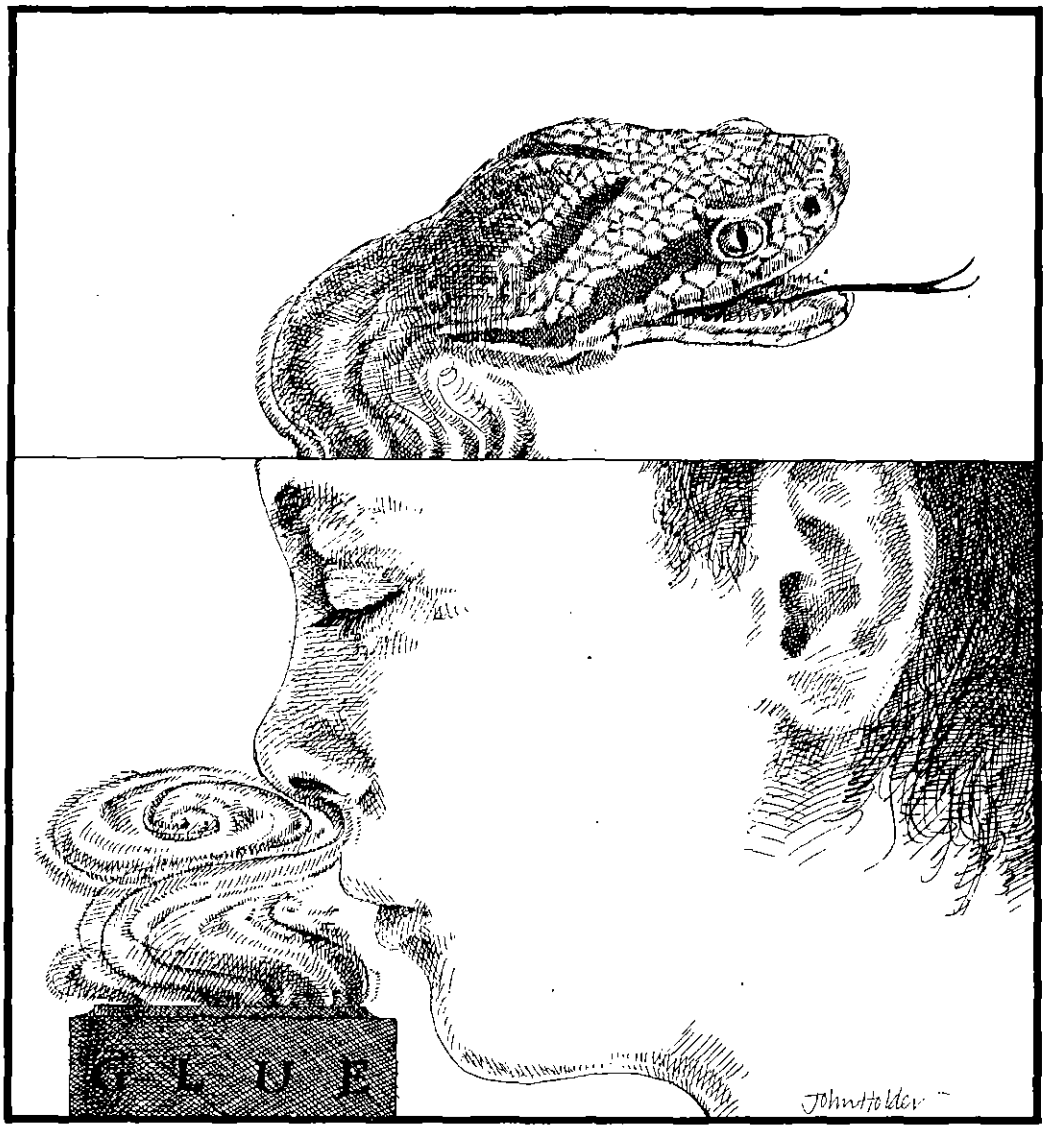
CHC NEWS

for Community Health Councils
April 1978 number 30



Credit: John Holder

Fume sniffing

Judith Stone and Felicity Taylor

YOUNG PEOPLE sniff the fumes from many products in order to get the thrill, the 'high', the feeling of intoxication it gives them. The very word intoxication originally meant 'the state of being poisoned', which sounds very unpleasant; but it has come to mean 'elation beyond the bounds of sobriety', which sounds very pleasant.

The effect is produced by inhaling fumes from a wide variety of products containing solvents or anaesthetic gases and the propellants in aerosols. Glue has had so much publicity that the term *glue sniffing* is used to cover any kind of fume sniffing, but the list of products which can be abused in this way includes many other things to be found in any kitchen cupboard. In this article, we have not named any of the products so as to avoid spreading awareness of such solvents to more young people. If a CHC wants more details, contact the Institute for the Study of Drug Dependence (address below).

Effects

Most of those who sniff fumes will suffer no permanent ill effects. The medical evidence suggests that fume sniffing is not addictive in the sense of leading to a *physical* dependence. However, when anyone goes in for fume sniffing over long periods of time, they are likely to develop a tolerance for the substance and a need to inhale greater quantities to get the same effect. It is certainly as possible for emotionally vulnerable young people to become *psychologically* dependent on fume sniffing as on any other form of escapism.

Some chemicals, however, can cause irreversible damage to organs such as the liver if they are sniffed in high concentrations long term. One chemical sometimes involved is related to thalidomide and can have similar effects on the foetus. There is rarely any way of knowing from the package whether these more dangerous chemicals are present, even if the young people understood the implications. While a less pure chemical may not make any difference to the proper use of a commercial product, it may make a relatively safe product lethal if it is abused by sniffing.

The significant difference between fume sniffing and other forms of intoxicants, such as alcohol, is the speed and unpredictability of the reaction to it. Getting drunk is a fairly slow process and it is usually possible for anyone to decide to stop drinking before

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CHC NEWS

April 1978 **number 30**

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Letters

Charging for sick notes

With reference to the item in February's *News from CHCs* section, the Joint Committee of Birmingham CHCs may be interested to know about a current survey of patient opinion in factories on South Tyneside. In one factory alone, 37 out of 199 workers spoken to referred to high charges made for 'private' sick notes required by their employers. Prices varied from 20p to 65p.

A sick note was required for all absences, including under three days and a visit to the doctor's surgery.

Those wives paying a small stamp had to pay for all periods of ill health and where this extended to, say, three weeks, they had to pay for three sick notes, one for each week. They also said that the doctors often wrote the sick notes without a medical examination.

Dilys Palmer
Secretary, S Tyneside CHC

Induction

In *A time to be born* (*CHC NEWS 27*), you use the terms 'medical convenience' and 'administrative convenience' as if you did not think it was a good thing for babies to be delivered 'when there is a wide-awake, full medical team at hand'. If the NHS was funded so that there were enough doctors available for full teams to be on duty day and night on a shift system and for there to be the same number of nurses and midwives on duty throughout the 24 hours, things could be different and I could accept your criticisms.

I have been on call for over 100 hours a week for many weeks on end when I was a junior doctor some years ago. I know how difficult it can be to think logically and carry out complicated procedures when one is not wide awake.

Dr L. M. Mayer-Jones
District community physician, Durham health district

Councillors on CHCs

With reference to John Hunter's letter about CHC membership (*CHC NEWS 26*), it is true that in 1973 CHC members on the whole did not realise the amount of time and work that would be involved. Certainly, some local authority members found this was more than they could cope with. After the initial weeding out, however, local authorities in this area now make it quite clear when appointing their representatives that CHC membership is not a sinecure, and the local authority members on my CHC really work very hard.

Cllr Mrs C. Bullen
Vice-chairman, Barnet and Finchley CHC

CHC national publicity

At a recent meeting of the Manchester CHCs' publicity sub-committee, it was proposed that the National Association asks every CHC in the country to transfer its publicity budget for one year for the use of ACHCEW.

We feel that until a properly co-ordinated *national* publicity campaign is mounted, money being spent locally is merely scratching the surface of public awareness and could be better spent at the present time. A national publicity budget, possibly approaching £200,000, would have a good chance of building a foundation through the national media; a foundation which local publicity initiatives could then supplement.

R. A. Faulkner
Secretary, Manchester Central CHC

Emergency dental scheme

We were interested to read Gil Gray's letter on emergency dental treatment (*CHC NEWS 27*). A scheme was set up in Southend health district about a year ago by a group of local dental practitioners to assess the need and viability of an emergency dental scheme.

The results suggested there was a genuine need for this service, but as the Area Health Authority was unable to sponsor the scheme, the dental practitioners themselves initiated it and have been providing the service privately from 10 am to noon on Sundays and bank holidays. In the year July 1976-77, there were 707 enquiries and 54 manned sessions, with an average of eight patients attending for treatment at each session. The average charge to patients has been £3.50, although some have received their treatment within the NHS arrangements.

We are currently pressing the AHA to accept responsibility for this scheme as the practitioners cannot continue indefinitely with the present arrangement.

We should be happy to send a full report of the scheme to any interested readers.

Mrs M. A. Hart
Secretary, Southend CHC

Maternity survey

Our CHC has been so encouraged by the outcome of a survey conducted by its Maternity and child welfare committee that we felt other CHCs might be interested in our experience.

Because of earlier criticisms by parents, a questionnaire was compiled by the committee and agreed by the relevant staff at the Edgware general hospital. It was handed out to 300 mothers who had just given birth in the maternity unit. Over 200 questionnaires were completed.

Our object was to find out the mothers' opinion of the service given — defects, good points and suggestions for improvement. The results showed *(a)* general satisfaction with the standard of medical care — although it was clear that many mothers did not understand the difference between the induction of labour and the procedures hastening labour which had started naturally; *(b)* the need to improve advice for first-time mothers, family planning counselling, advice given by nurses (which often differed), and visiting times; *(c)* considerable dissatisfaction with laundry, food and cleaning.

The report was sent to the hospital staff concerned, and, as a result, a consultant obstetrician/gynaecologist, the divisional nursing officer (maternity) and the sector administrator joined us for a very valuable meeting. All the points raised by the survey were fully discussed. It was obvious that the hospital representatives had given considerable thought to its findings, and had swiftly tried to make improvements.

I have spoken with several mothers who have had babies in the Edgware hospital since. There have been no more complaints about laundry, food or cleaning. In fact, the mothers were all very happy with their stay in the hospital.

Mrs Evelyn Brand
Chairman, Maternity and Child Welfare Committee, Edgware/Hendon CHC

Fume sniffing

Continued from page 1

they lose control altogether. A bad reaction to fume sniffing can be sudden, unexpected and severe enough to be fatal. There are incidental hazards from the rapid onset of unconsciousness, such as a bad knock on the head in falling or asphyxiation. Bizarre and dangerous behaviour, such as climbing walls or jumping from windows, is often associated with fume sniffing.

The main danger is that the central nervous system becomes highly sensitised or over-stimulated to a degree that can put the heart at risk. It is for this reason that the Chairman of the Technical and Regulations Committee of the British Aerosol Manufacturers' Association told us: 'The only answer to "How much can be accepted safely?" is *zero*. Anything more is not worth the risk at any time.'

Dr Joyce Watson, Senior Registrar in Community Medicine in Glasgow, has made a special study of this problem. She estimated that in 18 months over 1975 and 1976, at least 15 young people in England and Scotland died as a direct result of fume sniffing. Reviewing all the known evidence, Dr Watson reached the conclusion that 'in most cases sniffing is a sporadic or occasional activity which attracts youngsters in the age group eight to 17 years. After their curiosity and that of their friends is satisfied the normal growing-up process takes place and the glue sniffing which is generally regarded as kid's stuff is forgotten'.

Attempts at protection

What is being done, officially or unofficially, to protect children from harming themselves by fume sniffing? While children are prevented by law from buying cigarettes, alcohol and fireworks, it is not illegal to sell the products involved in fume sniffing, nor is sniffing them a crime.

Last February, an MP asked the Secretary of State for Prices and Consumer Protection if he would bring in legislation to ban the sale of glue to young people in view of its proven misuse. The Minister's reply was that 'a wide range of products can be used for sniffing which are not harmful in normal use and I do not consider that it would be either practicable or justifiable to prohibit their sale to young persons'.

In America, an attempt has been made to control fume sniffing by restricting the sale of the products involved. In some states, children cannot buy glue in small size packages; in others it is not available unless the child has written permission from his parents. While this has had some effect on *glue* sniffing, the children switched to some of the other products which are still readily available at a very low cost.

The intractable problem is the extraordinary variety of products which can be potentially misused in this way. Should there, for example, be a total ban on the use of aerosol packaging, which many manufacturers and users find convenient? Should do-it-yourself experts have to use less efficient, less easily managed and more expensive adhesives because some people misuse these products?

It has been suggested that additives which cause nausea should be put into products to make sniffing unpalatable. The Department of Prices and Consumer Protection considered the feasibility of a deterrent that would be safe to normal users and would not detract significantly from the effectiveness of the product. But according to advice from the Chemical Defence Establishment, a research programme to identify just one additive (and probably several would be required) would be very costly, without any guarantee of success. Further, it is always possible that an additive might be more damaging than the original substance. In any case, it would be unreasonable to make household products, which are in constant use, so unpleasant for the normal user.

The two major manufacturers' associations are very concerned with this problem. Although considerable research has been done to find substitute solvents and propellants which would not have the appeal of sniffing, the British Aerosol Manufacturers' Association feels that no 'safe' product could be formulated because deliberately inhaling concentrations of any substance whatever other than air is itself inherently unsafe.

The British Adhesive Manufacturers' Association expressed its views on fume sniffing in a recent comment. We quote from the first paragraph:

'All constituent members take great care to use specially pure grades of solvent thus reducing toxic impurities to a negligible amount. In general, where a safe water based adhesive can be formulated for a specific task, then solvent based adhesives have been withdrawn. The basic problem is that many sticking jobs around the house and workshop can only be done effectively by general purpose solvent based adhesives. Strenuous research programmes continue in an attempt to find a safe substitute.'

Another idea is for products to carry a 'government health warning'. The DPCP consulted the Health Education Council and took account of the views of local drug liaison committees who had reported to the Home Office on this. Their view was that any advantage from warnings about misuse would be more than outweighed by the undesirable side-effect of making it very easy for young people to identify which products were most likely to give them the 'high' they are looking for.

The same fears extend to the idea of publicity on the lines of road safety or anti-smoking campaigns. All the official agencies, manufacturers' associations and voluntary bodies are agreed that propaganda of the shock-horror kind is dangerous. For those young people who are already antagonistic towards society and the adult world, activities officially labelled anti-social appear distinctly attractive.

More factual and informative education programmes are not necessarily any more successful. There is always controversy about the value of education programmes on sensitive subjects, whether sex and contraception, drugs or smoking. A strong body of opinion believes that they do more harm than good, unless very carefully devised and handled; for example, they may encourage experiments that people might not otherwise have thought of.

Long term work

This is a rather depressing catalogue of potential solutions that have to be rejected. Solutions that *could* work are undramatic, piecemeal and long term.

Police have difficulty in dealing with fume sniffing because it is not in itself illegal — although the behaviour resulting from it may be a breach of the peace. However, in some areas where sniffing is prevalent, police patrols have dispersed groups of young people indulging in it and have returned children to their homes with a warning to parents about the dangers.

There may be some simple practical steps which could be taken in a single neighbourhood when an epidemic of fume sniffing has broken out locally. For example, it could be helpful to persuade local shops to put appropriate products which are suspiciously popular under the counter.

Specific information, counselling and education programmes directed informally to very small groups of young people in areas where the problem already exists and to their parents, teachers and social workers may also be effective in tackling local outbreaks without spreading them further. The object would not be to present anti-drug propaganda, but to help young people to take responsible and rational decisions about their own lives and learn to withstand the pressure to follow the crowd.

In conclusion, it is as well to say that none of this will sound very convincing to anyone who, for example, faces a future of unemployment in a Glasgow slum. In the end, it is always the same underlying problems which really need solving: housing, employment, money.

Judith Stone and Felicity Taylor write frequently on aspects of education, health and children. They are the authors of the Arrow paperback A handbook for parents with a handicapped child.

where to find out more

☐ **Institute for the Study of Drug Dependence** Kingsbury House, 3 Blackburn Road, London NW6 1XA (01-328 5541) runs a library and information service. *The Institute can supply a Bibliography on solvent use* and will be pleased to help CHCs wanting to pursue this issue further.

☐ **British Adhesive Manufacturers' Association** 20 Pylewell Road, Hythe, Southampton SO4 6YW (0703 842765)

☐ **British Aerosol Manufacturers' Association** Alembic House, 53 Albert Embankment, London SE1 7TU (01-582 1115)

☐ **St Helens and Knowsley CHC** has produced a useful report *Solvent abuse*. Contact A. N. Richards, 71 Corporation Street, St Helens, Merseyside WA10 1SX (0744 55018)

☐ **Tripping off the shelf** by Gavin Weightman (New Society, 23 October 1975)

☐ **The growing problem of glue sniffing** by Dr Joyce Watson (Social Work Today, 19 October 1976)

News from CHCs

❑ Yawning gaps in the provision of NHS dental services in **West Roding** have been revealed by a CHC telephone survey. Of the 49 dentists in the east London district, nine were accepting no new NHS patients, 23 were not providing NHS crowns and 23 were not providing NHS dentures. The CHC has reported this situation to its FPC, the DHSS and local MPs.

❑ Advice from a Local Dental Committee that dentists should do less NHS work has been condemned as 'utterly selfish' by a member of **Winchester and Central Hampshire CHC.** The Hampshire LDC argued that dentists should switch partly to private work to maintain their incomes. But Mrs Elizabeth Cloyne, who is also chairman of Winchester Labour Party, sees no reason why dentists should be exempt from income restraint. She hopes anyone refused NHS treatment will complain to their CHC.

❑ A community bus project is to get a one-year trial in the **Worksop and Retford** health district, backed by £12,000 from Nottinghamshire County Council. The scheme stems from a CHC survey which revealed severe transport difficulties for rural patients. The timetable of the bus will be geared to the needs of patients visiting GPs' surgeries, clinics and health centres. The special vehicle can carry 21 people and two wheelchairs, which are loaded using a side lift.

❑ **West Birmingham CHC** has written to all members of its AHA, proposing an alternative strategy which would avoid any need to close Birmingham hospitals for financial reasons. The CHC claims that £700,000 a year could be saved throughout the area by more economical use of drugs and dressings, based on new procedures in the West Birmingham district which are already saving £200,000 a year. Further savings could be made by reducing 'unnecessary use of investigative procedures'.

❑ The campaign against the closure of Seaham Hall chest hospital — backed by **Sunderland and Durham CHCs** — is continuing at full steam, despite an RHA

Credit: Northern Echo

thumbs-down. The Seaham Hall Action Committee has mass support in its tightly-knit coastal mining community, and from a town of 12,000 households has forwarded 7,000 separate letters of protest to David Ennals. The CHCs' joint plan accepts that chest treatment will cease at the hospital, but proposes alternative uses for long-stay and convalescent care.

Sunderland CHC secretary, Drew Kimber, commented: 'The whole community has galvanised itself into action. We've given them the weapons, and they're merrily firing the bullets'.

❑ The West Midlands RHA is asking Birmingham AHA to set up two new NHS abortion units, with financial support from the region. The RHA is also setting up a pilot scheme to train health education and pregnancy counselling workers. In 1975, 78 per cent of legal abortions in the region were carried out in non-NHS premises, and the RHA's decision follows pressure from the **West Midlands Regional Association of CHCs.**

❑ Visits by CHC members to hospitals in Aberystwyth have revealed that the last meal of the day is served at 5.30 pm, leaving a gap of over 14 hours during which patients must manage on hot drinks only. **Ceredigion CHC** has asked its district administration to look into the staffing problems and come up with proposals for better-spaced meals.

❑ **Tower Hamlets CHC,** in London, has found itself at the centre of an argument over proposed changes of use at a local hospital. The Keep Bethnal Green Hospital Open campaign has criticised the CHC for refusing to hold a public meeting to discuss the proposals. The CHC argued that if it did this the public would see it as a 'mouthpiece for the AHA'. It asked the AHA to hold its own meeting, or at least to provide the speakers, but the AHA maintained it was the CHC's responsibility to inform the public.

❑ **St Helens and Knowsley CHC** has sent David Ennals a report on the trial dental emergency service being run at Whiston hospital on bank holiday mornings. Twelve emergency sessions attracted an average 11 patients each, and 93 of the 105 cases were accepted as genuine emergencies. The CHC asks that the sessional payment for dentists doing this work be reviewed, to give a 'fair and equitable rate'.

❑ This cartoon, in **South Hammersmith CHC's** latest annual report, has upset local health service trade unionists. They feel it implies that staff are only courteous to patients because the CHC exists. Meanwhile **Kidderminster CHC** members are being issued with special identity cards, to allow them to make less formal checks on local hospital conditions 'at all reasonable times'.

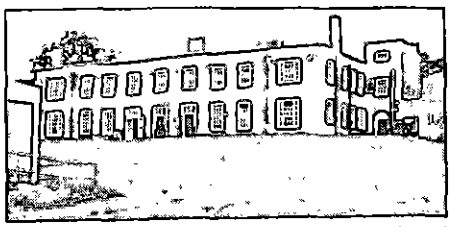
❑ **Crewe CHC** has published *I like my doctor but . . .* (50p inc post), which surveys GP, dentist and pharmacist services, general hospital services, community services and preventive medicine. Public concern centred around GP appointment systems and receptionists, access to services, and privacy in hospitals and GPs' surgeries. *Living in hospital,* from **East Roding,** reports a survey of a multiple sclerosis ward in Chadwell Health hospital, and shows a need for a coordinator to help patients develop the 'intellectual, spiritual, aesthetic, recreational, sexual and work' parts of their lives. **Leeds Western** has published *Wharfedale general hospital: outpatient survey,* which found high levels of satisfaction at ten outpatient clinics, but some problems with lengths of time spent waiting for doctors and ambulances. *Survey of National Health Services within the city of* **Plymouth** shows a low level of public awareness of community nursing and chiropody services.

❑ **Islington CHC** has issued a six-page *Counterproposal on the transfer of neurosurgery,* as the latest stage of its fight to get neurosurgery facilities returned to the Whittington hospital. They were moved temporarily to the Royal Free hospital two years ago following an equipment breakdown, but the RHA now wants to make the transfer permanent. Islington sees this as 'an attempt to subvert the democratic planning processes and to distort the area's priorities'. **North Camden CHC,** which is responsible for the Royal Free, is supporting Islington's stand.

❑ A pilot 'hospital-at-home' scheme, to provide care at home for people suffering from illnesses such as cancers, strokes, heart conditions, fractures, multiple sclerosis and terminal illness, is described in issue two of **Kensington, Chelsea and Westminster South's** *CHC newsletter.* The CHC has printed 75,000 copies and is sending them to every household in its district, sharing distribution costs with a borough newspaper.

The NDT goes public

Gavin Weightman



Tatchbury Mount Hospital (Southern Newspapers Ltd)

SINCE IT was set up in 1975, the National Development Team for the Mentally Handicapped has produced about 70 reports. Until February this year, none of these investigations into health and social service provision for the mentally handicapped in various parts of the country had been published.

But on 9 February, Wessex RHA made public the report it had asked the Team to make on services in Hampshire. This was one of the Team's more wide-ranging investigations, which took about two weeks to research: others have been only half-day visits.

Wessex was under a great deal of pressure to publish, from Southampton and South West Hampshire CHC which had called a public meeting in July 1977, as well as from the local and national press. Mr Kingsley Williams, the RHA chairman, acknowledged this at a press conference on publication day. Nevertheless, the region's attitude is commendable, particularly as the Development Team saw fit to criticise Wessex policy.

In one sense, the decision to call in the Team and to publish its report backfired on Wessex. The investigation was sparked off by the conviction for assault of a nurse from the Tatchbury Mount hospital in Southampton just over a year ago. What the CHC wanted was an investigation into the goings-on there which had been the subject of complaints over a long period.

There had been a report by the Hospital Advisory Service as long ago as 1971. But this was not published, and nothing was done. When Wessex, along with Hampshire AHA and the county social services, invited the Development Team in, they asked them to look not only at Tatchbury Mount but at the whole of Hampshire services. They were being tactful, and trying to take a positive stance. One of the functions of the Team is supposed to be to encourage 'good practice' around the country — it is not simply a trouble-shooting body.

But at first the Development Team could not get into Tatchbury Mount because of objections from the doctors and the unions. The Team, unlike the Health Advisory Service whose responsibilities it took over in the field of mental handicap, cannot insist on going into a hospital. However, it would have been absurd not to include Tatchbury Mount in the investigation, and, after a good deal of political pressure, the Team went in.

The resulting report, although hopelessly scrappy, badly written and turgid, did make some criticisms of Tatchbury. But at the same time, it took a swipe at the Wessex policy of establishing hostels for the mentally handicapped, based on defined geographical catchment areas. There is a sharp irony here, for when Barbara Castle (then Secretary of State for Health and Social Services) set up the team, Wessex was one region singled out as an authority with some good ideas that the Team might disseminate around the country.

For the region, the Team's report itself is not only a disappointment but something of a rack of its own making. It would be understandable if Wessex regretted publishing it. But a more robust attitude seems to have been taken. For in making the report public, the workings of the Development Team have been given general exposure and its practice opened to criticism.

In about two months' time, the Development Team will publish its annual report. Before this report is brought out, it will be sent to health and social service authorities for consultation. One of the issues raised is whether or not authorities which ask the Team in should publish the resulting reports, as they are entitled to do.

Now is the time for all concerned to examine the workings of the Development Team. It looked at the whole of Hampshire services in only two weeks. It met the local CHC, but hardly gives it a mention in the report. It went to the Medical Research Council-funded Health Care Evaluation Research Team, which in effect helps Wessex region with research and development. But according to its director, Albert Kushlick, did not make use of available data. For example, the Team reported no significant differences in family contact between mentally handicapped and their families in hostel and hospital settings. Kushlick says he has research data showing much more contact in the hostels.

Wessex region's decision to break with precedent and to publish may not have solved Hampshire's problems, but it has been invaluable in starting a debate which has national implications.

Gavin Weightman works for New Society.

Medical centre for the homeless

Anne Davies

ON THE 9th January this year, after four years' negotiations, the Great Chapel Street Centre for young homeless people opened in London's Soho. It aims to provide primary medical care for young people under 25 and not registered with a local doctor. The Campaign for Single Homeless People — CHAR — was asked to set up the scheme in 1974 by a group of youth workers and social workers who were finding problems getting a GP to attend the homeless. The main funding is from the DHSS and money has also been raised from charities.

The Centre is unusual in that it is managed jointly by the Kensington, Chelsea and Westminster AHA and by CHAR on behalf of the voluntary agencies. Since the majority of services for the single homeless have traditionally been provided by the non-statutory agencies, the involvement of the AHA is very welcome. When the Centre was at the planning stage, CHAR also benefited from the advice and support of the local CHC, Kensington, Chelsea and Westminster South, in securing equal representation with the AHA on the planning committee.

A fundamental problem was to quantify need. The original recommendation in 1972 was for a 24-hour, walk-in service. This requires a high level of funding, which could not be justified in terms of numbers. CHAR accepted that any project for this group would have to be on a far smaller scale.

We should have preferred ground floor premises but this was not possible. We were able to lease a wing of a former nurses' home in Soho. With some refurbishing the place is a cheerful blend of informality and clinical authenticity.

Staff at the Centre are a nurse, a doctor and a full-time administrator who handles the reception of patients, the retrieval of information, and the day-to-day running of the place. The clinics take place each weekday afternoon from 2 to 4.30 with the nurse present at each session, and the doctor attending on Mondays, Thursdays and Fridays.

Many young people are referred to the Centre from voluntary agencies. After a month we were beginning to see people who had heard about the Centre 'on the grapevine' which is encouraging, and the number of patients is building up steadily. After six weeks, or 30 afternoon clinics, there had been over 80 attendances, involving 37 different people. This is roughly what we anticipated, since it is impossible to advertise the service directly to its potential users. We had mailed several hundred individuals and agencies likely to be in contact with the homeless young.

CHAR has always argued that, ideally, homeless young people should receive medical care in the same way as anyone else. This is a stigmatised group and in separating them off, even for the purposes of medical care, we can perpetuate that stigma. However, in far too many areas we have learnt that GPs cannot be found to take homeless people (including those living in hostels) on their lists. CHAR is not in a position to stand on its principles while the medical needs of homeless people are neglected. Although we try in any city, often with the help of CHCs, to get normal GP services for the homeless we accept that where that approach fails, special services like the Great Chapel Street Centre have to be provided.

Anne Davies is assistant director of CHAR. Contact CHAR at 27 John Adam Street, London WC2 (01-839 6185).

The district community physician

Dr William Kearns

THE DISTRICT community physician came into being in 1974 along with the reorganisation of the National Health Service. Although taking on some of the functions of the medical officer of health, the DCP is a very different animal. Most of the work relates to activities which are entirely new, or organised in a completely different way since 1974.

The thinking behind the creation of community physicians was the need for a doctor with an overall view of health and illness which could encompass a whole community for whom health services are provided. This contrasts with the vast majority of doctors — the GP, the hospital doctor — who are concerned primarily with patients in one particular specialty.

Thus my patient is the district with its entire population of some 160,000 people, whether ill or healthy. I am particularly concerned with the health needs of vulnerable groups within the community — such as the elderly, single mothers, and the mentally handicapped — and the overall balance between the different elements of health and related services available to them. However, the DCP's concern is not just the cure of patients who are already ill and the rehabilitation or long-term care of those for whom total cure is not possible. It is also the prevention of illness in the healthy; the early diagnosis of those who become ill; and the promotion of health generally.

Training

To help me carry out my work as DCP, I have received further special training on top of my basic qualifications as a doctor and my own experience of the clinical care of patients. This training has included epidemiology, statistics, health services organisation and social sciences.

My knowledge of epidemiology — the study of patterns of disease in populations — makes me more able to appreciate the need for health care in my community and the changes likely to occur in the future.

My knowledge of statistics and organisation is relevant to the collection, interpretation and use of information on which the evaluation and future planning of the services can be based.

My training in social sciences has given me an understanding of social factors in what causes disease; the way in which different groups within the community use, or fail to use, the services provided; and the inter-relationship of health care with other services *eg* social services, housing, education.

Responsibilities

An important factor in my day-to-day work is my membership of the District Management Team. This is the means whereby my particular skills and outlook in viewing the needs of the community as a whole can be applied to the running and development of the health services in the District. As DCP, I have leading planning responsibilities — notably the establishment and work of District Planning Teams. New developments in my District resulting from the work of planning teams include progress on a new psychiatric unit, the setting up of a district handicap team for children, and an increased allocation of money for the long-term care of younger chronic sick patients. We have also recently started building the first health centre in the District.

The DCP may take on other responsibilities which vary from one District to another. For example, the DCP may also be the 'proper officer' who advises the local authority on control of infectious disease and other environmental health matters. I myself have been involved in the identification, tracing and surveillance of contacts of a patient in my district hospital who turned out to have had Lassa fever before returning from Africa. I have also helped to investigate the possible risks of lead pollution from an elevated motorway to children in a nursery centre to be built nearby.

Because I work in a teaching District, I also contribute to the training of medical students as well as talking to different groups of health workers about the health problems and services in the District. I take a special interest in *all* activities in the community related to health. Unlike some DCPs however, I do not have specific management responsibilities for community health services such as chiropody, community doctors and physiotherapy.

Problems

It is perhaps early days to make a comprehensive evaluation of NHS reorganisation and the setting up of community medicine. However, some problems deserve mention.

Firstly, the geographical differences between the local authority boundaries and health districts make the task of the DCP and those providing services much more difficult; London is particularly problematic. Having to communicate, plan and coordinate with three different boroughs (as in my District) makes a complex job much more so. Secondly, the complicated way the NHS is organised makes for waste and frustration.

Thirdly, the immense scope of the DCP's work demands considerable support. I am very fortunate in working with four members of staff, not all full time, who between them have medical, sociological, research and secretarial skills; many DCPs have only a secretary. Finally, there is a shortage of doctors training for or working in community medicine, which increases the workload and the isolation of those doctors already community physicians.

I have no doubt that community medicine has a vital role to play in the NHS. The importance of the work of the DCP has not yet been fully appreciated, perhaps not even by DCPs themselves.

Dr William Kearns is a district community physician in the Kensington and Chelsea and Westminster AHA(T).

Credit: Western Mercury

Credit: Dave Thomas

Where now for Court?

Jean Davis

On 27 January this year, the Secretary of State finally gave the government response to the recommendations of the Court Committee's report *Fit for the future* — in a written parliamentary answer, in the Eleanor Rathbone memorial lecture and, later, in DHSS circular HC(78)5. What then is the future for the Court recommendations? What effect can CHCs have on child health services locally, armed with Court and their own considered responses to the report (see CHC NEWS 29)? We asked Jean Davis what opportunities she feels have been opened up.

IN THE HOUSE of Lords debate on the Court report, the government spokesman said that the report would become the Bible of the child health services. David Ennals' response has at least one feature in common with the Bible: it is capable of many interpretations and many different glosses will be put on it. An article in the *Lancet* called it a 'drab' response. *Education* magazine refers to its 'refreshing realism'. To health and local authorities who are committed to improving child health services, however, it offers a great deal of scope.

The practical reason for setting up the Court Committee was the need to incorporate within the NHS structure the local authority services — maternity, child welfare and school health — after the 1974 reorganisation. The main message in the government's response is that there is no single answer to suit the whole country.

CHCs will therefore have to examine the local needs of children, try to assess the relationship between needs and provision, and consider possible patterns of care. This means looking critically at the location of general practitioners, clinics and hospitals with particular attention to the take-up of preventive services. Are they in the places where they are most needed? Are they being used? If not, what can be done about it? Which pattern of primary care is most suitable?

GPs for children

The Court report looked forward to a time when all primary care of children would be in the hands of GPs, but these would be GPs with a special interest and training in child health. David Ennals' reply accepts that 'all general practitioners should in future have adequate training in child health and play an increasing role in preventive work particularly for children below school age', and he will encourage developments along the lines proposed by Court, where agreement about the arrangements can be reached between the AHA and the GP. The Secretary of State recognises, however, that not all GPs are willing or able to take on preventive as well as acute services. Therefore, adequately trained clinical medical officers are essential if these important services are to be maintained.

We are now in what Court saw as a transition period. The danger is that the transitional arrangements become permanent and the division into acute and preventive medicine, which the report saw as wasteful and possibly harmful, may be allowed to continue as though Court had never reported.

School health

School health is likely to remain in the hands of clinical medical officers. The Secretary of State does not see many GPs able to take on that area of responsibility. But the Court recommendation that every school should have a nominated school nurse is reinforced by the promised discussions about a national training scheme for school nurses, and I think we can look forward to the time when the most important health professional for children in schools will be a well-trained school nurse.

The job descriptions of the Specialist in Community Medicine (Child Health) and the Area Nurse (Child Health) are attached to the circular on Court: HC(78)5. This is because they are responsible for organising and planning integrated health services for children, including child health. If CHCs do feel concern about the adequacy or quality of provision in their district they should contact both the Specialist and the Area Nurse.

Most important of all, CHCs should look at how some children always fall through the net. A few never see a doctor until they start school. The Court Committee wanted to see a service which reached out to these children. It found many possible approaches. One recommendation was the restoration of a geographical responsibility to the health visiting service. Some authorities already do operate versions of this. The draft document on preventive services for children — currently out for comment — suggests other ways as well.

There is, in fact, very little in the Court recommendations which is not happening somewhere in the country. One example is the District Handicap Team, the principle of which has been fully accepted by the Ministers. CHCs can certainly press for this multi-disciplinary approach to handicap and see that links are established with parents and voluntary organisations.

In his speech, David Ennals particularly mentioned the problem of inner cities and clearly the Court idea of GPs with an interest in children cannot flourish where accident and emergency departments are used as suppliers of primary care and where there is a dearth of GPs. New solutions need to be found.

Both the circular and the speech draw attention to the use of Joint Finance Funds — 'there is no reason why these funds should not be used to strengthen primary care'. This is one area that CHCs could usefully explore, for they are in a position to propose patterns of care in line with how families see and use the health services.

Foundations

The Court report was looking 20 years ahead. Given the immediate professional opposition to any special interest in children for general practice, David Ennals has given as much encouragement as he can to the reorganisation proposed by Court. Where GPs wish to take on the challenge of total care, they can. But arrangements do have to be made for children to be adequately cared for, whatever the professional decisions.

However, the Court report is not just about the organisation of services. It is concerned with the relationships between education, health and social services, and between professionals and consumers. It is also about children being important in our society. At national level, the new Children's Joint Committee (another Court recommendation) can press for children to get a fair deal. At local level, it is up to CHCs to maintain vigilance and pressure on their authorities to see that services for *all* children are improved.

Jean Davis is in the Public Affairs Unit of the National Consumer Council and was a parent member of the Court Committee.

Health News

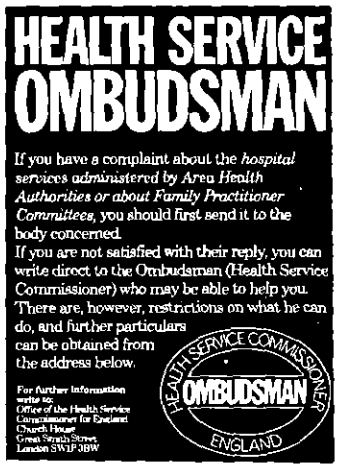
Poster points

The new poster advertising the Health Service Ombudsman has come in for some severe criticism from CHCs. As you can see, there's no mention of CHCs at all — a first line of information and advice for the consumer in trouble.

Other criticisms include bad grammar, the use of the term *Ombudsman*, and not enough detail of the areas of complaint the Ombudsman can (*eg* community health services) and cannot (*eg* issues of clinical judgment) investigate. In its favour, the poster is visually uncluttered. . . .

One remedy would be for CHCs to be consulted about the drafting of this and similar material, particularly now ACHCEW's new working group on communications has been set up.

As reported in this month's *Parliamentary questions*, it's too late to revise the current poster. But the COI might like to consider a new policy after a



recent members' survey by the Consumers' Association. This revealed that consumers wanting to make a complaint about some aspect of the health service tried 23 different sources in order to find out how to go about it.

The Ombudsman comes a long way along the line in the complaints procedure; the COI might well consider putting resources into broadening general public knowledge of how to make any type of complaint — not just ones that qualify for the Ombudsman.

Complaints procedures

A draft circular on health service complaints, other than those relating to family practitioner services, is being issued for consultation by the DHSS. CHCs are amongst the bodies being asked for comments on the draft. This is the latest development in the review of hospital complaints procedures which began in 1973 with the report of the Davies Committee *(1)*.

In 1976 a draft circular and draft code of practice on complaints were circulated (2; see *CHC NEWS 10, page 8*), but since then the Select Committee on the Parliamentary Commissioner for Administration has reported (see *CHC NEWS 27, page 1*), commenting on the draft code of practice and recommending a widening of the Health Service Ombudsman's powers to include complaints about clinical judgment. RHA chairmen and the medical and dental professions have been consulted about this report, and the new draft circular will take into account both the report and comments arising from it.

At present, guidance on complaints is based on DHSS circular HM(66)15, *Methods of dealing with complaints by patients*, and Appendix 5 of HRC(74)4, *Community Health Councils*.

(1) Report of the committee on hospital complaints procedure, HMSO, 1973, £1.45.

(2) Accompanying HN(76)107, Health services complaints procedure.

Helping handout for CHCs

Grants to CHCs of up to £30,000 for research projects may be applied for from the DHSS/Welsh Office Small Grants scheme. Details from Room A327, DHSS, Elephant and Castle, London, SE1.

Book reviews

Directory for the disabled compiled by Ann Darnbrough and Derek Kinrade (Woodhead-Faulkner, £4.25).
Disability rights handbook for 1978 available from the Disability Alliance, 5 Netherhall Gardens, London NW3 5RJ (60p plus 15p if ordered by post).

Two information books for the disabled and for advisers to the disabled: the Handbook — a guide to income benefits and certain aids and services — is an essential tool; the Directory — information and opportunities for the disabled and handicapped — is a useful reference work.

The Directory is certainly more wide ranging, covering not just the statutory services, benefits and allowances but also, for example, further education, holidays, sport, sexual problems, contact and tape organisations. It also lists suppliers for aids and conversions at home and for cars.

However, it does have a tendency to pass you on to other sources; the Handbook gives you what you need in its own pages. For example, on incontinence problems, the Directory merely refers readers to 'health visitors or district nurses'. The Handbook explains what help might be available, *precisely* where and how to get it.

Its style and format make the Handbook more accessible: it asks the crucial questions and then answers them *eg* What is mobility allowance? What is it supposed to be for? Do you qualify? How much do you get? and so on. Finally, there is the price. . . .

The new women's health handbook
edited by Nancy MacKeith (Virago, £1.95 paperback)

Women often say that their bodies feel rather mysterious and unfamiliar to them and, in an evasive and condescending way, doctors often discourage women from gaining an understanding of the normal processes of their healthy bodies. Women in pregnancy, childbirth and the menopause are all regarded as 'patients', in other words, as sick. This book aims to help women know their own bodies as well as they know their own faces, to stay as healthy as possible, and to judge when medical advice may be needed. It is written entirely by women, many of them active in the self-help women's health field.

The accent throughout the book is on maintaining health, and encourages regular examination of the breasts and also internal self examination, using a speculum. It is clearly written with good diagrams. While I have been reading it, women have lighted eagerly on it, and have had no problems in finding the sections they want to read.

There are chapters on the menstrual cycle, the menopause, and all the different kinds of contraception, mental health, cancer in women, venereal disease. Nutrition, smoking, drugs and health are briefly covered and there is a short chapter on the NHS.

The acceptability of risks
available from the Council for Science and Society, 3/4 St Andrew's Hill, London EC4 (£5).

In recent years we've lived through asbestosis, thalidomide, Flixborough and vaccine damage — yet we still need reminding that there's no such thing as 'safe'. In particular, it would seem unwise to regard any drug or other medical procedure as being free from real or potential risk.

This report, prepared by a charity researching the social effects of science and technology, looks mainly at the risks of work in industry. It points out that statistical chance is by no means the only factor to be considered when assessing risks, since people insist on higher safety standards when they have no control over their exposure to a hazard. It discusses whether safety limits can be set 'fairly' when the people controlling the degree of risk are not those actually exposed. This of course applies as much to 'nanny knows best' expert committees as it does to industrial management.

The report proposes the setting up of community-based 'risk advisory centres', along the same lines as law centres. Anybody who wants to think seriously about risks will find this report rewarding, though at £5 for a 104-page paperback maybe it's one to order from the public library!

Checklist of CHCs' surveys

IN DECEMBER last year, CHC NEWS carried some of the results of the questionnaire we had sent to CHC secretaries the previous August. One question asked for details of surveys, completed or in progress. We promised to report on this in detail later on. Here is that report.

It is almost two years since we first published details of CHCs' surveys *(CHC NEWS 8 and 9);* much of that information is included again. The new picture emerges from the replies of 180 CHCs. Even so, it is not a complete list of all CHC surveys.

How to read the checklist.

Where a survey led to some improvement in the district, or used a particular method, this has been briefly included.

☐ Some CHCs have (P) next to them: this means that at the time of their reply, the survey was being planned or in progress.

☐ If a survey covers more than one subject, it has a multiple entry *eg* SE Cumbria's survey on child health clinics is under *Children's health services* and *Health clinics*.

A

Abortion
N Hammersmith, S Hammersmith, City and Hackney, Bexley, Liverpool C and S.

Accident and emergency services
Newcastle upon Tyne, Bury St Edmunds, Isle of Wight, Kettering.

Alcoholism
S Camden, Maidstone.

Ambulance services
Darlington, Rotherham, Edgware and Hendon, Crewe.

C

Chemists' services
N W Herts, Bexley, Isle of Wight, Kettering, Pembrokeshire.

Children's health services
(see also School health services)

General *Sheffield* N (P) *(postal q'aire).*

Clinics S E Cumbria, Sheffield C, Cambridge, Tunbridge Wells, W Berkshire, High Wycombe, Salford.

Infant mortality Northumberland (P).

Court report Enfield.

Pre-school checks W Roding.

Handicapped Brighton.

In hospital Wandsworth and E Merton (q'aire to parents).

Baby milks Crewe (compare prices in region).

Chiropody
General S E *Cumbria, Cambridge,* Yarmouth and Waveney, Edgware and Hendon, C Birmingham (q'aire to 1000 on waiting list/receiving treatment), W Birmingham.

Elderly Peterborough, E Surrey.

Waiting lists S E Kent.

Community Health Councils
N Tees, E Leeds, E Wakefield, Barnsley, Doncaster, Haringey, Bury, S W Durham.

Community hospitals
C Derbyshire, Lincolnshire N.

Community services
Darlington, Sheffield N, N Tees, Oxford, Kensington-Chelsea-Westminster N E, N Birmingham, W Birmingham.

Complaints
S Camden, Tower Hamlets, Liverpool C and S.

D

Dental Services
(see also Fluoridation)

General N Derbyshire (P), S W Herts (P) (with Social Education Project Team).

Scope of NHS work Kensington-Chelsea-*Westminster* N E (P) *(postal q'aire to* dentists), N Surrey (to dentists).

Dental charges N W Leics (public awareness of charges).

Services for special groups Peterborough (schools) (P), Islington (elderly in residential care), Wirral S (mentally and physically handicapped).

Services for the disabled
Review of local services S E Cumbria (P) *(for arthritic and rheumatic),* Harrogate (chronic sick/disabled — led to leaflet on local services), Brighton (children), Southampton (P), Bromsgrove and Redditch (access), Wirral S (general services and dental services).

Finding the disabled E Wakefield, Rugby (P) (with Voluntary Services Association).

Equipment/appliances S E Cumbria, Northampton (return of loan equipment and wheelchair repairs).

Younger chronic sick unit Rochdale.

Drug dependency
Northampton.

E

Services for the elderly
General needs and services Rotherham (P), N Herts, W Essex (3,000 q'aires, given via clubs, so excluded housebound), East Somerset, Aberconwy, Winchester, Worthing (Job Creation Programme).

In the community E Herts (rural services), W Birmingham (hospital discharge and *after care),* Islington (P) *(needs of families* of elderly at home), Bexley (laundry services for incontinent), E Somerset, Neath and Afan *(feasibility of an 'at risk'* register), Worthing (P) (health visitors' involvement with old people).

Hospital services Worthing (survey to GPs about access to geriatric beds), E Herts (deficiencies in bed provision), Kettering (short stays), Merioneth (bed shortages).

Special services Peterborough (chiropody), Islington (dentals).

Ethnic minorities
Sheffield N (P), *Sheffield* C, *Kensington-*Chelsea-Westminster N E, Northampton.

F

Family planning and contraception
Haringey, S E Kent.

Fluoridation
Darlington, Wakefield W, S W Herts, Eastbourne, Maidstone, Isle of Wight, *Winchester,* E *Somerset, Weston, Salop.*

G

General practitioner care
General Wakefield E *(P)* (CHC *members* to visit GPs), Barking, Islington, Kensington-Chelsea-Westminster N E (use of GPs' service by Chinese *community* — via interpreter).

Patient satisfaction N Derbyshire (2,000 q'aires given out by students), Haringey (street survey), W Roding (interviewed patients in waiting rooms).

Finding/changing GP Kensington-Chelsea-Westminster N E ('phoned surgeries, posing as patients), N Camden (with cooperation of FPC).

General practitioner practice organisation
(see also Health centres)

Out-of-hours services Rotherham (deputising services), N Surrey (wrote to all GPs).

Nurse attachment scheme Grimsby (P).

Premises Guy's (P) (interviews with GPs).

Attitudes to referral Guy's (P).

Appointments systems C Birmingham.

Glue sniffing
St Helens and Knowsley.

H

Haemophilia patients
Northampton.

Health and safety at work
Rotherham (P).

Health centres
Consumer satisfaction Maidstone, Mid-Surrey, N Surrey (transport — q'aires given out at centre), W Surrey (P) (centres vs. GP group practices), Isles of Scilly (P) (appointments and waiting time), Isle of Wight (house to house survey by sixth form students).

Proposals for health centres E Cumbria, Northumberland, Chester (1:10 household survey), N *Manchester,* Rochdale (site of centre — 1:3 q'aire to households in area), Trafford (600 interviews done with school students).

Health clinics
General Cambridge, Chichester.

Children S E Cumbria, Sheffield C, High Wycombe, W Berkshire, Salford, Tunbridge Wells.

Continued on next page

Checklist of CHCs' surveys

Maternity/ante-natal W Roding (with cooperation of DMT), Canterbury (with help from University), Tunbridge Wells (P) (transport).

Health education

S W Durham (P), Edgware and Hendon (P), Mid-Surrey, Kettering, C Birmingham, Neath and Afan.

Hearing problems

S E Cumbria (P), Kensington-Chelsea-Westminster S (P), Northampton (psychiatric patients).

Hospital services — general

Inpatients' views Haringey, Sutton and W Merton, Salisbury, Swindon (P) (joint project with DMT), Weston (P), W Birmingham.

Consumer satisfaction Northumberland (P).

Patients' views on possible savings Hastings.

Hospital admissions

Admission procedures Roehampton (P), High Wycombe, Salford.

Waiting time for admission E Somerset, W Birmingham.

Hospital discharge procedures

Discharge and aftercare Darlington, High Wycombe, C Manchester, Roehampton (P) (postal q'aire), E Roding (with health authorities and social services).

Psychiatric patients W Roding (P), Mid-Surrey.

Elderly Ealing.

Hospital 'hotel' services

Catering Darlington, Wakefield W (P) (interviewing patients in hospital and after discharge), Rotherham, Bath (P) (with cooperation of DMT), Salisbury, Southampton (P) (acute and long-stay patients), Crewe (continental breakfasts).

Hospital radio Stockport.

Linen Wirral N.

Hospital outpatients

(see also Transport)

Patients' satisfaction Dewsbury (P), Leeds W (P) (using King's Fund scheme), York (waiting times), N Derbyshire (P) (with students from College of Technology), S Derbyshire (P), Sheffield C, N Bedfordshire (P) (with K F scheme), Haringey, W Roding (P) (with K F scheme), Dudley, Worcester (P), Salford (waiting times and reception problems).

Hospital visiting

(see also Transport)

Visiting times E Cumbria (public use/abuse of visiting), Bradford, Doncaster (for husbands to maternity hospital), Cambridge, Kensington-Chelsea-Westminster S (P) (q'aire to visitors), Sandwell (led to less restricted hours), Neath and Afan, Swansea and Lliw Valley (AHA requested survey and ignored results — 'Utter waste of time').

Children Stockport (P) (with National Association for the Welfare of Children in Hospital).

M

Maternity services

Consumers' views of hospitals/services Newcastle-upon-Tyne (P) (professional interviewer/independent research consultant), Cambridge, Edgware and Hendon, N Herts (q'aire to mothers six months after discharge), N Camden (P) (with Assoc. for Improvement in Maternity Services), Newham (P) (sample of mothers in borough over last two years), King's (P), W Surrey/N W Hants (P), High Wycombe (two surveys), Crewe (survey hindered by DMT and consultants).

Home confinements — patients' views Mid-Surrey, Northumberland, Sutton and W Merton.

Home confinements — GPs views Preston (to see if GPs would be willing to deliver at home).

Male midwives Sunderland, C Derbyshire, Sheffield C, Haringey, Chichester.

Ante-natal clinics N Camden, Canterbury and Thanet (with University), Coventry (with AHA, result: administration improved), N Staffs, Tunbridge Wells (P).

Visiting for husbands Doncaster.

Effect of 48-hour admissions Rotherham (P).

Patients' views on induction of labour Peterborough.

Public views on services Islington (P).

Views on proposed closure Bexley.

Services for the mentally handicapped

(see also Sterilisation of minors).

Facilities, services, needs S Tees (P), Harrogate (result: published leaflet on local services), Rotherham, W Roding (P), Southampton (used 'informal' methods 'most useful'), Winchester (q'aire to voluntary organisations).

Caring for the mentally handicapped at home E Roding (survey by sociologist), Medway (result: special counsellor for mentally handicapped appointed).

Public attitude to proposed day-centre Havering.

Health and dental services Wirral S.

Services for the mentally ill

General Rotherham, Sutton and W Merton.

Hospital services Mid-Surrey (discharge procedures), Isle of Wight (inpatients' views of hospital), W Roding (P) (discharge procedures), Dewsbury (visiting).

Mental health E Somerset, W Somerset.

Public attitudes to proposed secure unit Wakefield W.

Incidence of self-poisoning Kettering.

Needs of deaf patients Northampton.

N

National Health Service

(see also Community health councils)

Consumer satisfaction Doncaster, Norwich, S W Herts (at Watford Show), Barking, City and Hackney (result: booklet *Health in Hackney*), Eastbourne, S W Durham, N Surrey, N Gwent with S Gwent, Walsall.

Consumers' views on priorities in NHS Enfield, W Essex, Haringey, Newham, Isle of Wight, E Berkshire, W Berkshire, Crewe, Weston, C Birmingham.

O

Ophthalmic services

Havering, Northampton.

P

Physiotherapy

Edgware and Hendon.

R

Rural problems

(see also Transport)

Access to hospitals Northallerton (with Transport and Road Research Lab.), Scarborough, C Derbyshire, Peterborough (P), N E Essex.

Rural services Aylesbury, Kettering (surgeries and pharmacies — with Women's Institutes), Northampton (with Women's Institutes), High Wycombe (with W.I.).

Services for elderly E Herts.

Effects of tourism S E Cumbria.

S

School health services

Peterborough (P) (dental services), Kettering, Rochdale.

Smoking

W Essex.

Social services provision

Isles of Scilly, E Somerset.

Services for the socially deprived

Sheffield N (P), Sheffield C (for single homeless and rootless), Liverpool C and S, C Birmingham (housing estate), Trafford (housing estate).

Sterilisation of minors

Hull, C Derbyshire, N Camden, Haringey, Weston.

Strokes

Northumberland (P), Northampton.

T

Transport

(see also Ambulances)

Access to primary care N Tees (questions included in Cleveland County Council Social Survey 1977), N Surrey (result: new bus service to health centre), Gloucester, Tunbridge Wells (effect of closing clinic), Torbay (effect of closing clinic).

Access to hospitals (except outpatients) E Cumbria, W Cumbria, Dewsbury (psychiatric hospital), Bury St Edmunds, Cambridge (P), Peterborough (P), Basildon and Thurrock (P), N E Essex, Aylesbury, W Berkshire (P), Gloucester (P) (effect of losing bus service), Dudley (traffic flow round four hospitals — dangers for emergency services), E Somerset, Salop (geriatric hospital), Sandwell, E Birmingham, Wirral S (P) (with sixth formers), Roehampton (to accident and emergency department).

Transport for outpatients Northallerton (with Transport and Road Research Lab.), Scarborough, Roehampton, Basingstoke and N Hants, Southampton and S W Hants, Rhymney Valley.

Healthline

Public awareness of CHCs

My CHC is planning a work experience project to survey the public's knowledge of CHCs. Can you give us any advice on how to set about such a survey?

Several CHCs have already done surveys of this kind and we suggest you ask them to send you a copy of what they did, plus any useful hints or experiences they may have picked up along the way. The CHCs are: North Tees, Leeds Eastern, Wakefield Eastern, Barnsley, Doncaster, Haringey, Bury and South West Durham.

It would also be worth asking Mr J. Hughes, Course Tutor, Graduate Management Course, Manchester Business School, Booth St West, Manchester M15 6PB (061-273 8228) for a copy of the report *CHCs: is the watchdog barking up the wrong tree?* which came out recently. This report looks at how good CHCs are at representing and informing the public, and includes a survey of public awareness of CHCs.

There is a useful article in *Community health* (vol 9, no 2, November 1977) called *A survey of public knowledge in relation to the NHS reorganisation* by Eskin and Newton, which includes a section on CHCs.

Two recommended books are *Survey methods in social investigations* by C. A. Moser and G. Kalton (Heinemann educational, £3.20) and *Questionnaire design and attitude measurement* by A. N. Oppenheim (Heinemann, £1.80). See also CHC NEWS 25 *Help with surveys.*

We welcome letters and other contributions from readers, but we would like letters to be kept short so that as many as possible can be included. CHC NEWS particularly welcomes letters (and articles) from CHC members.

We reserve the right to cut any contributions for reasons of space.

Pain relief clinics

I have been approached by a patient who is suffering severe pain after an operation. His family doctor and consultant have found, after extensive tests, no cause for the pain and wish to discharge him from hospital. I recall seeing some information about a centre to which patients can be referred for further investigation. Can you help?

The Intractable Pain Society (IPS) keeps a list of pain relief clinics. IPS secretary, Dr Keith Budd, will let enquirers know their nearest clinic. You can contact him at the Department of Anaesthetics, Bradford Royal Infirmary, Duckworth Lane, Bradford, West Yorkshire BD9 6RJ (0274 42200).

HRT clinics

Where can I go for advice about hormone replacement therapy? My GP doesn't agree with it and he won't help me.

The Family Planning Association (FPA) will put you in touch with your nearest menopausal clinic — NHS or private — where you can get advice and, in some cases, hormone replacement therapy (HRT) itself. The FPA is at 27/35 Mortimer Street, London W1 (01-636 7866).

The Association for Women's Health Care (WHC), 16 Seymour Street, London W1 (01-486 4069) provides a clinic financed by five drug companies which are major manufacturers of hormones. You don't need to be referred by your GP. WHC charges an initial fee of £10.

You can always change your GP, but check other GPs' views on HRT before signing on.

Funds for hostels

Where can I find out more about the capital grants now available for hostels for battered women, the single homeless and former psychiatric patients (*Notes CHC NEWS 28*)?

The Housing Corporation, 149 Tottenham Court Road, London W1 (01-387 9466) can supply full details, including the relevant circular 1/77, December 1977. There is also a useful article in the *Times* dated 10 December 1977.

The Healthline column publishes selections from the queries received by our information service. This service is for CHC members and secretaries, and for other organisations and individuals interested in the NHS and the work of CHCs. Contact the information service on 01-267 6111 ext 267, or write to the CHC NEWS information service, 126 Albert Street, London NW1 7NF.

Parliamentary questions

Closures

Replying to questions from Michael Marshall MP, Roland Moyle listed the health buildings whose closure the Secretary of State has approved, in spite of CHC objections. He named 27 buildings, many of them maternity hospitals, for which closure has been approved since 1 April 1974. Representations from CHCs to the Minister have saved one hospital (St Nicholas's, SE London) and deferred closure for a year of one other (Cosford, Wolverhampton).

Beds

The DHSS will issue new guidance on targets for bed/population ratios in the various acute categories, Roland Moyle told Joan Maynard MP. She had questioned the adequacy of the methods used to calculate bed norms.

Chiropody

The elderly, the handicapped, expectant mothers and children still at school are considered priority groups for the community chiropody services, Roland Moyle said, in answer to a question from Robert Hicks MP.

Home confinements

When a woman chooses to have her baby born at home, health authorities should ensure that conditions for the delivery are as safe as possible, David Ennals said, replying to a question from Patrick Jenkin MP. He added that some areas are having trouble maintaining the level of services needed for home births.

Elderly disabled people

Joyce Butler MP asked what plans there are for assisting elderly disabled people whose age disqualifies them from the mobility allowance. David Ennals replied that at present it would cost too much to remove the upper age limits for the allowance.

Wheelchairs

When the DHSS reviews the wheelchair service, as it intends to do, interested organisations will be consulted. Alf Morris, in reply to a question from Lewis Carter-Jones MP said that 'arrangements for recommendation, prescription, supply, repair and maintenance of wheelchairs' would be included in the review.

NHS spectacle frames

Displaying the full range of NHS spectacle frames is now being discussed by the opticians and the DHSS. The DHSS would like to make it part of the opticians' terms of service, Roland Moyle told David Watkins MP.

Nurses' education and training

The Government is trying to find Parliamentary time to legislate a new statutory framework for nurses' education and training. Replying to Dr Gerard Vaughan MP, David Ennals said this would implement some of the recommendations of the Briggs' Committee on Nursing.

Migraine

There is no central information about special migraine clinics, but it is thought that there are about ten in Great Britain, Roland Moyle told George Park MP. The Migraine Trust has estimated that 10 per cent of men and 16 per cent of women suffer from migraine.

CHCs and the Ombudsman

The Government has no power to revise the poster about the Ombudsman, published by the Central Office of Information. This was Roland Moyle's answer to Keith Stainton MP, who had asked for the poster to be withdrawn since it fails to mention the role of CHCs in advising patients about how to complain.

Scanner

The mentally handicapped and joint financing

The Government has invited comments on the pamphlet *Day services for mentally handicapped adults*. They should reach the DHSS by 30 May; then a revised model of good practice will be considered. Speaking to a conference on day services for the mentally handicapped, David Ennals said that so far over 30 per cent of the money spent through joint financing (arrangements between local authority social services departments and the NHS) has been spent on projects for the mentally handicapped. And Alf Morris, Minister for the Disabled, has reminded local authorities that the provisions of the Chronically Sick and Disabled Persons Act 1970 apply to mentally ill and handicapped people as well as to the physically disabled. *Day services for mentally handicapped adults – pamphlet no 5*, free from National Development Group for the Mentally Handicapped, Alexander Fleming House, Elephant and Castle, London SE1.

Outpatient ambulance transport

Is the name of a report published from the conference on ambulance services for outpatients, convened in December by the National Corporation for the Care of Old People. The report urges the DHSS radically to re-examine the service in relation to other forms of transport. From NCCOP, Nuffield Lodge, Regent's Park, London NW1 4RS (01-722 8871) (£1).

Family Planning Information Service

Is for members of the public and health and social service workers. Leaflets and handbooks are also available. FPIS, 27-35 Mortimer Street, London W1N 7RJ (01-636 7866).

Guide to mental health

Mental health in Bristol is a guide to facilities and services for anyone in the city facing a mental health problem. There are sections on problems such as legal matters, medical terms, retirement, loneliness, employment. The jobs of professionals are described, as well as details of voluntary organisations. Much of the information would be useful in other cities. *Mental health in Bristol* from Bristol Association for Mental Health, 7 East Priory Close, Westbury-on-Trym, Bristol (60p).

Drug safety

A new scheme to detect and record bad reactions to drugs has been announced by the Committee for the Safety of Medicines. Under the present yellow card scheme an estimated one to ten per cent only of adverse reactions to drugs are reported. Also, one of the main difficulties is that doctors may not recognise a reaction. The new 'recorded release' scheme involves patients who are being treated with a specified drug, being selected and closely monitored. They will also be checked years after the treatment. Meanwhile the yellow card scheme will continue.

Allergy Information Centre

Provides details of allergies and their treatment. It is sponsored by a pharmaceutical company. Allergy Information Centre, 1 Roberts Mews, Lowndes Place, London SW1 (01-235 4086).

Information for GPs

Advice on practice premises and equipment, appointment systems and practice organisation is now available for GPs and their staff from Central Information Service, 14 Princes Gate, Hyde Park, London SW7 1PU (01-589 1252).

Whooping cough vaccine

The Joint Committee on Vaccination and Immunisation is severely criticised in the *Lancet* (18 Feb 1978, p370), for not considering all the evidence available on the effectiveness of whooping cough vaccine and its dangers. The Committee's review of the issues came out last year (see *Notes CHC NEWS 23*).

It is accused of ignoring important evidence from West Germany, where a fall in the number of whooping cough cases has occurred, even though the policy of routine vaccination has been dropped. Vaccine damage cases have also fallen.

Media Project News

Aims to encourage broadcasters in radio and TV to exchange information and experiences with people involved in social action. The first issue describes how a group in Cumbria, linked with parish councils, produce their own radio programme each month. From the Volunteer Centre, 29 Lower King's Road, Berkhamsted, Herts HP4 2AB (£4 a year).

Opposing the cuts

A pamphlet on how to oppose hospital closures has been published by staff of four London hospitals. In three of these, staff are 'working-in' (EGA, Hounslow and Plaistow Maternity), and the fourth (St Nick's) has been reprieved. *Keeping hospitals open* (10p + post) describes how to start and run a work-in, how to develop a support campaign and how the consultation procedure works, including the role of CHCs. Also available is *Fightback*, the first issue of a new 'bulletin against cuts in the health service' (10p + post). This describes campaigns in Hemel Hempstead, Wallsend, Birmingham, Sheffield, S. Glamorgan, Lancashire and London. Both publications from Hounslow Hospital Occupation Committee, Staines Road, Hounslow, Middx (01-570 4448).

More claims for mobility allowance

Mobility allowance will soon be available to a wider range of people. In a statement in Parliament, David Ennals said that people unable or almost unable to walk because of a physical condition which results in a mental handicap (*eg* Down's Syndrome) would be able to claim under the proposed regulations. There will also be a review of claims which so far have been rejected. And later this year the age limit for the benefit will go up from 55 to 58 years, allowing 10,000 more disabled people to make claims.

Pensions for home responsibilities

If you give up work to care for a sick or elderly person, or for a child, you may be entitled to a basic state pension. Under the rules of the new scheme which begins this month, a person must receive child benefit for the child being looked after, or a supplementary allowance which lets them stay at home caring for someone old or infirm. Or there must be an attendance allowance being paid.

HN (78) 20: Coal for the NHS

A discount on coal prices, which is expected to save the NHS £2.5 million over three years, has been agreed between the DHSS and the National Coal Board. In return, a list of buildings which the RHAs guarantee to keep heated by coal, must be provided.

Directory of CHCs

A directory of the names, addresses and telephone numbers of all the community health councils in England and Wales is available, price 60p. Corrections are published monthly in CHC NEWS. Please notify the editor of any changes.

Cheques and postal orders should be made payable to 'ACHCEW' and sent with orders to: CHC NEWS, 126 Albert Street, London NW1 7NF.

Please note the following changes:

Page 3: NW Durham CHC 6 John Street Square, Consett, Co Durham DH8 5AR (Consett 509241)
Page 6: Bradford CHC Secretary: Mrs Sheila M. Lago
Page 7: Leeds Eastern CHC Centenary House, North Street, Leeds LS2 8AY (Leeds 39998)
Page 14: South Bedford CHC Chairman: Mr A. F. Thelwall
Page 14: North Herts CHC Chairman: Mrs M. R. Hall
Page 21: Eastbourne CHC Chairman: Dr R. G. Chitham
Page 35: Hereford CHC Chairman: Mrs Ursula Attfield
Page 45: Trafford CHC Secretary: Ms Jane Andrews
Page 56: Yorkshire Regional Council of the Association of CHC Secretaries Hull CHC, 83 Ferensway, Hull (Hull 24411) Chairman: R. W. J. Wood, Secretary: Mrs Irene Watson
Page 57: NE Thames Regional Association of CHC Secretaries Convenor: Mrs Joan Gornall, Havering CHC, High Wood Hospital, Ongar Road, Brentwood, Essex CM15 9DY (Brentwood 219933)