CHC NEWS

For Community Health Councils

July 1978 No 33

Health Minister Roland Moyle in the gymnasium at Oakmere Photo: Northwich Guardian

Oakmere Hall saved by Crewe

Roland Moyle, Minister for Health, has refused to approve proposals to close the Oakmere Hall rehabilitation centre near Northwich, Cheshire. The centre will remain open and its future will be reviewed in five years' time.

Crewe CHC led the objections to the closure, supported by Bury, Bolton and Wigan CHCs. The campaign involved a deputation to Mr Moyle last December and in May he visited the centre and again heard the CHC's arguments.

Cheshire AHA's case for closure rested mainly on the underuse of the centre, which had led to very high costs per patient, and also on the fact that many patients came from outside Cheshire. It claimed that Cheshire patients could be adequately catered for in the area, without Oakmere.

Until 1948, the centre was used by miners from the South Lancs coalfield and accident victims from Lancashire are often still referred to Oakmere. Many such patients, victims of strokes, serious burns, road and industrial accidents, have been "written off" by other hospitals and Oakmere has an excellent rehabilitation record.

Crewe CHC argued that no proper comparative costs had been made — eg the cost per patient of a physiotherapy session in the district hospital. It also urged that the centre should accept more day patients, patients directly referred by GPs and also female patients.

A detailed case was made by the CHC to show that no adequate alternative facilities exist and that Oakmere is a unique unit, serving the Mersey and North West Regions.

Some of the CHC's proposals have already been acted upon — there are more day patients and GP referrals are being accepted. Crewe CHC is suggesting that the AHA should regard the counter-proposals as guidelines for action and is assuming that by his decision the Minister has given his support to the CHC's ideas.

DHSS figures for the period January 1976 — March 1978 show that of 191 whole or part-closure proposals in England, 164 were agreed locally and 27 went to the Secretary of State who approved all but one — St Nicholas' Hospital in London. The DHSS also knows of six closure proposals withdrawn before they have reached the Secretary of State.

Since the end of March two closure proposals have been rejected — Oakmere Hall and a part-closure proposal at Stoke Mandeville Hospital, Bucks.

Royal Commission research

Too many administrative levels and a top-heavy and over-elaborate management system — these are the main criticisms reported by the research team which the Royal Commission invited to carry out a study on decision-making in the NHS.

The report* is based on interviews with 516 workers in the service and health authority members and CHCs. The Brunel University team, led by Professor Maurice Kogan, has not suggested a wholesale reorganisation of the NHS. It recommends that each region and area should review its structure to see how it could be simplified, that the consultative process should be streamlined, and that there should be more delegation of authority.

CHCs are approved in principle but the team thinks that many CHCs act overhastily on complaints, particularly in disclosing details to the press. Their only recommendation on CHCs is that there should be more carefully worked out processes for ascertaining, evaluating, and publishing facts. **The workings of the National Health Service, HMSO £3.75.*

To mark the 30th birthday of the NHS the DHSS has brought out a series of posters and two leaflets; one (see above) describes the history and present scope of the health and social services (NHS. 7), and the other does the same for social security (FB. 3). A book by Professor Brian Abel-Smith gives a more detailed account of the service (£1.95 from HMSO). Leaflets and posters are available from DHSS Leaflets Unit, PO Box 21, Stanmore, Middx HA7 1AY.

Your letters

Health education

Alastair Mackie, Director General, Health Education Council

One can have nothing but respect for the sincerity of Sam Keyte's criticisms *(CHC NEWS 31)* of the relatively unimportant part of HEC's work which consists in public advertising. Two of his most important points, however, are based on a misunderstanding of how this kind of health education works.

First, we do not use "sex as a selling point". The main reason for this is that so crude a technique would not work, but there would also be moral objections about which we feel just as strongly as anybody else. What we do, rather, is to base some of our advertising on what common sense and research tells us — that the self esteem and the creative urge underlying sexual motivation can also be used to motivate people to look after their health. As a result, not only are people not, as Mr Keyte puts it, rebuffed — they, and especially those most in need and least accessible, pay attention to what we say and even do something about it.

Second, there is no evidence that advertising has any direct effect on mental health. But it does have a very important link with health as a whole. A lot of advertising encourages consumption of substances that do harm to health. The only way to correct this is to put the same skills of public persuasion to work in the opposite direction. To desist, as Mr Keyte suggests, would be simply to neglect our duty.

H Creaser, Member York CHC

It is a pity that Sam Keyte *(CHC NEWS 31)* fails to recognise the difference between "love" and "sex". These terms are *not* synonymous and I would like to see us distinguishing them very carefully in all health education publications. A drunk does not make love, he has sex and we must recognise this for what it is. Love is important in health education, sex may not be. Perhaps we could not only press the HEC to get it right but begin to demand that all advertising gets it right too.

How open is ACHCEW?

Julian Knox, Scholar-in-Residence, National Library of Medicine, National Institutes of Health, Bethesda, Maryland 20014, USA.

May I as former Secretary of Islington CHC and as a researcher with over ten years' close interest in the development of participatory democracy in health care in the United Kingdom, the USA and in other countries, raise with you a matter of great concern — the extent to which the minutes of the Association of CHCs are published and thus available for scrutiny by its constituent councils and by the public at large. It is my understanding that the Standing Committee's minutes are not made public.

If this is indeed the case and it seems almost unbelievable in view of continual demands by CHCs since 1974 that the NHS should conduct its business openly, I believe the Standing Committee is making a grave error. By restricting the availability of its minutes, it is well on the way to being a laughing-stock at best and the object of well-deserved derision by the opponents of democracy at worst.

Mike Gerrard, Secretary of the Association of CHCs, replies:

The Standing Committee decided in September to publish a newsletter after each meeting, summarising decisions and including a "forthcoming attractions" section, inviting CHCs' comments. This goes to *all* CHCs. CHCs interested in particular topics are specifically kept in touch with developments. It has recently been agreed to distribute minutes to the regional groupings and CHCs can obtain copies this way.

Personal clothing

Marcia Saunders, Secretary, Islington CHC

Islington CHC has been trying for several years to get our district to establish a personal clothing scheme for geriatric patients. Over a year ago the money was allocated and clothing bought, which has languished in cupboards while systems don't get worked out. We would be delighted to have details of systems operating successfully elsewhere.

Bottle feeding

Michael Silver, Dental surgeon 64 Wentworth Road, London NW11.

A great deal of the bottle feeding in maternity homes and hospitals is of highly sweetened drinks. Optrose and Ribena manufacturers seem to send presents of cartons of their unhealthy, expensive, sugar/water products. And in most nursing homes these products become the new babies' first drink.

It is also very important that babies are not given sweetened milk to drink — it gives them a "sweet tooth", leading to an addiction for sweetness, with all of the tooth rot and overweight later in life. Mothers need to realise that "loving" does not have to be equated with sugar.

Friends of the health centre

Betty Ross, Member Cuckfield and Crawley CHC

This CHC has been exploring the avenues of voluntary support for community nurses and health visitors working from health centres, none of which have leagues of friends. I approached the organiser of the district voluntary services department and with encouragement from the district administrator we visited health centres and local committees of leagues of friends. We also wrote to the National Association of Leagues of Hospital Friends.

It was soon clear that a "Friends of the Health Centre" group was not important in itself but that the nurses needed a focal point where they could ask for voluntary help or for up-to-date information on local organisations. Each centre has different needs. We understand that there have been attempts to set up such schemes for health centres, but that no actual league of friends has yet been registered for a health centre. I would be pleased to hear of other experiences or to help readers engaged in similar projects.

Fees for certificates

Joan McGlennon, Secretary North Surrey CHC

Members of the public have often asked us about fees charged by doctors for private certificates, cremation certificates, vaccination forms, etc. We discovered that guidelines were issued but the BMA regretted that they were only released to BMA members. We have, however, managed to acquire a copy of the guidelines for use in our office. It is proving extremely useful and I would certainly commend it to other CHCs. If we receive a stamped, addressed envelope, we could supply a photocopy.

Thirtieth anniversary of the NHS

W J C Rossiter, Secretary East Roding CHC

Circular HN(78)47 asks health authorities, CHCs and voluntary organisations to consider ways of marking the 30th anniversary of the NHS. There is little doubt in my own mind that there is very little to celebrate at present and that many of the authorities and organisations approached may well feel it is entirely inappropriate to use any funds at all for this purpose when essential staff requirements are not being met because of the standstill in NHS financing.

Ed: Unfortunately this letter arrived just too late for us to be able to include it in CHC NEWS last month.

Younger chronic sick units

Winifred Howarth, Member Bradford CHC

As a result of a car accident 16 years ago, I became severely disabled. After my discharge 13 years ago from a spinal injuries unit, I have been cared for at home by my family and excellent community services. I agree with Jean Symons *(CHC NEWS 29)* that people who are physically disabled or in need of chronic sick care usually prefer to live at home. However, this is not always possible and there is a serious need in Bradford for purpose-built units for the younger, mentally normal, physically disabled who need *accommodation* as distinct from the chronic sick whose needs are quite different.

We welcome letters and other contributions, but we would like letters to be as short as possible. We reserve the right to cut any contributions for reasons of space.

Comment

Britain was the first country in the world to introduce a comprehensive health service, available to everyone, free of charge at the point of use. It is hard to imagine now what life would be like without the NHS, and the DHSS may perhaps be forgiven for wanting to linger a little, in this anniversary month, on the achievements of the past 30 years. And we can surely all be grateful that the principle of universality on which the NHS was founded has survived more or less in tact.

The health service was beset with defects and disputes in 1948 just as it is in 1978. That standards and morale have been falling lately is grim, but that people — patients and providers — protest shows that they care about what happens to the health service. The founders of the NHS believed that as the service got under way health would improve and demand would fall; it is perhaps no less misguided to expect that the service will settle down into permanent contentment as soon as the Royal Commission gives the magic word — or indeed at any time.

CHCs are one of the many good things to have come out of the NHS in its first 30 years (and they were born out of upheaval). They reflect and embody people's interest in the NHS as their service, and their right to have a say in how it operates. The NHS may have become a very different animal by the end of the next 30 years, and CHCs could well themselves have to face change. But as long as, and in whatever form, they exist they have a responsibility for the future of the whole NHS — as well as for their particular corner of it.

Health News

Drugs essential . . .

Interest in drugs — their side-effects, their costs and in some cases whether they work at all — is now running at a consistently high level. One major talking-point has been the World Health Organization's list of about 200 essential drugs "indispensable for the care of the vast majority of the world's population".

The suggestion that such a list should be produced for Britain — advising GPs of the safest, cheapest and most effective drugs — has caused consternation in the pharmaceutical industry. A recent article in *New Scientist* magazine (18 May) makes a strong case for such a list, despite objections from the industry that future research could be inhibited.

The author, Dr Frank Lesser of the Pharmacology Department at Chelsea College, suggests that an essential drugs list could even have the opposite effect — it might "act as a spur to research workers to aim for really new developments, because otherwise the chances of their product 'getting on to the list would be reduced".

The article mentions Italy's restricted list, which names 396 drugs and is said to meet 70-80% of the needs of Italian GPs. An essential drugs list for Britain would also concentrate GPs' minds on the crucial question: "Does this patient need a drug at all?"

. . . and not so essential

On the side-effects front, a "shock report" published in *Woman's Own* (20 May) reveals a need for big improvements. A survey of over two thousand women taking drugs found that over half had experienced side-effects. Oral contraceptives, tranquillisers and drugs for treating rheumatism caused the most problems.

Only 22% of the women with "fairly serious" side-effects had been warned by their GP of this possibility. Over half the women surveyed were "generally dissatisfied" with the amount of information given by their doctor, and GPs rarely asked if a patient was taking other drugs bought over the counter.

Woman's Own concludes: "It is a worrying fact that the average GP is ill-informed about drug interactions which can be dangerous".

Dentists under the microscope

The Consumers' Association is investigating how easy it is to get NHS dental treatment, for an article to be published by *Which?* magazine in August 1979. CHCs could help by doing brief telephone surveys of their local dentists. For details contact Julian Edwards, CA, 14 Buckingham Street, London WC2 (01-839 1222). CA has already discussed this with ACHCEW, to avoid unnecessary overlap with ACHCEW's own study of dental services. This will probably be carried out by university researchers, and an application for a £5,000 grant is being considered by the Nuffield Provincial Hospitals Trust.

Council coyness over VD

Islington Borough Council, in London, has landed itself in a health education row — by censoring an article on venereal disease scheduled for publication in its own newspaper, *Focus*. The article, prepared with the help of Camden and Islington AHA, gave advice on symptoms and where to get treatment, and generally tried to dispel the guilt and ignorance which tend to surround this subject.

Islington's chief executive Hugh Dewing and council leader Gerry Southgate developed qualms about the article, and Coun. Southgate had it banned. He said it was "Not the sort of article to put in a paper that goes through everyone's front door. It described symptoms in very frank terms — symptoms that would offend a number of people". Lobbying is continuing, with strong medical support, to have the article included in a future issue of *Focus*.

Medical records and a legal blunder

The English Court of Appeal has been misinterpreting the Administration of Justice Act 1970 as it relates to the disclosure of hospital records ever since the Act became law, according to the House of Lords. This is revealed in *The Times* Law Report of 23 May, which summarises the case of *McIvor and Another v Southern Health and Social Services Board, Northern Ireland*.

Section 32(1) of the Act gives courts the power to order disclosure of hospital records "to the applicant" and his or her legal advisers, where the applicant is a party to an action for personal injuries.

In this case the records were required to settle the degree of incapacity for work caused by a road accident, but the Southern HSSB appealed because it wished to restrict disclosure to the medical advisers of the two parties. Lord Diplock decided that the wording of the Act was unequivocal, and that earlier decisions of the English Court of Appeal were wrong.

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CHCs—a mixed blessing?

Personal View

by Morris Malin, Vice-chairman of the Wandsworth Society for the Mentally Handicapped, and Chairman of Roehampton CHC

Community health councils can be a tremendous force for the good of the NHS but we must not get carried away. Success has been achieved at a price — an enforced change in the role of the voluntary organisations, which used to be able to approach health authorities directly, but must now, by official edict, go through the CHC.

On 9 June 1975 Dr David Owen, then Minister of State in the DHSS, informed an MP that the suggestions of the Richmond upon Thames Society for Mentally Handicapped Children, and the views of other interested bodies, on facilities at Normansfield Hospital, should get to health authorities through the medium of the CHC.

This neat arrangement, making the CHC the recognised spokesman for the entire community, would work if the CHC made proper use of the expertise the voluntary organisations have gathered over many years. But if the CHC, for one reason or another, chooses to disregard the voluntary society, then one might well ask whether the CHC has become a mini-authority instead of the grass-roots organisation it was intended to be.

In the case in point the CHC's elected officers gave *de facto* approval (without repudiation by the CHC) to a major scheme on new residential facilities at Normansfield Hospital without first consulting the Richmond Society for Mentally Handicapped Children, which had asked again and again to be involved. The society in fact opposed the scheme on the ground that the CHC and AHA had not looked into more acceptable — and cheaper — alternatives, but had simply bought a DHSS package deal based on an economic design exercise known as the Sheffield Design Project. This scheme has been attacked for being out of touch with modern thinking. It is vital for CHCs to recognise that they need all the technical support they can get if they are to deal intelligently with the health authorities, who have full-time professionals behind them.

In addition to the spurning of the voluntary sector there are other pitfalls CHCs must beware of. Some CHCs find it convenient to go along with the policies and practices of the health authorities, since it would mean a lot of hard work for them to question or resist the policy set by the administration. Other CHCs are really one-man organisations, completely dominated by a single personality, usually the chairman; the rest of the council rubber-stamps whatever "Mr CHC" recommends. If the chairman is non-progressive, the voluntary sector is in a bad way.

The secretary and assistant secretary of the CHC are the only paid officials. However, while their salaries come out of the CHC's budget, they are employees of the NHS, specifically of the RHA, and cannot be fired by the CHC. Will the RHA act, if requested? The question does not arise if the secretary does the bidding of the CHC members. But what if in fact the secretary is interested only in a few issues and takes decisions in the name of the CHC without consulting the members? Such a CHC is a liability to the voluntary organisations — except for the few which are lucky enough to be in favour — and RHAs have shown an understandable reluctance to intervene in CHCs' internal wrangling.

This contribution has been extracted from an article in the Spring 1978 issue of Parents Views, *journal of the Wandsworth Society for the Mentally Handicapped.*

A small step forward?

by Alison Wertheimer, Policy Officer for MIND and a co-opted member of St Thomas' CHC

The White Paper, *Better Services for the Mentally Ill*, which appeared in October 1975 forms the blueprint for development of services for mentally ill people. The Paper had four main objectives:

- the expansion of local authority services — residential and day-care provision, domiciliary services and social work support.
- the relocation of specialist services, away from the large, often isolated, specialist hospital into smaller settings.
- the establishment of the right organisational links, eg between health and social services departments and between professional groups.
- the improvement of staffing levels.

Although these do not constitute a "specific programme", they are a set of objectives for long-term implementation to which the DHSS is firmly committed.

The consultative document, *Priorities for health and social services in England* (1976) reaffirmed those aims and spelt out a programme for increasing local authority day and residential places by 1,200 and 350 each year respectively. The proposed annual capital programme of £25 million for hospital services would allow for some progress in developing district-based services as an alternative to the large hospitals. However, a further priority was to be the improvement of hospital standards for staffing, food, accommodation and other facilities, to reach the minimum standards set in 1972.

The way forward, published in 1977, again stressed the importance of giving greater priority to under-financed "Cinderella" services such as those for the mentally ill. But despite central government's commitment to giving psychiatric services a better deal, progress has not been exactly rapid.

Looking at the most recent published figures there are still 33 local authorities with no residential provision for the mentally ill and 46 with no day-care facilities. The programme set out in the priorities document has lagged behind; in 1976-77 there were under 700 new day places against a target of 1,200; progress in residential provision was much faster and it was certainly boosted by grants from sources such as the Housing Corporation.

Regional strategic plans show that prospects are still remote for developing small units or hospitals. This delay has not been compensated for by any major leap forward in the standards of existing large hospitals. At the most recent count there were still 46 large psychiatric hospitals which had not reached all the minimum standards set in 1972 (*letter to secretaries of regional hospital boards DS 86/72*).

What can CHCs do to improve the services for mentally ill people?

1 Encourage the AHA and the local authority to make maximum use of joint funding. More local services could keep some people out of hospital *and* bring home some of those long-stay patients who no longer need a hospital bed.

2 Find out if your local psychiatric hospital measures up to the 1972 minimum standards of the DHSS. Physical conditions are not a complete answer to a good hospital service, but they are a start.

3 Has your region begun to plan for the run-down of any large psychiatric hospital? In your regional and area plans, what provision is being made towards a district-based service, to replace the large hospital?

4 Contact your local MIND group (address from MIND, 22 Harley Street, London W1) who will be a useful source of knowledge about services in the area.

Photo: Liz Heron

Patients' committees are here to stay

by Ruth Levitt

Are patients' committees a threat to CHCs? There have been several reports in *CHC NEWS* of moves to strengthen the patients' committees idea (see *September 1976* and *June 1977*), and perhaps it is now time to assess the facts.

The idea started in 1972. Dr Peter Pritchard and his partners had moved into a new health centre in the village of Berinsfield, near Oxford, and they wanted to know more about what their local community wanted from its GPs. They invited local organisations and the staff of the health centre to a meeting, which despite some doubts was judged to have been a success. Three meetings a year have been held since then.

The Berinsfield Community Participation Group has three stated functions:

Planning instrument: to help primary care staff plan a service which is accessible, acceptable and meets the health needs of all the community in the most effective and efficient manner;

Safety valve: to help staff and patients maintain a dialogue, so that they can each express their feelings about obtaining or providing care at an early stage;

Eyes and ears: to provide information to CHCs and health authorities about areas of health care which may need more resources.

In 1973 Dr Alistair Wilson and his partners moved into a new health centre in Aberdare. Quite independently, they too decided to involve their patients more closely. They wanted a committee, elected from the 10,000 patients in the practice, to join the staff in running the service, considering complaints and suggestions, providing opportunities for health education, communicating the opinions of patients to other bodies such as the CHC, AHA and local authority, and improving levels of care.

Similar developments occurred in the next few years in Bristol, the Isle of Wight and Glyncorrwg. In 1976 the BBC TV programme *Open Door* made a film of the Aberdare committee in action, and this spread the news to a very wide audience. The film has since been repeated on TV, and shown to smaller audiences around the country.

In May 1977 the Aberdare, Bristol and Berinsfield committees called a meeting in Bristol, at which existing committees and other people came together to exchange views. A steering committee was formed to work towards setting up a national forum, which could strengthen further developments. Elfed Morgan, a member of the Aberdare committee, agreed to act as coordinator, and received many enquiries about the practicalities of setting up patients' committees.

February 1978 saw the first meeting of the National Association for Patient Participation in General Practice*, called by the steering committee and held in Oxford. This confirmed that there was wide support for a national forum and network, to overcome the isolation of individual committees and provide a point of reference for the increasing numbers of enquiries from doctors, patients and CHCs. The meeting did not lay down a detailed constitution, but agreed to meet again in October to review developments.

There appear to be at least 12 active patients' committees in England and Wales. Many more are planned, and the signs of interest among CHCs are growing. Not all the committees work in the same way or have the same objectives. Some have been set up by doctors, others arose from the initiative of patients or CHCs. But it is by now clear that patients' committees are not a crank idea or a short-lived fashion — they represent genuine innovation, with very good reasons behind it.

First, they provide practical methods for improving communications between patients and doctors. It is widely agreed that this is a necessary aspect of primary care, and patients' committees offer an unfussy way of setting it in motion.

Second, committees do not have to work to any blueprint of rules imposed from outside. Each group can agree on the arrangements that will be acceptable and workable for the purposes they decide.

Third, there are benefits for the wider community if patients' committees inform CHCs and AHAs about their activities. This kind of "grass roots" knowledge is indispensable to the rational development of the health service.

Last November the Central Manchester CHC held a public meeting to "explore the Aberdare experience, and the way this could be used for a model for patients' democracy in urban health centres developing in Manchester". Doctors at the meeting voiced reservations about the benefits they would receive from investing time and energy in the committees, and about interference with their freedom to run their practices as they think best. There were also arguments about the duplication of work done by health education staff, and about the desirability of having yet another committee to be consulted by the AHA.

But on the plus side the meeting agreed that the Aberdare committee did actually work well, and that patients' committees could counteract a major criticism of health centres — that they make the doctor-patient relationship more impersonal. Many of the social responsibilities of the primary care team could be shared by the committee — thus spreading the load — and the educational role of the team could be strengthened by the committee. This is particularly important if staff do not live in the communities they serve.

Establishing a successful patients' committee requires commitment from all those involved, and demands that time and work be given in a voluntary capacity. But the benefits can be considerable, particularly for CHCs. At Glyncorrwg, for example, relations between the committee and the CHC started off rather badly. The committee did not think much of the CHC's efforts, and the CHC thought the committee was interfering with its activities. But now both groups enthusiastically agree that they benefit from each other's existence. In several other places it is now being suggested that patients' committees should be able to nominate people for CHC membership.

**Contact person for the NAPPGP is now Dr Tim Paine, c/o The Practice Association, Whiteladies Health Centre, Whatley Road, Bristol BS8 2PU.*

Ruth Levitt is a lecturer at the School for Advanced Urban Studies, Bristol University, and a former editor of CHC NEWS.

Better dental services for all

*by Aubrey Sheiham and Diane Plamping**

Photo: Sunday Telegraph

Dental disease is one of the most common kinds of illness, and one that causes a good deal of pain, misery, inconvenience and economic loss. In Britain the two major dental diseases, *caries* (tooth decay) and *periodontal disease* (gum disease), affect every man, woman and child who has teeth. One leading dentist has called these diseases "the last epidemic"(1). Caries is so common that only three in every 1,000 adults have never experienced it, and so severe that 97 per cent of 15-year-olds have at least one third of their teeth affected. In adults this figure rises to over half their teeth. Periodontal disease affects nine out of ten people and in four out of ten adults it is so advanced that they are about to begin losing their teeth.

These diseases cause the extraction of eight million teeth per annum. Four out of ten adults have no natural teeth at all, and half the adult population wears some kind of denture. The social and psychological toll, barely recognised and never totally estimated, must be considerable — it includes pain and discomfort, anxiety, dietary restrictions, embarrassment when laughing, talking and yawning. The financial costs — also never totalled — include £300 million per annum spent by the NHS just to deliver treatment, and the loss of 20 million hours per year spent at the dentist.

The current emphasis in treating dental disease is almost entirely on repair. Over 90 per cent of NHS payments are for reparative work, and even in the community dental service the principal measure of output is the number of fillings performed per session. Most fillings have a short life, and most teeth which have been frequently filled are eventually extracted.

Could reparative dentistry be made more effective? There is now general agreement that a greater concentration on prevention can increase the effectiveness of repair. This combined approach has been accepted by the British Dental Association and explained in the report *Dental care for the community* (2).

Prevention must include a coordinated food policy aimed at reducing the consumption of refined sugars. Halving the total sugar consumption and reducing the frequency of taking sugar would virtually eradicate dental caries. Increasing the resistance of teeth to acid attack by using fluoride in water, tablets, toothpaste or rinses would reduce the amount of decay, and more effective toothbrushing would control gum disease.

If dental diseases can be prevented in this way, why has so little been done? One answer is that the NHS was set up to treat disease — prevention was only tacked on later. Also, the DHSS has accepted the cost-effectiveness of water fluoridation but has failed to inform the public sufficiently about fluoridation, so that many people still doubt its efficacy and safety(3,4).

Fluoridation has been delayed further by the reluctance of Ministers to clarify the legal position of water authorities who have been asked to fluoridate their water(5).

Yet another barrier to the implementation of prevention is the system of paying dentists. The present system is organised to pay for work which can be independently checked on. Paying a fee for each item of prevention would require more careful controls, which would be unacceptable to many dentists.

Structure of dental services

The main effect of the 1974 reorganisation of the health service was to give the *area dental officers* responsibility for planning and coordinating dental services. However, since the largest segment of the dental service, the *general dental service* (GDS), consists of self-employed dentists doing NHS work on a contract basis, the opportunities for planning are limited to the *community dental service* (CDS) and the *hospital dental service* (HDS).

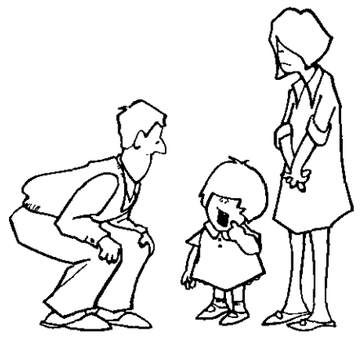
In some areas the coordination of services *has* been improved. The CDS has concentrated on prevention and the treatment of special groups, referring patients to general dental practitioners whenever possible. Greater cooperation between the HDS and the CDS has led to hospital-based dentists carrying out treatment in health centres. Unfortunately these changes are not common.

The general dental service: Over 75 per cent of dentists are *general dental practitioners*. Their contractual agreement is between the Family Practitioner Committee (FPC), the dentist and each individual patient. The patient, if the dentist agrees, is accepted for a single course of treatment — the dentist has no "list" in the way that doctors have.

For each item of treatment dentists get paid a fee by the FPC, and they earn on average £20,000 per year from the NHS. About £12,000 of this is spent on practice and laboratory expenses. This leaves a net income of about £8219 — the *target net income* for dentists from April 1978. In addition to their NHS income, dentists earn on average about £2000 a year from private practice.

In addition to the fee-for-service dentists there are also *salaried general dental practitioners*. Some, working as health centre salaried dental officers and treating all categories of people, have a maximum salary of £7137 from April 1978. Others are employed in industry, to treat employees of particular companies.

The hospital dental service: Dental treatment in hospitals is carried out by salaried consultants and their teams. They provide specialist advice, and treat cases of special difficulty referred to hospitals by general and medical practitioners. Consultants are responsible for all patients in hospital.



WHAT CHCs CAN DO TO IMPROVE PREVENTION

1. Refined sugars should be removed from infant foods — as in Canada and Norway.
2. Advertising of sugared products directed at children should be banned.
3. Foods should be more clearly labelled.
4. Water supplies should be fluoridated.
5. Fluoride tablet schemes should be set up through dentists, GPs and schools.
6. *Topical* (ie locally applied) fluoride treatment should be available to children with a high caries rate.
7. Health education officers should be encouraged to ensure that people are given basic information about cleaning their teeth and dentures and on the need to reduce their sugar consumption.

The community dental service: This is the new name for the school dental service. Its salaried staff can treat children and pregnant mothers, and recently their scope has been enlarged to include treatment of the adult handicapped. Most of the work done in the CDS is treatment — relatively little attention is given to prevention.

How are dentists paid?

The problems that people have been having recently in obtaining dental care are intrinsically tied to the system of paying the general dental practitioners, and although the recent agreement on pay for dentists — whereby they received a minimum 31 per cent increase spread over three years — temporarily overcomes some of the problems, a long-term solution is called for. The fault does not lie with the review body system of assessing dentists' income but with the *fee-for-item system of payment*, which distorts the treatment patterns qualitatively and quantitatively. This system in the opinion of the Tattersall Sub-Committee on Methods of Remuneration(6), puts a "premium on speed and takes no account of quality", and makes the profession "pre-occupied with 'turnover' and generally more commercially than professionally minded"

Despite these deficiencies, the dental profession decided to maintain the fee-for-item system and reject the suggestion in the Tattersall report that a capitation system similar to the system of payment for medical practitioners should be introduced. The profession was allowed to choose how dentists should be paid, and the Government set up a *Dental Rates Study Group* to determine the fees for each item.

The present system works like this: Each year the *Review Body on Doctors' and Dentists' Remuneration* decides on the target net income of doctors and dentists (for a good summary of the body's terms of reference see its Sixth Report, for 1976; HMSO, £1.80). Then the Dental Rates Study Group, composed of equal numbers of representatives of the health departments and the dental profession, under an independent chairman, determines the gross fees for each item of service, so that the target net income for the average dentist would be achieved in the standard number of hours of work.

As part of this procedure, the profession and the health departments can suggest changes in emphasis of dental treatment. For example they could suggest that more money should be paid for giving dental health education.

WHAT CHCs CAN DO TO IMPROVE DENTAL CARE

1. Encourage the employment of health centre dental officers. This will involve the construction of an attractive career structure. Their method of payment could be changed along the salary-plus-bonus lines of the Glasgow Woodside Scheme(7). The bonus should be based on the number of people maintained in a state of dental health, with special responsibility payments for treating elderly and handicapped people.
2. The hospital and community services should liaise more closely. Area dental officers and consultants should be asked to create posts which allow dental workers to spend some time working in the hospital and some in community clinics. For example, a *prosthetist* (a dentist concerned with dentures) can be appointed to the hospital and do sessions in the community. Priority should be given to posts involving dental treatment of the handicapped and elderly, *orthodontics* (improving the position of teeth), children's dentistry and restorative dentistry (which mainly involves "crown" and "bridge" work).
3. Appointments of dental practitioners on a sessional basis should be made, to treat all long-stay patients under consultant supervision.
4. Dentists should be employed on a sessional basis to treat people in Part Three accommodation (for the homeless and people who cannot look after themselves in their own homes).
5. Area dental officers should ensure that the handicapped and the housebound receive a high standard of dental care. Mobile dental clinics can be used to bring the services to them and to the more inaccessible schools.
6. Industries should be encouraged to employ dental teams.
7. Dental technicians should be registered with and paid by the FPC to encourage more dentists to do dentures and crown and bridge work on the NHS.

Future trends

Dental health is improving because people are using more fluoride toothpaste and sugar consumption has gone down. In future, fewer dentists will be required and there will be a trend to specialisation, which will lead to more complicated work being done, which in turn will increase costs. Already, the cost for making crowns on the NHS takes up about 10 per cent of the expenditure on the GDS in England and Wales, and this percentage has doubled in the last eight years.

Because of the rising costs of dental care and Government policy on cuts in social services, there will be a tendency to increase the patients' contributions. Whenever that occurs, dentists will become more insecure about the future of NHS dentistry, and will therefore attempt to convert NHS patients into private payers.

Unplanned changes of this kind do not allow a rational policy for training dental workers — currently the effect of this lack of planning is redundancies among dental technicians who make dentures.

Solutions

Possible solutions are listed in the two boxes on this page. Some are already in operation in London, Cardiff and Glasgow. We have not proposed a solution to the fee-for-service problem nor to the emphasis on treatment. Solutions to these major problems may be suggested by the Royal Commission on the NHS — or perhaps by the representatives of the community, the CHCs.

FURTHER READING

1. *Dental disease — the last great epidemic*, by G. L. Slack, Royal Society of Health Journal, July/August 1958, pages 476-483.
2. *Dental care for the community*, report of a BDA working party, British Dental Journal, 5 December 1972, pages 493-500.
3. *Fluoride, teeth and health*, a report of the Royal College of Physicians, Pitman Medical, 1976, £2.50.
4. *Fluoridation of water supplies: Questions and answers*, published jointly by the BDA, The Fluoridation Society and the Health Education Council, January 1976, 30p.
5. *Fluoridation of water supplies*, circular HC(76)34, June 1976.
6. *Methods of remuneration*, report of a committee under the chairmanship of W.R. Tattersall, British Dental Journal, 20 October 1964.
7. See Appendix III of *A challenge for change in the dental services*, report of a working party chaired by Laurie Pavitt MP, April 1976, 50p from Literature Sales, The Labour Party, Transport House, Smith Square, London SW1.

**Aubrey Sheiham is a senior lecturer in community dental health at the London Hospital Medical College. Diane Plamping is a community dentist.*

Cartoons courtesy of the British Dental Association, from their series of leaflets on dental disease and hygiene. These can be obtained through dentists, but not direct from the BDA.

Ethical committees
a lay member's experience

by Joan Woodward, Member of Central Birmingham CHC.

I felt interested, honoured and uncertain when last year I was elected by Central Birmingham CHC to be the lay representative on the local research ethical committee. The committee tries to safeguard patients and volunteers taking part in clinical research, as well as protecting the reputation of the hospitals and the research workers.

Ethical committees developed in the 1960s, following a report from the Medical Research Council, which laid down criteria to be met when making medical investigations on human subjects. First, consent to the procedures should be obtained from the subject. Secondly, he or she should come to no harm. Thirdly, if any doubts about the propriety of the investigations are raised, the opinion of experienced colleagues should be sought.

In 1973 the Royal College of Physicians recommended that a lay member should be included on the committees. In June 1975 DHSS circular HSC(IS)153 asked area health authorities to consider choosing a lay member from the appropriate CHC to the local ethical committee. I questioned if this could be done and got landed with the task!

This committee consists of four consultants, a senior nursing officer and myself. The outgoing lay member was a well-known physicist, and so was hardly seen as "lay". But his appointment had broken new ground while maintaining medical confidence, making it easier for a successor. There was a short period of overlap when we both served.

The committee chairman, a professor in clinical pharmacology who has written about ethical committees, provided a large dossier of background reading. He gives me information and advice very generously. Because so much of the material is highly technical, it would be very difficult for a lay member to contribute usefully unless the chairman or other members offered this kind of support. One needs quickly to pick up an understanding of what is involved from the patient's point of view, as well as something about basic techniques and drugs which may be used. I would like to urge other CHC members who may be contemplating a similar appointment not to be too apologetic about feeling ignorant — part of their task is to question and find out unashamedly!

As batches of projects, some of them quite lengthy, come through the post, they have to be carefully read. A form is ticked, that one "approves" or "approves plus comment" or does "not approve" and on what grounds. The form has to be signed and returned within a week. The committee meets quarterly to consider all projects submitted since the last meeting.

Being on the ethical committee started me thinking about the concept of "informed consent". I believe that not enough is done to train doctors in how to communicate with patients and parents of child patients, whose consent is frequently sought.

One of the main duties of lay members is to make it widely known that research projects are scrutinised with great care, and that a reasonable balance is constantly sought. It would be unethical *not* to do research, but it must be done and seen to be done, without unnecessary risks being taken.

Book reviews

Dictionary of social services — policy and practice

by Joan Clegg, for the National Council of Social Service. From Bookpoint Ltd, 78 Milton Trading Estate, Abingdon OX14 4TD, £3.35 inc. post.

This book will help to light the path of anyone needing to find their way around the world of social services. It is not a guide to the regulations, but is intended to provide simple explanations of a wide range of terms. A few random examples are, "notice to quit" "patrial", "group therapy", "rate rebate". It is occasionally rather superficial and there are some gaps — no entry for joint consultative committees. But it is scrupulously cross-referenced and easy to use.

Whose benefit?

Economist Intelligence Unit, Spencer House, 27 St James's Place, London SW1A 1NT. £3 plus 85p post.

DIG, the Disablement Income Group, commissioned this hefty and thought-provoking investigation into the tangle of social security benefits for disabled people. The book examines the issues not only in national terms (eg the high administrative costs which arise as the system gets more complicated) but also from the point of view of the handicapped person.

"A handicapped person's livelihood ought not to depend on such a loaded gamble" as the uncertainties of the cash benefits system, with its gaps and duplications, its confusion and injustices. The book is clearly set out and designed to convince our decision-makers that the whole system needs complete rethinking.

Children living in long-stay hospitals

by Maureen Oswin, Spastics International Publications with Heinemann Medical £5.

There are 5,000 children under 16 now living in long-stay hospitals in England and Wales. Many of them are multiply handicapped — they may be speechless, mentally handicapped, deaf, incontinent, and perhaps unable to dress, wash or feed themselves without help.

This book describes the lives to which many such children are now condemned. Chapter headings include families, the nurses and hospital schools. It shows clearly the acute deprivations which the children suffer, for example even in getting cuddled or played with by anyone.

Maureen Oswin has some harsh comments to make about CHCs' representation of "this very inarticulate group of consumers". Since many CHCs have grouped themselves into special sub-committees on "physical handicap" and "mental handicap", they are unlikely to be able to focus on the needs of these children *as children*. She considers that the CHCs might have helped the children in her study, by drawing attention to: "(a) The children's need for therapy services. (b) The children's need to have the same standard of health care services as is received by ordinary children living in the community, particularly with regard to glasses, hearing-aids, orthopaedic attention and dental care. (c) The fact that understaffing in the wards was affecting standards of child care and depriving the children of mothering attention. (d) The need for more community accommodation to be made available for multiply handicapped children."

The book concludes that the lack of any national policy towards children in long-stay hospitals partly accounts for the acute under-staffing and financing of these institutions. But material improvements alone do not add up to good practice. Staff need to be aware of what Oswin calls "the human element" in residential care.

Books received

The place of birth edited by Sheila Kitzinger and John A. Davis (Oxford University Press £7.50).

A refuge for battered women by Jan Pahl (HMSO £1.75).

Benefits and hazards of the new obstetrics edited by Tim Chard and Martin Richards (Spastics International Publications £6).

WHEN IS A FRIEND NOT A FRIEND?

The complaints which make the best headlines are usually concerned with hospitals. A wrong limb amputated, brain damage from incorrectly applied anaesthetics, these are the stuff of drama. Few CHCs become involved in these cases since they go to court and are settled in a civil action.

No less dramatic to the patient, however, are the problems arising from an alleged failure of primary care, and it is in this field that CHCs find themselves increasingly active. It might be helpful to other CHCs if I outline a case in which I was involved and attempt to draw some conclusions from the experience.

The complainant — call her Mrs. X — wrote to the Family Practitioner Committee complaining about her GP, and was granted a formal hearing. She approached me for help and I assisted in preparing her case — trying to foresee possible lines of questioning, and high-lighting the major points on which her case rested.

The hearing was before a Service Committee consisting of three doctors and three lay members of the FPC, with a lay chairman who happened to be legally qualified. The procedure of such hearings is laid down by regulations (1) and in this case was conducted in a friendly and reasonable way. Committee members, complainant and respondent had all received in advance the written submissions of both parties. Both Mrs X and the respondent GP had the right to be assisted by a "friend". I helped Mrs X and the doctor was unaided. Each party had the right to make opening and closing statements and each was subjected to questioning by the panel and cross-examination by the other party. I was not allowed to address the hearing but sat beside Mrs X whispering advice or writing messages.

The committee found the doctor in breach of contract. He appealed to the Secretary of State. The appeal was upheld and a tribunal was set up by the DHSS. Although one might have expected the case now to be between the FPC and the doctor, Mrs X had to attend the tribunal and re-submit the complaint. (The case would have been re-heard in exactly the same way had the complainant appealed.)

Tribunal proceedings are quasi-legal — the usual rules of evidence as used in the courts are followed and all witnesses are on oath. Both parties may have their case presented by a "friend", whether legally qualified or not. Mrs X asked me to present her case, resisting advice from the FPC to employ legal help. The doctor's case was presented by a solicitor.

The tribunal consisted of a barrister from the DHSS (in the chair) and two doctors: one from the DHSS and one nominated by the General Medical Services Committee. This hearing was a very different experience from the Service Committee. Within minutes of the start, I was asked a series of questions which appeared to be designed to establish that I was a "paid advocate", and subsequent questioning verged on the hostile. The doctor's solicitor and I called witnesses, were able to cross-examine, and allowed to sum up at the end. Some six months after the hearing Mrs X was informed that the doctor's appeal had been dismissed. She had won her case.

As this was a good example of the entire process, what can be learnt from it? First it must be remembered that FPCs can only

by Pauline Phillips, Secretary East Herts CHC

investigate complaints where there seems to be a *prima facie* case that a doctor (or dentist, optician or pharmacist) has breached the terms of his contract. Some of these terms are precise — e.g. "a doctor shall supply drugs or listed appliances needed for immediate treatment of a patient before a supply can be obtained otherwise" (2). However, much of the wording is woolly in the extreme. For instance, a doctor is required to "render to his patients all necessary and appropriate personal medical services of the type usually provided by general medical practitioners"! Also the clauses relating to premises and record-keeping contain the words "proper", "sufficient" and "adequate". All this leaves scope for widely varying interpretations. Small wonder if practice varies from FPC to FPC and if CHCs pursue red herrings.

Secondly the very vagueness of most of the wording invites endless litigation. It is presumably with this in mind that the regulations for the Service Committee stage state that "no person shall be entitled in the capacity of Counsel, Solicitor or other paid advocate to conduct the case for any party by addressing the Service Committee or examining or cross-examining witnesses" (1).

At the tribunal stage, of course, both parties may be legally represented. Mrs X chose not to be because, as she put it, "*I* could just about afford it, but it might have been some little pensioner. Besides, I didn't bring the appeal, *he* (the doctor) did." The DHSS notes on tribunals (3) state: "The Secretary of State has the power to award costs. This means that the Secretary of State may decide that one party shall pay the other party's costs (his own expenses and those of his witnesses and any legal expenses). *This power is not often exercised*" (my italics). The effect of this is that the party not bringing the appeal has no guarantee that legal costs will be refunded even if the appeal is dismissed. The doctor has his defence organisation. The patient has no such safety net — not even legal aid.

In practice, I suppose, those most involved in helping complainants will be CHC secretaries rather than members. In trying to give the best possible advice and help, they will pool experiences over the years, building up a measure of expertise. They are paid to do this job. Is it so far-fetched, therefore, to call them "paid advocates" as some FPCs have done, and as the tribunal appeared to be trying to do in my case?

How long, therefore, might it be before either they are excluded from participation in the Service Committees on the grounds that they endanger the present "informality", or before practitioners develop a similar paid "friend", thus bringing the formal complaints procedure into the same quasi-legal field as the tribunal? Perhaps the latter course is the next logical step. I would be reluctant to contribute to such a development because I think it might intimidate all but the most determined and articulate of complainants.

One final word — confidentiality. Under present regulations proceedings of Service Committees and tribunals are confidential. At the last Society of FPCs' conference speakers accused CHCs of being incapable of being trusted to keep confidential matters from Service Committee hearings out of the press. This article in itself may reinforce that view. However, the methods by which complaints are handled are clearly a matter of legitimate public concern. The content of individual hearings is almost certainly not.

We may want to use our growing experience to try to change the system. If so, by all means let us do so, but let us do it with discretion and understanding.

Further reading

1 Statutory Instrument (SI) 1974 No 455 — NHS (Service Committees and Tribunals) amended by SI 1974 No 907 Amendment Regulations (from HMSO)

2 SI 1974 No 160 — NHS (General Medical and Pharmaceutical Services) Amendment Regulations 1975 (from HMSO)

3 NHS: Appeals from decisions of FPCs on complaints about doctors, dentists, chemists and opticians. (From DHSS, Eileen House, 80-94 Newington Causeway, London SE1.

Parliament

NHS Finance

In 1976-77, 7.1% of total national insurance contribution income went to the NHS in Great Britain — 9.7% of the cost of the NHS that year. Contributions from charges in the same period represented 2.1% of gross NHS expenditure; this compares with a peak of 5% in the years 1961-63. (William Molloy MP: Ealing North 28 April 1978.)

Chiropody services

The DHSS has issued guidance (HC(77)9) to health authorities advising them to examine the scope for more economical alternatives to home chiropody treatment which would not affect the standard of service. Greater use of chiropody services in day-care centres and clubs for the elderly will help to make the best use of resources until the money can be found to provide home visiting again, but there is still a shortage of State-registered chiropodists; the DHSS says it is doing its best to expand the output of chiropody training schools. (Hal Miller MP: Bromsgrove and Redditch 9 May 1978.)

Psychosurgery and ECT

Statistics on psychosurgery operations and electroconvulsive therapy treatments carried out in mental hospitals and units are now being collected by the DHSS. The first full returns will be for 1978, but information for 1977 supplied by 353 hospitals shows that 32 psychosurgery operations were performed in 16 hospitals. The Royal College of Psychiatrists is currently conducting a survey on the types of operations used. (Arthur Latham MP: Paddington 18 April 1978.)

Joint planning

The Government is aware that joint planning of complementary services by health and local authorities in England may reveal factors unquantified in the Resource Allocation Working Party's formula for assessment of relative need. The priority considerations thus uncovered will have to be taken into account when health authorities determine area or district allocations and when local authorities decide on the use of their block grant under the Rate Support Grant distribution and of other funds. (Lewis Carter-Jones MP: Eccles 14 April 1978.)

Male midwives

Two centres have been approved by Mr Ennals (under powers given him by the Sex Discrimination Act 1975) as places where men can be trained and employed as midwives, and the first two pupil male midwives are now completing their training. The DHSS is waiting for evidence on male midwifery practice as well as training before bringing up in the House of Commons the whole question of male midwives. (Patrick Jenkin MP: Redbridge, Wanstead and Woodford 21 April 1978.)

Swedish artificial hand

The DHSS is urgently arranging trials of an artificial myoelectric hand developed in Sweden. It is designed for children under five without fully formed arms. (Jack Ashley MP: Stoke-on-Trent South 21 March 1978.)

Kidney transplants

An attitude survey on kidney transplants including views on a contracting out scheme will be conducted this summer. (Tam Dalyell MP: West Lothian 21 March 1978.)

Confidential records

Access to an NHS patient's medical records is a matter for the doctor responsible for the patient's treatment. Confidentiality is safeguarded by the ethics of the professionals concerned. The fact that the Government is the legal owner of the records does not confer on anyone the right of access to them. (Patrick Jenkin MP: Redbridge, Wanstead and Woodford 22 March 1978.)

Healthline

Area health authority committees

Our AHA has established a policy and resources sub-committee which conducts its affairs in private. What powers do AHAs have to set up committees?

Circular HRC(73)22 *Membership and procedure of regional and area health authorities* states in its section on committees, "The Secretary of State considers it undesirable for standing committees to be appointed to deal with parts of an Authority's functions . . . Decisions on planning and resource allocation which will be the main function of members should be the concern of the whole membership."

CHC posters

Which CHCs have printed posters to advertise the CHC and its services to the public?

The list below is very probably incomplete, but we know of the following CHCs: Warrington, St Helens and Knowsley, Hastings, Coventry, Kensington-Chelsea-Westminster (South), Tunbridge Wells, East Somerset, Wandsworth and East Merton, Edgware and Hendon, Oldham, Newham, Wolverhampton, Rochdale and Hereford. Some CHCs used professional designers, others have held competitions among school-children.

Blood for private patients

Is it true that blood given by donors to the NHS reaches people in private hospitals? If so, is there any charge made for the blood?

All blood in England and Wales is collected by the National Blood Transfusion Service (see *page 11 CHC NEWS October 1977*). Some of it — 2% — is distributed for use in private hospitals and no charge is made for this. The DHSS is working out a scale of charges to reflect the handling and processing costs of supplying the private sector, so that the NHS is not out of pocket.

Copying from *CHC NEWS*

We are a non-commercial organisation which runs a quarterly news sheet and we would like to reprint an item which appeared in *CHC NEWS* — would this be alright?

Yes, provided that you acknowledge that the article first appeared in *CHC NEWS* and give our address so that people can contact us. We should also be grateful if you will send us a copy of the publication.

Community hospitals and GP beds

My CHC is interested in finding out more about general practitioner beds and community hospitals — can you suggest sources of background information?

The concept of GP beds seems to have become closely linked with that of community hospitals. This is because DHSS Circular HSC(IS)75 *Community hospitals; their role and development in the NHS* envisaged these hospitals mainly developing from the existing GP hospitals. Below are some references.

GP hospital beds: a review by S Israel and P Draper (British Medical Journal 20 Feb 1971)
The future of GP hospital beds by Michael Clarke (Update Plus August 1971)
Problems in the development of the community hospital by D P Kernick and S Davies (British Medical Journal 5 Nov 1977)
The use of surgical resources at a GP hospital in an urban area by F Homard et al (Health and Social Services Journal 26 May 1978)
Community hospitals — what is their role? by K S Cliff (British Medical Journal 25 Oct 1977)

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

Scanner

CHCs and the Ombudsman

Complaints about health authorities are continuing "at a high level", according to the *Annual Report of the Health Service Commissioner 1977-78* (HMSO, 70p). The commissioner notes that many CHCs are acting "very effectively" as the patient's friend, and that his relations with CHCs have been good. But he rejects criticisms of his posters, which fail to mention the role of CHCs in assisting complainants. The posters, he says, "are not intended to provide a comprehensive statement on how complaints can be put forward, but are concerned with the Ombudsman". A report giving details of 36 complaints investigated during the period December 1977 to March 1978 has also been published (HMSO, £2.60).

Work hazards in the NHS

A 115-page pilot study called *Working conditions in the medical service* has been published by the Health and Safety Executive. The study was carried out in the NW Thames region, and looked at six hospitals, two ambulance stations, a blood transfusion centre and health visitors. The HSE will be using the report as background in deciding how best to implement the Health and Safety at Work Act 1974 in the NHS. HSE, Branch RPD A3; Baynards House, 1 Chepstow Place, London W2.

Exercise and health

A new phase of the Sports Council's *Sport for all* campaign is being launched this summer. The council feels that the Health Education Council's *Look after yourself* campaign is convincing people of the health benefits of exercise, and *Sport for all* will aim to show that sport and physical recreation are enjoyable ways of taking that exercise. Sports Council, 70 Brompton Road, London SW3.

Drugs and psoriasis

The controversy surrounding PUVA therapy — the treatment of the skin disease psoriasis by a combination of the drug *psoralens* and ultraviolet light — is described in the Winter 1977 and Spring 1978 issues of *Beyond the ointment*, the journal of the Psoriasis Association. The Spring issue also looks at the side-effects of steroid skin-creams and ointments. Copies from 7 Milton Street, Northampton.

Detecting and correcting deafness

A useful survey on NHS hearing testing arrangements has been published in *Health Visitor* magazine, May 1978 (65p inc post from the Health Visitors Association, 36 Eccleston Sq., London SW1). Of 210 health districts in England, Wales and Northern Ireland, 63% routinely test infants and children, and a further 25% test infants only. In 90% of districts testing is done by health visitors, but in 27 districts there is no test of competence for this work. In 159 districts health visitors are not themselves tested for hearing defects.

Deaf children and their hearing aids, a report from The National Deaf Children's Society, recommends better fitting and testing procedures (50p from the NDCS, 31 Gloucester Place, London W1).

Stricter controls over medical practice

The Medical Act, which became law on 5 May, introduces new powers to maintain and improve medical standards, along the lines of the Merrison Committee's report (Cmnd 6018). New controls over doctors' fitness to practise and the registration of overseas doctors will be introduced. The General Medical Council, which will exercise these powers, will be reconstituted with a majority of members elected from the profession.

When am I on?

Grapevine — the BBC2 TV show which aims to "introduce people about to begin self-help schemes to those involved in schemes which are alive and kicking" — returns to the air this month. Most of the subjects covered in last year's series began as letters from

viewers, and suggestions for this year's shows should be sent to *Grapevine*, BBC TV, London W12.

Special education

A new framework for special education, based on a broader concept of educational need, is recommended by the report of the Warnock Committee*. The proposed new approach would include not only children with disabilities of mind and body but also those with significant difficulties in learning, and those with emotional or behavioural disorders. The report says that 20% of all children may require some form of special education at some time during their school career.

**Special educational needs*, Cmnd 7212, HMSO, £5.65.

Asbestos ban proposed

A ban on the use of asbestos-containing products for heat and sound insulation is proposed in the first report of the Advisory Committee on Asbestos. A second report from the ACA recommends a monitoring programme to assess people's exposure, especially around asbestos factories, waste disposal sites and buildings where asbestos has been used during construction. *Work on thermal and acoustic insulation and sprayed coatings* (HMSO, 50p plus post), and *Measuring and monitoring of asbestos in air* (HMSO, £1 plus post).

Payments for vaccine damage

People "severely damaged by vaccines recommended for the benefit of the community" will be able to claim lump-sum tax-free payments of £10,000, David Ennals has announced. This is not a compensation scheme — families receiving these payments will still be entitled to take legal action, Mr Ennals told the Commons. Jack Ashley MP commented that vaccine-damaged children could be entitled to £250,000 each if inflation-proofed awards were made on a loss-of-earnings basis.

Chiropody services: HC(78)16

Advises health authorities that they may provide free chiropody services to patients in nursing and mental nursing homes, on the same basis that such services are provided to patients in their own homes. This clarifies HRC(74)16, which was misleadingly worded.

Prescription Pricing Authority: HN(FP)(78)25

The PPA, the body which prices all NHS prescriptions in England, has been reconstituted along the lines of the Tricker report (*Inquiry into the PPA*, DHSS 1977, £3). The PPA's 16 members now include a CHC representative for the first time, and ACHCEW has nominated Leeds Eastern CHC's chairman Leslie Rosen for this post.

Directory of CHCs: changes

A directory of CHCs in England and Wales is available from *CHC NEWS*. This was last updated in February 1977, and a revised version is now in preparation.

Changes are published monthly in *CHC NEWS* — please notify us of any alterations in address, telephone number, chairman or secretary.

Page 15: Edgware/Hendon CHC Secretary: Mrs Laurie Millward
Page 15: Barnet/Finchley CHC Secretary: Mr J Corbett
Page 16: Ealing CHC Secretary: Josephine Barry-Hicks
Page 23: Bexley CHC Chairman: Mrs E Tod
Page 23: Bromley CHC Chairman: Mrs M E Thomas
Page 29: Bath CHC Chairman: Mrs D Howlett
Page 35: Salop CHC 21a High Street, Shrewsbury SY1 1SJ
Page 39: Walsall CHC Secretary: Miss June Smith
Page 43: Manchester Central CHC Chairman: Mr Jack Chadderton

News from CHCs

☐ **South West Leicestershire CHC** has had thousands of phone calls and letters in support of its all-out campaign for a well-woman clinic in Leicester. With support from the city council, the Leicester Mercury and the other CHCs in the county, a mass rally is being planned. More than 1,000 women have promised to attend. The AHA says that a well-woman clinic would duplicate existing cytology facilities. CHC Secretary, Brian Marshall, commented, "Every member of the community has a shareholder's interest in the running of the NHS. The rally is really a meeting of lady shareholders who want to bring a deficiency to the notice of the health authority".

☐ **North Warwickshire, Rugby** and **South Warwickshire CHCs** have each been asked to nominate one member to serve on a new ethical committee, which the AHA has set up to oversee the computerisation of birth and immunisation records. The AHA will nominate three further lay members to the 14-person committee.

☐ Concern about the injectable contraceptive, Depo-provera, has been voiced in **Manchester Central** and **Rochdale CHCs.** The injection is effective for three months and CHC members are worried that women are not being told enough about possible risks and side-effects, such as excessive and prolonged menstrual bleeding. **Wandsworth and East Merton CHC** has announced that it will investigate the basis on which the drug is given in Wandsworth.

☐ Worthing's MP, Terence Higgins, asked a parliamentary question to help **Worthing CHC** get a reply to a letter which had been sent to David Ennals and had been unanswered for two months. Within a week the DHSS sent a two page reply. And local MPs have responded to **East Glamorgan CHC's** request that they support a House of Commons motion calling for chemists' services to be planned by FPCs along the same lines as GP services. Parts of East Glamorgan health district have had a rapid population increase and chemists' shops are few and far between.

☐ A group of parents of mentally handicapped children organised and ran a one day conference, with the help of **South Sefton CHC.** The CHC publicised the event and a child-minding service was arranged by a CHC member. 200 people came to the meeting, mostly local parents.

☐ When three cases of typhoid were confirmed among school-children in the district, **Hillingdon CHC** co-operated with the AHA and the local authority and published 5,000 fact sheets about the disease. The CHC acted as an information centre and organised speakers at a meeting held to dispel alarm. In its regular newsletter the CHC poses a number of questions which the exercise raised such as when people should be alerted of a possible notifiable disease, how much information should be given and whether there is a danger that unnecessary public alarm will necessitate expensive over-reaction.

☐ **Rochdale CHC** has applied to the RHA for a loan of £450 to buy balloons, badges and plastic bags (5,000 of each) publicising the CHC. These would be sold at 4p each at fetes and summer shows. This has provoked the resignation of the CHC Chairman and two members and has prompted the CHC Secretary Andrew Devenny to leave two months earlier than planned. All four left because they did not wish to be associated with this kind of spending, described by Mr Devenny as "gimmicky". Margaret Edwards, who chairs the publicity committee of the CHC, argues that the scheme is not frivolous — the idea is to attract people to come and hear about the CHC — and that publicity is of crucial importance. The Chairman and Secretary consider that the CHC receives more than adequate news coverage and that there are much more important spending priorities for NHS money.

☐ *Idris Davies, Chairman of the* Isle of Anglesey CHC, *has been appointed Chairman of the Gwynedd Area Health Authority. This is the third instance known to CHC NEWS of a CHC member being appointed to the chair of an AHA. Idris Davies is also Chairman of the Association of Welsh CHCs, and a member of the Association of CHCs for England and Wales.*

☐ With the full backing of **North Lincolnshire CHC,** Geoffrey Callaghan, the Secretary, made a 10 day tour of Holland, Belgium and West Germany to compare opportunities for mentally handicapped people. The visit included Lincoln's twin city, Neustadt an der Weinstrasse. One result of the trip will be a follow-up to the book published by the CHC in 1976, "Employment of the Mentally Handicapped".

And the CHC has decided unanimously to end its attempts to gain observer status on the FPC. Members are attending FPC meetings as members of the public.

☐ When told that abuse of the system threatened the future of flexible visiting hours at the district hospital, **York CHC** printed a leaflet for visitors. This reminds them not to stay too long, lists the visiting times on all wards and includes a chart on which people can co-ordinate the times of their visits to a patient.

☐ At the Royal Society of Health's annual congress in May, speakers included Emrys Roberts, Secretary of **South Gwent CHC** and Rod Griffiths, Vice-chairman of **ACHCEW.** At an RSH conference on the role of the volunteer in the welfare state, **West Essex CHC** Secretary Angela Alder gave an account of her CHC's links with local voluntary organisations.

☐ The three **Manchester CHCs, North, South** and **Central,** have launched a search for children damaged by hormone pregnancy testing drugs (see *CHC NEWS* May 1978). Health councils in England, Wales, Scotland and N Ireland have been sent background information, model press releases and questionnaires. Families who respond will be put in touch with the Association for Children Damaged by Hormone Pregnancy Tests.

☐ *Miss G. M. Webster, a member of* North Birmingham CHC, *has arranged two informal short courses for GPs' receptionists at a local college where she teaches. The course lasts ten weeks, one day a week, with discussions on running the office, relationships with patients and with doctors and simple first aid. There are visits to the FPC and to the records section of the hospital and outside speakers have included the CHC Secretary. Our picture shows one group in a first aid training session.*

Photo: Sutton Coldfield News