing and social services support.

☐ In its reply to **West Dorset CHC**'s latest annual report, Dorset AHA records it gratitude to the CHC for providing a "valuable link between the AHA and the general public", and for contributing to a "cordial relationship". **Solihull CHC** receives similar pats on the back from its AHA, for the way it publicised problems with anaesthetic cover at a maternity hospital. In contrast, **West Birmingham CHC** is asking its RHA to "consider in necessary depth the question of the adequacy of future responses from Birmingham AHA". The CHC notes that its 1977/78 report dealt with over 40 topics, whereas the AHA's reply dealt with only seven and took eight months to appear.

☐ If you want NHS dental work you must begin by completing the first part of form FP17 — but that is no guarantee that you'll get what you want. **North Camden CHC** has uncovered this bizarre state of affairs following an appeal to the DHSS against its FPC's dismissal of a dental complaint. In a decision taken without an oral hearing, the Secretary of State ruled that even when FP17 has been completed it is still "for the dentist himself to decide" whether the work will be done on the NHS, and that patients must still "ensure" that their dentist has accepted them for NHS treatment. This is in line with the warning published in *Your teeth and the NHS* (DHSS leaflet NHS4). The complainant still maintains that she *did* raise the matter with her dentist, and the CHC is taking the matter up with the General Dental Council.