CHC NEWS

For Community Health Councils July 1981 No 68

Smokescreen at the zoo

Norway's tough new tobacco laws are reducing juvenile smoking, but in Britain a fresh attempt to introduce similar legislation has been thwarted — by MPs with an over-riding concern for the state of the nation's zoos.

In 1975 the Norwegian Tobacco Act banned all forms of tobacco promotion, stepped up health education about smoking and increased the help available for smokers who want to give up. Since then, according to figures just released by the Norwegian Council on Smoking and Health, smoking amongst 13- to 15-year-olds has fallen noticeably, and the sharp increase in smoking by girls has been dramatically reversed (see graph). Before the Tobacco Act cigarette consumption in Norway had been rising steadily, but it has now levelled off and may even be starting to fall.

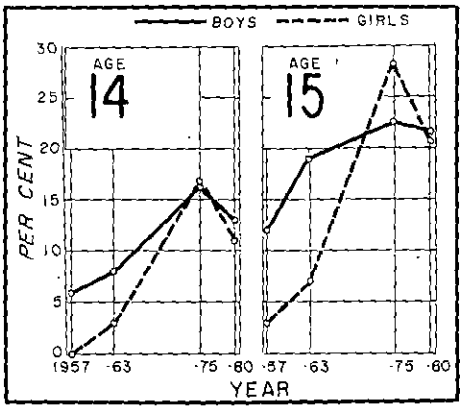
Meanwhile in the House of Commons, Laurie Pavitt MP's latest attempt to get a second reading for his Tobacco Products etc Bill has been blocked by a small number of Conservative MPs. The Bill would have given the Social Services Secretary considerable new powers to control tobacco advertising and sponsorship, and the Government was not planning to oppose it.

But on the day before the debate 164 amendments were tabled to the Zoos Bill, a measure which until then had seemed fairly uncontroversial. Such was the belated interest in zoos amongst pro-tobacco MPs that Mr Pavitt's Bill was effectively "talked out".

The Action on Smoking and Health group says the Norwegian figures leave the British Government with "no excuse for holding back". According to ASH, Britain has the highest rate of lung cancer in the world, and for every person killed on

The tobacco industry escapes yet again.....

Britain's roads twelve to fifteen people die prematurely because of smoking. The director of ASH, David Simpson, has condemned the lobbying of MPs by "tobacco and advertising men", describing this as "little short of criminal".



The two graphs above, based on surveys carried out at every school in Norway, show the percentages of 14- and 15- year-olds who smoked daily. The Norwegian Tobacco Act came into force in 1975.

WHY NOT JOIN THE MANAGEMENT?

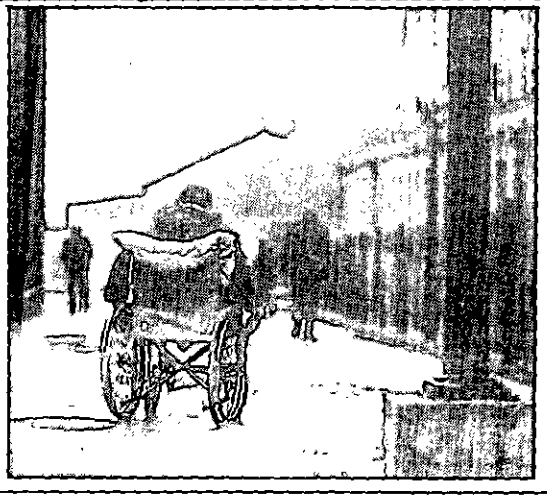
Community health councils are being invited to recommend people for appointment to the new District Health Authorities, and the recent DHSS circular on DHA membership makes it clear that people with CHC experience are particularly well qualified for the job.

In most cases DHAs will take over from the Area Health Authorities on 1 April next year, but as soon as members can be appointed they will begin work as "shadow" authorities until the handover takes place.

Circular HC(81)6 explains that existing CHC members cannot simultaneously be members of DHAs, and so would have to resign if appointed to the "shadow" body. DHA members must live or work locally, or have other ties with the health district. They should be ready to devote "2-4 days a month, during and outside normal working hours" to the job. The need for an influx of younger people, to "provide for continuity of experience for the future" is stressed. DHA members are expected to contribute to the planning and administration of local health services in a "constructive as well as questioning way", without concentrating on matters of particular personal interest.

The circular also cancels all restrictions on the formation of health authority committees and sub-committees, leaving DHAs free to "establish committees as they see fit". But the DHSS warns that it will be important to guard against any erosion of DHA members' collective responsibility for major decisions, and against any possible diminution of public knowledge of the authority's affairs.

Appendix 4 gives detailed guidance on relations between CHCs and DHAs, aimed at promoting the maximum "open and public discussion" of NHS affairs, and at ensuring that the CHC voice is "clearly heard at the point of decision making".



Your letters

New for old

Emrys Roberts, Secretary, South Gwent CHC

My heart bleeds for the poor people of Bury! Bury CHC (*CHC NEWS 64*, page 13) was quite right to oppose plans to provide a district general hospital by re-developing an existing site. In South Gwent we speak from experience.

A decision to re-develop an existing site instead of building on a green-field site was made in Newport over 20 years ago. The re-development began in 1964. Today — 17 years later — it is still only half complete and we shall be lucky if the scheme is completed before the end of the century.

Any re-development scheme of this nature has to be broken down into many stages in order to cope with the technical difficulties of maintaining services while re-development takes place. However a more serious complication in our case was that a separate application for funding had to be made for each stage of the re-development process so each stage had to compete with other capital developments in other parts of Wales. With a green field site, once funding has been allocated the bulk of the work can then proceed without further funding delays.

The result of all these difficulties is that the level of service in our district is amongst the worst in Wales — with much lower ratios of staff to patients and total population, fewer beds and much longer waiting lists.

Our experience would certainly indicate that any CHC should strongly resist any attempt to secure its agreement to the re-development of an existing major hospital rather than building on a new site.

Fluoride tablets

Patrick Stocker, Fluoride Supplement Association, 51 Greencroft Gardens, London NW6

In *CHC NEWS 64* (page two) Professor Neil Jenkins mentions certain objections to fluoride tablets which we wish to answer

He says that tablets are unlikely to be taken after childhood,which we think is probably correct — but it has never been suggested by the dental profession that this is necessary. As manufacturers of tablets we would be unwilling to advise their use after 30 at the very outside.

As to whether tablets cost more or less than water fluoridation, there is a point at which it becomes uneconomical to use fluoridation and the figure is about 1000 cubic metres per day. Clearly at that point tablets would be more economical.

Professor Jenkins mentions that the regular use of tablets cannot be guaranteed. We would point out that when parents pay about £2 per year they are not going to let their children forget to take them. We know in fact that the habit of taking fluoride tablets is as easily taught as cleaning teeth.

We give full support to water fluoridation and think that there is a place for this and tablets. We only claim one area where tablets are superior and that is when they are given to expectant mothers in the last six months of pregnancy. Children of these mothers are so well protected that they probably won't need any tablets until they are about five. Water fluoridation seems to give a much more limited benefit.

Statistical methods

Rod Griffiths, Member, Central Birmingham CHC

Mr Condon (*CHC NEWS 67*) says that Birmingham pays "a heavy price" for the benefit of fluoridation "in its greatly increased cancer death rate". This oft-repeated statement is simply not true. The Cancer Registry in Birmingham, one of the most complete in the world, has examined this claim several times, tracing each cancer death back with the water authority to check on fluoride levels in the supply. No link has ever been found between cancer deaths and fluoridation by this exact method.

The claim of a link seems to be based on research work by Dean Burke, who uses a particular statistical method, but the effect he shows is an artefact of the way he has applied the method (he appears to work backwards from the answer he expects). No link can be found if the same data is analysed by methods which do not presume the answer before they start. In the research papers I have been able to obtain Mr Burke makes no allowance for changes in the age and racial structure of the population, which have been substantial in the fifteen years since Birmingham was fluoridated, nor for changing levels of pollution and smoking, which certainly affect cancer deaths.

It is important that we continuously monitor to detect possible ill effects of fluoride, but those who oppose fluoridation seem to claim that it causes almost everything. For instance, it is claimed to cause all cancers, and Dr George Waldbott in his book *Fluoridation: The great dilemma* lists 26 so-called major symptoms. When such wide claims are made they make the whole case appear irrational, and obscure sensible debate.

Ed: This round of correspondence on fluoridation is now closed.

Recalling mental patients

Charlies R Schreiber, Secretary, North Herts CHC

North Herts CHC has been studying the DHSS circular HN(80)44 — *Recall of mental patients subject to Home Office restrictions on discharge.* What concerns the CHC is not merely that there should be provision for a patient's recall, but that there is no period laid down during which the third party — friend or relative — must be informed. We suggest a maximum of 48 hours.

It would be interesting to know if other CHCs are able to cite cases where relatives or close friends have not known of the whereabouts of a patient who has been recalled, until some while after the recall.

Continental quilts

R Valerie Dabbs, Secretary, East Cumbria CHC

Following receipt of the circular HN (Hazard) (80)21 — *Fire risks associated with furniture, furnishings and textiles* — Cumbria Area Health Authority agreed that continental quilts should be removed from use in long-stay hospitals except when they were considered clinically necessary.

While appreciating the need to protect patients from fire hazard, East Cumbria CHC felt that the problem was one of preventing patients from smoking in bedroom areas. The use of continental quilts has done much to brighten the appearance of wards, and has helped to create a more home-like atmosphere — particularly as the quilts have been purchased by the patients or their relatives. Consequently the CHC feels disappointed with the AHA's decision.

The CHC would be interested to know the reaction of other CHCs and AHAs to this circular.

Reporting back

John Carey, Vice-Chairman, Worcester District CHC

The Liberal Party's health panel (*CHC NEWS 64* page 15) advocates that CHCs should have a right to information from public bodies other than health authorities. But surely what CHCs really need is representatives on all committees pertaining to the NHS, who could then report back to their councils. At the moment such committees only release the information *they* think we should have.

The elderly's only support

A P Fletcher, Member, Edgware/Hendon CHC

I would suggest that the front-page headline in *CHC NEWS 65* "Leaning on the community" might lead readers into the fallacy of thinking that the elderly can have some support on which to lean other than the community — in the sense of the whole able-bodied population.

Continued on page 14

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Comment

The advert for the vacancy could well read: "The successful candidate will have the patience of a saint, the tact of an ambassador, the versatility of a trapeze artiste, nerves of steel, pressure group perseverance, an eagle's eye for detail, a passion for committees and all the time in the world". This would not be an exhaustive list of the qualities a community health council secretary needs and it does not even touch on the equally impossible list of skills which are required. Cynics might argue that it also omits the warning, "this is a dead-end job".

A report from the Society of CHC Secretaries and the Society of Welsh CHC Secretaries brings into focus the knowledge and skills required to be a CHC secretary. The report, based on a survey of all the secretaries in England and Wales, is being submitted to an NHS committee which is investigating the recruitment and career development of administrators.

The research reveals the extraordinary range of skills needed for the job. Secretaries rate the most important ones as — counselling members of the public, administration, public relations, knowledge of health care issues and terminology, and dealing with members of the council. The report highlights the lack of training opportunities for secretaries both before and after appointment. It also draws attention to the maverick nature of the job in relation to the rest of the NHS machine — "it is difficult to imagine a post of similar scope or responsibilities in the NHS which is so isolated professionally".

Where do secretaries come from? And where do they go? At first many came from the NHS, displaced by the 1974 reorganisation. But now over 60% of new entrants to the job have no experience of the NHS. The report strongly recommends induction training for all new arrivals as well as day-release for established officers.

The lack of a career path in the NHS for CHC secretaries is striking. Secretaries develop a high level of expertise and knowledge of the health service and are expected to deal directly with senior officers in the NHS. But most of them can usually only develop their careers by leaving the NHS.

Could the lack of a career path in the mainstream of the NHS be a good thing — from the patient's point of view? There is a widely-held view among secretaries themselves that an individual who wants to forge a career in the NHS machine might be inhibited about representing the patient's interests fearlessly. The fact that the job does not fit into the system may serve as a useful deterrent to types who are mainly concerned not to rock the boat.

The survey does not go into the qualitative aspects of CHC work — the motivation, the degree of job satisfaction, relations between officers and members. But it highlights the awesome demands which are made on CHC secretaries, often with little preparation and very little back-up support. The lack of post-employment NHS training betrays a "sink or swim" attitude to the CHC's principal officer which is clearly not in the interest of the NHS consumers who secretaries are supposed to represent.

The administrative function of community health councils from the Society of CHC Secretaries, c/o Bury CHC, 1 Murray Road, Bury, Lancs.

Health News

Axed Children's Committee may refuse to go quietly

The Children's Committee — set up in 1978 as a voice for children with direct access to the Secretary of State — is to be closed down in October. But its members say they may decide to carry on as an independent Children's Council, which would work to influence Parliament and the public.

Social Services Secretary Patrick Jenkin says the Government's policy is to retain only those non-Departmental public bodies which are "clearly essential", and the Children's Committee has failed this test.

A statement from the Children's Committee expressed its disquiet and perplexity at the decision: "The committee was originally set up as a joint committee of the Personal Social Services Council and the Central Health Services Council. However, within one year of its inception, the present Government had closed these two parent bodies, and it was already becoming increasingly clear that the Government was less inclined than its predecessors to receive advice or indeed to offer advice to those working in the field.....

"The need for improvement in the health care and social care of children is of even greater importance now than was the case in 1978. Many services have been cut back and there is little evidence that the Government's stated desire to protect the interests of children has been adequately achieved.....

"The members of the Children's Committee therefore intend, in their

personal capacities, to explore with urgency the possibility of creating a framework for a Children's Council, so that all who are persuaded of the need for a voice for children may secure an independent means of working collaboratively to influence Parliament and to improve public understanding of the needs of children".

Advocacy Alliance

For the first time in this country three of the largest mental handicap hospitals will shortly be opening their doors to 120 volunteer "advocates", who will each take on an individual patient and represent his or her interests at every level of the hospital's hierarchy.

This project is being run for two years on a pilot basis by the Advocacy Alliance which is a new offspring of Mind, Mencap, the Spastics Society, Cheshire Homes and One-to-One.

Carefully recruited non-professional volunteers will be expected first to establish a personal relationship with "their" resident patient, and then to look at the patient's quality of life in the broadest sense, taking up issues affecting the patient's well-being at three possible levels. The day-to-day level might involve speaking to the charge nurse about the patient always sitting in a draught or the quality of the food. Next it may be necessary to contact the administration about matters of hospital policy such as the use of the patient's mobility allowance. And finally the pursuit of the patient's statutory rights may bring the advocate onto a more "political" level.

The volunteers will be expected to make a considerable commitment of time and effort. They will start with a three month part-time training programme which will include four days on the ward getting to know the residents and their routine. It is hoped that, perhaps at this stage, the patients will have the final say about which volunteer will be allocated to them. Thereafter the advocates should visit their patient at least once a week for a minimum of two hours.

Advocates will have greater access to senior staff than is usual for volunteers and it is hoped that they will be fully accepted as a normal presence on the wards. Staff at

Continued on next page

Photo: Raissa Page

Health News

Continued from previous page
two of the hospitals involved, Normansfield and Little High Wood in Brentwood, have been fully consulted and have shown "a very positive response" to the idea. Officials at the third hospital, St Ebba's, near Epsom, have approved the scheme "in principle" and are currently talking about it to the nursing staff.

Bob Sang, the coordinator of the Alliance, hopes that the new project will be of great interest to CHCs. He can be contacted at 16 Chenies Street, London WC1E 7ET. Tel: 01-580 7790.

London's primary care

The torrent of reports on the problems of the NHS in London shows no sign of diminishing. Two more major documents on primary care in London have now appeared, and Patrick Jenkin's own London Advisory Group has warned him that his personal commitment to change is essential if progress is to be made.

Perhaps the major document of the current crop is the report of the London Health Planning Consortium's Primary Health Care Study Group (1), chaired by Professor Donald Acheson, professor of clinical epidemiology at Southampton University. This states unequivocally that "primary care as it is currently organised and provided in inner London cannot for long continue to cope with the needs of the population, particularly in view of the reduction in acute hospital services which is already being implemented".

In 115 detailed recommendations the Acheson report seeks to encourage the development of GP group practices and inter-professional working, to improve the conditions for the delivery of primary care, to improve patients' access to services, to reduce the barriers between different services, and to improve arrangements for education in general practice and community nursing. Small lists should be discouraged, GPs should be helped to retire earlier, minimum standards should be set for surgery premises, and public understanding of services — eg deputising services — should be increased.

The second report, from the Royal College of General Practitioners (2), paints much the same picture, concluding that "What appears to be required in London are young, enthusiastic doctors with new ideas, prepared to tackle the very considerable problems of the metropolis".

The London Advisory Group, in its final report to the Secretary of State (3), makes it clear that its proposed strategy for acute services in London "depends fundamentally for its success on a complementary strengthening of the primary health care services". On the question of changing London's regional structure, the report recommends that this should be deferred until the Secretary of Stae has carried out his proposed review of regional functions in England as a whole. But in the meantime there would be a role for a "pan-London" liaison body. In a foreword to the report, LAG chairman Sir John Habakkuk tells Patrick Jenkin that without his personal commitment to implementing the recommendations of the Acheson report "little progress will be made in this vital area".

A one-day conference to discuss action on these reports will be held at the King's Fund Centre in London, on Tuesday September 22. Details from Jane Hughes on 01-267 6111.

1. *Primary health care in inner London.* Copies from LHPC, Euston Tower, 286 Euston Road, London NW1.
2. *A survey of primary care in London,* by Brian Jarman. £4 inc post from the RCGP, 14 Princes Gate, London SW7 1PU.
3. *The development of health services in London.* Copies from DHSS, Alexander Fleming House, London SE1 6BY.

Primary health care teams

The concept of the primary health care team should be promoted wherever possible in the interests of improved patient care, according to a new report* from the DHSS joint working group on primary health care teams.

The group was set up in 1978 because of the growing awareness that belief in the team concept was waning and reports were appearing about GP/nurse attachment schemes being dismantled — especially in inner city areas.

By "primary health care team" the group meant an interdependent team of GPs, secretaries and/or receptionists, district nurses, health visitors and midwives "who share a common purpose and responsibility". The group does not believe there can be any particular model for such a team — each has to develop its own ways of working.

The group found three major problems which were hindering teams' efficiency — lack of resources, including inadequate premises; misunderstandings among team members about each other's role — especially the changing role of nurses; and the difficulty of reconciling two very different management structures — independent GPs linked to virtually autonomous family practitioner committees in contrast to the other staff who work within the hierarchical health authorities.

There are 50 recommendations in the report for improving the situation. These include giving priority to the expansion of health visiting and district nursing services; and introducing consultation over the design of new or adapted premises with the eventual users. Expenses attributable to AHA nurses working in GPs' premises should be reimbursable to the GP by the AHA, and training for teamwork should be included in medical and nursing education.

There are suggestions for facilitating liaison between primary health care teams and nursing management and for improving communication between members of the team itself. Health authorities are asked to set up reviews of their existing arrangements for attachment of nurses to GPs.

A chapter on the particular problems of rural and urban areas makes specific proposals such as enabling health authorities to employ salaried GPs and concentrating training resources on mature nurses and providing part-time courses for nurses with domestic commitments.

* Report of the joint working group on the primary health care team, available from Mr D W Baker, Room C203, Alexander Fleming House, Elephant and Castle, London SE1 6BY.

Stats cuts

The Government has produced a White Paper* outlining its proposals for cuts in statistical services. Following its study of the Rayner recommendations (see *CHC NEWS 66* page 15) which advocated savings of £20m in statistical services, the Government has firmly decided on cuts totalling £12½m — the other savings have either been approved "in principle" or are still being considered.

The total cost of DHSS statistics will be cut proportionately more than for any other department except the Inland Revenue, ie by 38%. The Government intends to limit "to the essential" the central collection of health and social service statistics. Health authorities and local government will be encouraged to gather their own figures which are necessary for local needs.

* *Government statistical services.* HMSO £2.10

Unemployed — unhealthy

Even the authors of a recent DHSS-funded study of the long-term unemployed were surprised at how frequently ill-health appeared in the families of the unemployed. This little-publicised report joins the growing body of research revealing the links between poor health and lack of work.

In *Unemployment and health in families** Dr Leonard Fagin describes the results of an in-depth study of 22 two-parent families whose male breadwinner had been out of work for at least four months but employed throughout the previous year. The idea was to "describe the process of unemployment in a few families in different parts of the country" by getting to know the families.

Health problems had been present in a few of the families prior to unemployment but where they follow its onset Dr Fagin believes that they are crucially associated with job loss rather than any other incident in the family's life.

Many breadwinners showed signs of both physical and mental ill-health, eg asthmatic attacks, psoriasis, backaches, increased use of tobacco or alcohol, violent out-bursts, insomnia and suicidal thoughts.

Unemployment in the family can also affect children's health — especially younger children who commonly became accident-prone and suffered feeding and sleeping difficulties, behaviour problems and various ailments.

* Available from Information Division, Block 4, Canons Park, Government Buildings, Honey Pot Lane, Stanmore HA7 1AR. Price £6.

A stitch in time

by Kenneth Kendall, Member, Ealing CHC

In recent months a succession of urgently-needed major repairs and building improvements in the Ealing Health District has been of some concern to my CHC. Emergency building work can totally disrupt both capital and revenue budgets, and can also result in patient services being provided in most unsatisfactory conditions. Such disasters often result from a lack of regular inspections, and to avert this kind of problem many organisations have adopted a system of *planned preventive maintenance* (PPM).

To implement PPM a detailed survey of all buildings must be done, to find out:

A. How each building has been constructed, and what materials its fabric contains.

B. What mechanical and engineering services are present, eg electricity mains, lifts, boilers, air conditioning, ventilation etc.

C. What equipment each building contains. This means basic equipment such as beds, stretchers, trolleys and machines for catering and cleaning, as well as highly specialised items of the kind used in X-ray departments and operating theatres.

A schedule is then drawn up showing the life-expectancy of all these items. From this it is possible to look at each building and make financial provision in advance for predictable failures, repairs and replacements. Regular servicing of fabric and contents can also be planned. With this system unexpected crises — and hence budget disruptions — should only occur when an "act of God" strikes.

The PPM principle is generally accepted within the NHS, but is not generally implemented. In Ealing, for instance, a PPM system has been set up for our new District General Hospital, but does not operate throughout the rest of the district. A major reason for this restriction on PPM, we understand, is the low level of funds available to the area works department. In 1980/81 the budget set aside for recommended maintenance was cut by 10% to enable cash limits to be met, and we feel this was a short-sighted move that will be costly in the long-term.

Care in action, the Government's new handbook on priorities for the NHS in England, points out that although major new construction work has been carried out on about 300 hospital sites during the past twenty years "a significant proportion of hospital care is still carried out in old and outmoded buildings". In the next ten years, expenditure of well over £350m is planned to update some of these buildings — but how much of this expenditure could have been avoided if PPM schemes had been in force for the last ten years?

There is certainly no shortage of *advice* available. There are of course the Building Regulations, and the DHSS has issued a whole series of Health (previously called "Hospital") Building Notes and Technical Memoranda, giving check lists of recommended examinations to ensure that plant and equipment are up to design and specifications, and suggesting that the Factories Acts, insurance reports and British Standards literature should be regarded as suitable guidance by those responsible for maintaining NHS property.

In particular, Health Technical Memoranda 12 and 13 discuss arrangements for routine inspections, overhaul and replacement of plant and equipment, and the general strategy of PPM. Unfortunately, this abundance of information is "for information only", as there is no system of enforcement within the NHS or the DHSS.

Since the Health and Safety at Work Act became law in 1974, inspectors from local authorities and the Health and Safety Executive have generally been invited into NHS buildings where appropriate, and there has been considerable improvement where their recommendations have been put into operation.

But the response of District Management Teams to this need has been patchy throughout the country, largely due to variations in the availability of funds. If essential maintenance work is neglected in any one year it can be taken for granted that it will increase in cost in the next and subsequent years. Can the NHS afford to waste funds in this way?

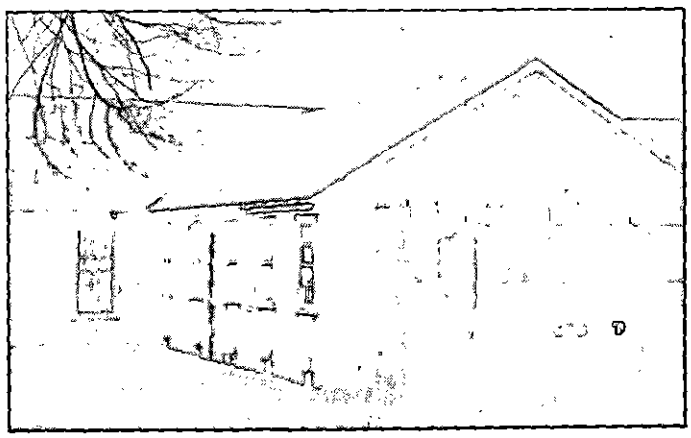
Some consideration should be given to an improved method of financing. Industries which use PPM accept that buildings and equipment deteriorate each year, and a depreciation fund is set up to provide for their eventual replacement. Maintenance systems are operated to try to extend the working life of the buildings concerned. In the NHS, on the other hand, a maintenance budget is provided for the district irrespective of its actual known needs, as shown in the cumulative register of outstanding maintenance work which all Area Health Authorities should be keeping. CHCs might do a useful service by trying to find out whether the size of the register in their area is being reduced or is still increasing.

In most districts the maintenance of engineering and technical services is probably kept fairly well up-to-date, since the whole functioning of the NHS depends on them, but in the event of any serious breakdown there should always be an investigation into how far this has been caused by faulty maintenance.

Some of the internal services will depend upon the proper upkeep of the fabric of the building. Ill-fitting doors and windows, for example, can call for extra heating and put extra pressure on the ventilation system, with consequent waste of energy and unnecessarily high costs. Inadequate maintenance of a building's eaves and drainpipes can cause seepage of water and consequent deterioration of brickwork, and in bad cases can cause disruption of electrical installations.

The old adage "a stitch in time saves nine" applies to all our buildings and equipment, and maintenance need not be expensive if routine checks and any necessary work are carried out at the same time. Neglect can only call for heavy capital expenditure later. It is appreciated that no proposal which involves the spending of money is likely to be welcomed in the present economic climate, but PPM should be seen as a major investment for the future.

The Association of CHCs is looking into the possibility of issuing a maintenance checklist, perhaps drawn up in collaboration with the Association of Area Works Officers, which CHCs could use in discussions with the new District Health Authorities. In this way CHCs would be able to play a part in planning the future of the NHS estate.



This dilapidated hut is part of the nurse training school at St Bernard's Hospital, Southall. It was built circa 1895.

Photo: Ealing CHC

'The lady from the welfare'

"Prevention" has become a much-vaunted but easily dismissed catchword in discussions about health care. It is sometimes forgotten that there is a whole profession — health visiting — whose principal function is precisely prevention. Its training council defines this role as "the promotion of health and prevention of mental, physical and social illness". Because "health" and "prevention" can sound so nebulous, members of the public — and indeed of other health service professions — sometimes become confused about what health visitors actually do and how they differ from social workers or district nurses. Even health visitors, according to their professional body and trade union, the Health Visitors' Association, "sometimes tend to lose their sense of identity and their clarity of purpose".

Health visiting evolved from the sanitary inspection and home-visiting carried out by ladies in the nineteenth century who aimed to bring ideas of hygiene and health care into the homes of poor people. In the early part of this century this effort became concentrated on mothers with young children, but the NHS Act 1946 defined the health visitor's role as also including giving advice about the care of expectant and nursing mothers, ill people and "the measures necessary to prevent the spread of infection". Although this section of the Act was repealed by the NHS Reorganisation Act 1974, a new statutory definition for health visiting is under discussion at the DHSS. As well as the preventive function, the Council for the Education and Training of Health Visitors defines the health visitor's role as including:

- Early detection of ill-health and the surveillance of high-risk groups,
- Recognition and identification of need,
- Health teaching, and
- Provision of care, including support during periods of stress.

In an ideal world ...

In theory, a health visitor's brief could involve visits to almost anyone in the community. In practice she or he (there are some male health visitors) has to set priorities because of pressure of work. In its recent review of the profession (1) the HVA drew up what it considers to be the three levels of priorities for health visitors.

For those working under the most pressure it recommends concentration on:

- Urgent home visiting where there are new births, newly arrived families with small children, possible cases of non-accidental injury, handicapped children, newly reported TB cases, ante-natal mothers expecting their first child and families requesting visits,
- Urgent referrals from other agencies,
- Efficient record-keeping,
- Involvement with training health visitor students, and
- Work in child health clinics

For those under less pressure the HVA's additional suggestions include routine visiting of all children under five and all ante-natal mothers, health teaching in schools and to adult groups, and following up children who are not brought to the clinic for developmental testing. And when health visitors have really small caseloads the HVA would like to see them giving support to families under stress from problems such as psychiatric illness, extending their counselling and health education role, visiting play groups and nurseries and getting involved in research projects.

What they do

Meanwhile a health visitor and researcher, June Clark, has been trying to find out what health visitors actually do, by looking at the 37 relevant research studies produced over the last 20 years (2). She has had to conclude that "No study to date has used a sample from which we can legitimately generalise about health visiting over the country as a whole".

However Clark does draw interesting conclusions from her review. "In very general terms it is possible to conclude that health visitors spend between a quarter and a third of their time on home visits, about a sixth on clinic sessions (mainly child health sessions), a further sixth on travelling, and about a quarter on clerical work". As might be expected, health visitors' major client group is families with young children. However the proportion of visits made to elderly clients is shown to vary enormously — from 3.4% of visits in one study to 36.2% in another. This may depend on whether the area has a large elderly populaton — studies in Worthing and Brighton show high percentages — and whether there are specialist geriatric visitors as in parts of London.

Clark found that the time allocated by health visitors to work in schools was very small. Only 14 of the studies listed it at all and the proportion of time spent on it varied from 0.8% to 9.6% of the visitor's time.

Photo: CETHV

Clark tries to look at what actually happens during the visit. Once again it is difficult for her to generalise from limited studies but it seems that the health visitor spends a considerable proportion of the time listening — as opposed to giving advice or information.

Attachment

Health visitors are employed by health authorities and work from health centres, clinics, GP surgeries or their own home. They either work within a geographical catchment area or, if attached to a GP, they draw their clientele from the GP's list.

"Attachment" to GPs — otherwise known as "membership of a primary health care team" has become a controversial issue in health visiting. It developed out of a desire for improved cooperation and communication between GPs and other health care professionals. Some health visitors have found working from a general practice very rewarding but others have been extremely critical of the arrangement. Their role is often misunderstood — they have been expected to carry out tasks that are not properly theirs such as immunisation. And, while a GP works with those who request help, part of the health visitor's essential role is to approach those who have not asked for help but may nevertheless be vulnerable. If health visitors get too many referrals from GPs they may be left with little time to carry out this wider function.

It is also argued that it is more costly for health visitors to cover the widespread area from which a GP's patients may be drawn than to work in a compact catchment area. However the surveys in June Clark's review do not suggest that attached health visitors spend more time travelling than non-attached ones. According to Clark the studies suggest that the differences between attached and unattached health visiting are small and cannot conclusively be attributed to attachment.

Despite the doubts health visitors may feel about attachment, they place great importance on links with other agencies. Clark quotes one study in which 93% of visitors were "very interested" or "interested" in liaison with

other agencies, and another in which 85% had been in contact with ten or more agencies during the previous month. These would include GPs, social workers, housing departments, hospitals, nurseries and voluntary organisations. Despite the considerable contact between health visitors and social workers, misunderstandings about each other's roles still arise between the two professions.

Training

Health visitors are registered nurses with obstetric or midwifery training who have then completed a post-registration course (which usually lasts a year) leading to the Health Visitors Certificate (3). At present this training comes under the CETHV but the passing of the Nurses, Midwives and Health Visitors Act in 1979 means that in a few years health visitor training may be brought under the Central Nursing, Midwifery and Health Visiting Council. However possible changes are still in the air, and before they are made there will be consultations with a Health Visiting Joint Committee which is to be set up from the Central Council and the national boards with a majority of practising health visitors as members.

The 1979 Act is a very modified offspring of the 1972 Briggs Committee report on nursing. Many of the Briggs proposals about health visiting caused enormous consternation in the profession — reduction in the length of training, its inclusion in general nursing education and a change of title to "family health sister". The HVA says that most of the unacceptable recommendations were "vigorously and successfully opposed" but it is still concerned about the jolt to the identity of the profession, and produced *Health visiting in the 80s* to provide "a re-definition of the true fundamentals of health visiting".

References

1. *Health visiting in the 80s* 40p inc post from the Health Visitors' Association, 36 Eccleston Square, London SW1V 1PF.
2. *What do health visitors do? A review of the research 1960-1980* by June Clark. £4 inc post from the Publications Department, Royal College of Nursing, Henrietta Place, London W1M 0AB.
3. For more details contact the Council for the Education and Training of Health Visitors, Clifton House, Euston Road, London, NW1 2RS.

Book reviews

Pharmaceuticals and health policy

edited by Richard Blum, Andrew Herxheimer, Catherine Stenzl and Jasper Woodcock, Croom Helm, £17.95

This book takes the form of individual papers on a wide-ranging list of topics relating to the drug industry from an international group of contributors. It is a somewhat complex study, which is inevitable with such a subject, and is clearly not intended as a "light read". This should not, however, deter the reader as the style and presentation of information make it very readable.

The discussion of the involvement of international organisations in medicines policy concentrates on the role of the World Health Organization, United Nations Industrial Development Organization and the European Economic Community. The change in the United Nations' emphasis, from attempts at regulation of commercial activities towards an integrated medicines policy is most interesting, and illustrates the inadequacy of any existing organisation to secure the public interest at multi-national level.

The multi-national nature of the industry and the problems this raises in co-ordinating an effective control mechanism, is also well illustrated by the chapter, "The promotion of prescription drugs and other puzzles". The methods used by multi-national pharmaceutical companies to market drugs and the claims made by the companies in the promotion of drugs appear to depend more on how ineffective are the controlling bodies of a particular country than on any other single factor. The differences between promotional information allowed in the United States of America and in Latin America, where "claims of efficacy were grossly exaggerated and warnings minimised, glossed over, or totally omitted" are quite startling.

This is a book which will oblige the objective reader to consider the enormity of the problems posed to society by the interests of multi-national pharmaceutical companies, and may even provoke the Office of Health Economics (which seems to act as the industry's public relations department) to issue a reassuring response. In short, if the price doesn't apparently make it good value, buy it, read it, and change your mind.

Brian Maunder
Secretary, Swansea/Llw Valley CHC

Defeating depression

by Dr C A H Watts, Thorsons Publishers, £5.25 (paperback £2.95)

This book is exactly what it claims to be — a guide for depressed people and their families — and as such it should be welcomed. It is written in simple language that should be understood easily by those who need it, at a time when they are often overwhelmed by technical jargon.

Dr Watts writes from a long experience as a family doctor and draws frequently upon collected case material to make his points. His sympathetic appreciation of the difficulties of the clinically depressed and their relatives, and his insistence that depression is a treatable illness, can only raise the reader's morale. This is not a book for psychiatrists, but it offers a great deal to their potential patients.

Mrs B Fitzgerald
Plymouth CHC

Parents as partners

by Gillian Pugh, National Children's Bureau, £3.50 inc. p and p to non-members of NCB

Since parents are a major influence on the child's development, it seems remarkable that professionals have until recently ignored their potential in contributing to the intervention programmes which have sought to develop skills and modify unwanted behaviours in the handicapped child. This brief yet concise book outlines a number of schemes which have involved parents to a greater or lesser extent. These include various applications of the Portage project; a home-based programme which trains parents in teaching skills to their handicapped children and also in evaluating their outcome; workshops for parents aimed at providing support as well as teaching skills, and self-help groups, often initiated by professionals but subsequently organised and maintained by parents.

This book is a useful introduction to the multidisciplinary approach which stresses the importance of what the handicapped *can* do as opposed to what they cannot do, and there are a manageable number of references at the end of many of the chapters for readers who want to find out more about particular schemes.

Belinda Newman
King's CHC

Education for childbirth and parenthood

by Elizabeth R Perkins. Croom Helm £10.95

The old proverb "ignorance is bliss" does not apply to parenthood. Effective antenatal and labour ward education can remove much of the fear associated with childbirth and can help a mother to be relaxed and co-operative. Education for parenthood can help to achieve higher standards of child care. But such education is not easy and in a series of studies this book attempts to examine current practices, identify problems and weaknesses and suggest how improvement can be achieved.

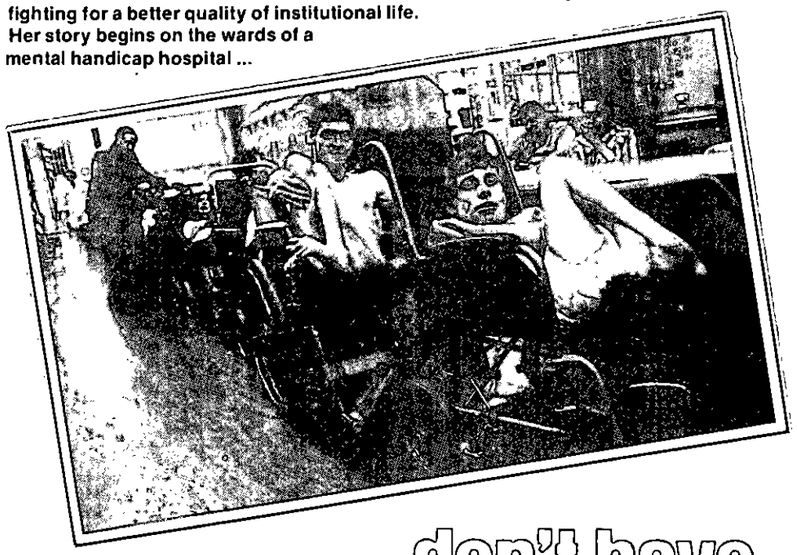
The role of midwives, health visitors, doctors and physiotherapists is considered and there is constructive criticism of the many booklets and leaflets which are distributed to parents. The work of the voluntary National Childbirth Trust is regarded by the author as a useful adjunct to the NHS and in no way competitive or antagonistic to it. On the whole the book is easy to read though the transcripts of taped interviews with parents are rather difficult to follow.

The value of education for childbirth and parenthood and the problems associated with it are relevant at a time when concern is being felt about the perinatal mortality rate and about the tragedy of child abuse. A perusal of this book would give CHC members a valuable insight into the whole subject, though it is unfortunate that it is so highly priced.

Olive Keywood
Worcester CHC

INSTITUTIONS

The TV programme *Silent minority* gave yet another glimpse of the deprivation which passes for life in most of Britain's mental handicap hospitals. If what was shown was atypical, as Social Services Secretary Patrick Jenkin has claimed, it was only atypical in the sense that the deep end of a swimming pool is atypical of the pool as a whole. Even so, it is all too easy to swallow the theory that in the short-term nothing can be done, because all large institutions of this kind inevitably produce dehumanised patterns of organisation and behaviour. In this article, Ann Shearer argues that if CHCs wish to oppose such fatalism they need to support staff within the service who share their concern and are already fighting for a better quality of institutional life.
Her story begins on the wards of a mental handicap hospital ...



don't have to be this bad

*by Ann Shearer**

On the surface there is not much to choose between these two wards in one of our larger mental handicap institutions. Both are a lot better to look at than they were a few years ago. New wallpaper is on the walls, and the standard-issue lockers and room dividers are in place. Both wards are "home" for thirty or so very severely handicapped people, and both offer, in their physical contours, no more than a travesty of what that word would mean to the rest of us.

But the differences are there in the air. In one ward, the sister in charge is enthusiastic with plans and projects. She drags you across to see the variety of new clothes that she has substituted for the uniformly dreary drabness that was deemed fit for the men who live here. Why shouldn't they look their best when they go out, like any of us? She introduces you to one very handicapped man and reminds him of a recent outing, a special trip to see his favourite football team play.

When she arrived on the ward, she says, only the more able men were taken out, but she soon put a stop to that. Surely everyone has the right to a bit of enjoyment and change? She complains vigorously to the visiting senior staff — and you can tell that it is not for the first time — about the state of the lavatory. How can people be expected to find toilet-training rewarding in that cramped room, with its total lack of privacy and even warmth?

But she has hopes of change, and of developing more individual programmes for the men who live under her charge. She introduces you to one young man, laboriously eating his lunch. A few months ago he couldn't eat by himself at all, just waited for the staff to push in the mush that is easier to get down than ordinary food. Soon, she hopes, he will master a real, adult diet. There is so much you could do for each person, she says. The staff shortage is chronic, of course, she can expect three other nurses at the most on this ward of highly dependent people. But she is sure, too, that if the staff just begin to see how they can encourage individual growth, they will find the ways to do more of it.

The women who live in the other ward sit quietly in their chairs as the meal-time comes to an end, their neat clothing brushed back into place by the silent staff. The charge nurse would like to see more being done for them, he says. He thinks one or two of them could perhaps benefit from individual programmes. But with only three other members of staff at most, what can you do? The best you can hope for is to keep them clean, well-fed and happy. And happy, he is sure, they are (though clean and well-fed more evidently).

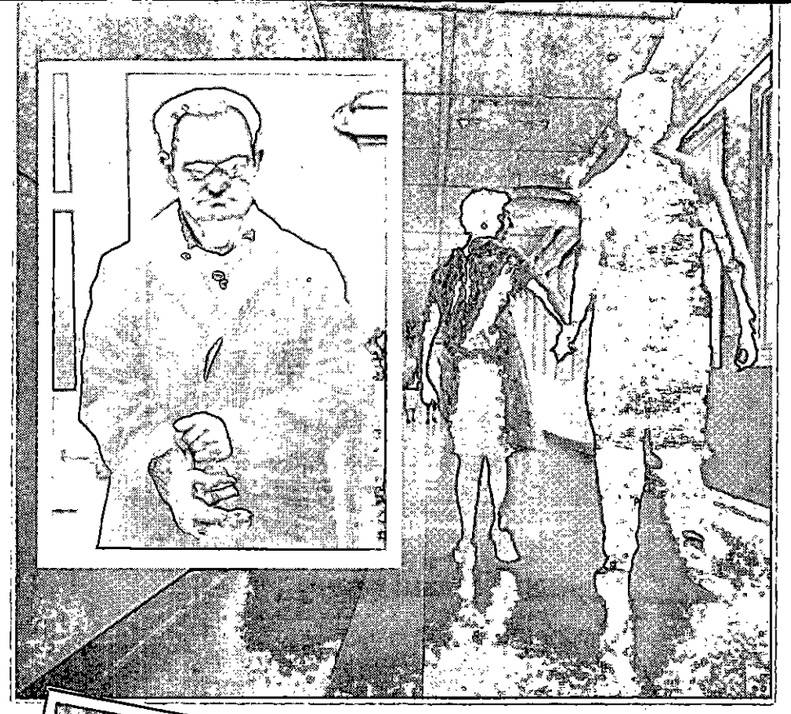
There is nothing so unusual about these scenes from institutional life. They have their echoes in any of our institutions for people who are mentally handicapped, or old, or mentally ill. But it is just *because* they are usual that they are important, for in their contrast they challenge the notion of institutional inevitability. And that challenge, it seems to me, is enormously important.

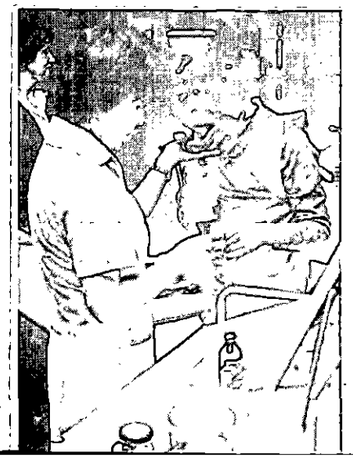
Remember Goffman's *Asylums* (1), that sharp and subtle analysis of the rules of the game of total institutions? So persuasive was it that the patterns of dehumanisation, of hierarchy, of people-processing, of "kindly" or not-so-kindly custody, have been woven into our understanding of such places. So recognisable is this analysis in the wards of our institutions that it seems almost pointless to wonder whether those institutions inevitably need to be the way they are.

And when the consequences of such wondering could upset the delicate balance of goodwill between us, the outsiders, and the staff who actually care for the people we put away, the exercise becomes not just pointless but dangerous. Supposing the staff walked out? So it is much more comfortable simply to "pick off" the staff who actually inflict criminal harm on their charges, and put the more subtle forms of dehumanisation down to the inevitability of institutional patterns.

And goodness knows there has been enough evidence to confirm that apparent inevitability in the past decade. Official report has drearily piled on official report to confirm it. Their findings no longer shock. Our reaction is no longer to say: "How could this place have become so destructive of human growth, and how can we learn to protect the growing in others?" Instead we say: "There, but for the vagaries of chance, is a portrait of every similar institution in the land".

Less official reports confirm both the picture and the diagnosis. Joanna Ryan, in her book *The politics of mental handicap* (2), prefaces Frank Thomas' raw and often terrible diary of the degradation of life on one particular ward with the reassurance that "This book is not intended as a vendetta against the ward staff, but is rather an attempt to show how the realities of ward life are the end result of a complex social process that we all participate in". In her analysis of why that ward was as it was, she shows how the institution's very contours, and the expectations of its staff, lead to the dehumanisation of residents — how the juggernaut rolls on, flattening human beings and their claims beneath the wheels of its impersonal demands, whether they are staff or residents. "Whatever the intent of individuals to the contrary, it is a dehumanised world, a world where the maximum amount of objectification has become almost inevitable".





But before we accept the standard theories of almost-inevitability, let us remember what we are condoning if we do so. We are condoning standards of care for children so low that the official Development Team for the Mentally Handicapped could say, in an analysis of the quality of that care, and in *exoneration:* "The staff were, however, concerned about the children's well-being. They were friendly and there was some hand-to-hand contact. They addressed children by their Christian names". (Whatever next? They might even remember the children's favourite games?)

We are condoning meals, those times of fundamental human sharing, which are enriched by responses like this to a man who asked for another helping: "How the fuck can you be hungry, you've eaten two bowls of this muck already. Oh, sod, here's another one, hope it makes you sick". We are condoning such intimate moments as the one in which a member of staff, helping another man to bath, enhanced his feeling of self-worth by saying: "Look at you, like a load of shit done up in the middle".

Is it really almost inevitable that this sort of abuse should become the small change of everyday life? Or is it time that we said openly that such behaviour is totally intolerable, and that its perpetrators — and the senior staff who taught it to them — must bear personal responsibility for having betrayed the trust invested in them in a way that simply cannot be condoned?

To keep quiet when it is not us, after all, who do the job, may be easier. It may accord better, too, with the prevailing helplessness of the times, when the favourite films are the ones which depict people overwhelmed by some gigantic natural disaster, or besieged by monsters, or helpless in the grip of economic recession. But surely to goodness there is a point when all of us, whether we work in institutions or not, recognise the need in ourselves and others to discover a certain freedom of spirit and a will to action within the constraints?

That is not to underestimate those constraints. So considerable are they in our traditional mental handicap institutions that those places can never, by their nature, offer the opportunities and conditions of life that the rest of us take for granted. That is why they should be abolished and replaced by locally-based housing and other services.

But even making every allowance for that, it still must be said that accepting the notion of institutional inevitability, or even almost-inevitability, not only opens the door to appalling abuse of individuals but also fails to honour, encourage and value the people who *refuse* to accept it. Instead of sinking back into helplessness, we should surely be asking some questions. What is it that makes some people fight for the human value and potential for growth of those they care for, while others are content to perpetrate a "kindly custody"? How do we encourage the first rather than the second?

The institutional answers the theorists have given us are: more autonomy for each

Continued on next page

Photos: Raissa Page

* *Ann Shearer is a former member of North Camden CHC, and a founder member of the Campaign for Mentally Handicapped People. This article first appeared in last month's issue of* Mind Out *magazine — our thanks to* Mind Out *for permission to reprint.*

Healthline

Second opinions

Do patients have a right to a second opinion if they have doubts about their GP's diagnosis?

Patients do not have this right, though most doctors would probably grant any reasonable request. It remains a matter of "clinical judgement".

Kornered!

What is the Korner report?

The Korner report hasn't been published yet. The Korner committee is a joint NHS/DHSS steering group, chaired by Mrs E Korner, vice-chairman of the South Western RHA, which is at present reviewing health service information systems "in the light of the needs both of the NHS and the Department". Priority is being given to a review of information about hospital activity, including waiting times, and it is expected that proposals will be published later this year.

Coroners' reports and the public

Do members of the public have a right to see coroners' reports?

Rule 39 of the Coroners' Rules (1953) says that anyone who in the opinion of the coroner is an "interested person" is entitled to inspect and be given copies of post-mortem reports and other evidence considered at an inquest. Inspection is free, but if copies are required there may be a charge. Coroners have absolute discretion to decide who is an "interested person", and there is no appeal against their decisions.

Glue sniffing

Where can I get information on "glue-sniffing"?

One excellent source of information about all forms of drug misuse is the Institute for the Study of Drug Dependence, which would certainly be able to help with information on this. The ISSD can be contacted at Kingsbury House, 3 Blackburn Road, London NW6 (Tel: 01-328 5541). The National Children's Bureau has just published a two-page briefing document called *Solvent abuse: A review of research* (15p from the NCB, 8 Wakley Street, London EC1), and you could also have a look at the article *Fume sniffing* which appeared in the April 1978 issue of *CHC NEWS*.

Glum groups

Are there any organisations which can be contacted for advice about depression?

Yes, there are several. Try Depressives Associated (c/o Janet Stevenson, 19 Merley Ways, Wimborne Minster, Dorset), Depressives Anonymous (21 The Green, Chaddesley Corbett, Kidderminster, Worcestershire) and Relatives of the Depressed (c/o Doreen Phillips, 27 Strickland Street, Deptford, London SE8).

When a doctor can ask for money

Can a general practitioner ask for money from a disabled patient who needs a report from the doctor in order to obtain motor insurance?

Yes. Under the terms of their contracts with the NHS GPs are not required to provide reports and certificates for patients' private purposes. If people ask for cremation certificates, vaccination certificates, reports for insurance companies or pension schemes, the doctor is entitled to ask for a fee. The British Medical Association issues guidelines about the scale of such fees, but only to its members. There are no special arrangements for disabled people.

For more about doctors duties under the NHS see *GP's terms of service*, in *CHC NEWS 53* page 6).

A state of limbo

We have been approached by a woman who has been claiming sickness benefit while off work with back problems. She has been getting sick notes from her GP, but recently a DHSS doctor saw her and pronounced her fit for work. Her GP disagrees and refuses to certify her fit to resume work — but he is also refusing to issue further sick notes, because he says the DHSS will not accept them. What can be done?

The DHSS tells us that it is quite in order for the GP to continue to issue sick notes, even though he knows that the DHSS doctor disagrees with his assessment. A DHSS official called the *local insurance officer* may then intervene to resolve the dispute, perhaps by obtaining a third medical opinion. You might find it useful to begin by contacting the appropriate DHSS *divisional medical officer*, to whom the DHSS doctor will be responsible. On the other side of the argument, it would appear that the GP may be in breach of his terms of service in refusing to issue a sick note, so a complaint to the Family Practitioner Committee might be appropriate. For further background you should read the DHSS booklet *Medical evidence for social security purposes* (see circular HN(79)20 for details).

The Healthline column publishes selected items from the work of our information service. This service is for CHC members and staff, and for others interested in the NHS and the work of CHCs. To contact the information service write to CHC NEWS, 362 Euston Road, London NW1 3BL, or ring us on 01-388 4943.

INSTITUTIONS DON'T HAVE TO BE THIS BAD

Continued from previous page

unit, smaller groups, and a constancy of staff instead of ever-shifting strangers. But where are the *human* answers, which would provide support for the individual staff who at every level challenge institutional inevitability? Without such support the abuses and th of the Depressed (c/o Doreen again, unbidden. How long before some latter-day Goffman takes his keen wit through some of our community hostels for people who are mentally ill or handicapped, and our residential homes for people who are old? Will the picture *his* book paints really be so rosy?

Joanna Ryan identifies the issue of support for individual staff as a key one, and surely she is right. As well as care and concern for residents, staff also have feelings of disgust and fear, and until they can express and grapple with these emotions how can we be confident that their consequences won't sometimes be visited on the people who inspire them? If staff do not feel cared-for themselves, how can they continue to care for others? If they are not told that their growth as individuals is valuable and precious, how can they find value and worth in the growth of others? The question is one for staff at all levels, in their attempts to challenge that almost-inevitability.

But the question is also one for us all, because Joanna Ryan is right too when she

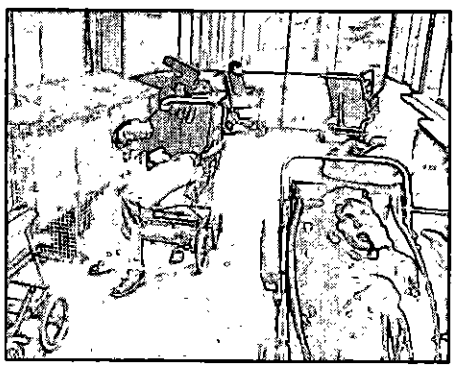


Photo:Raissa Page

sees the institution as the end result of a process in which we all have a part. If we shrug off the everyday dehumanisations and abuses as simply part of the almost-inevitable pattern of institutional life, we are devaluing the capacity of the staff for assertion of their selves. We are saying that they are no more than cogs in the juggernaut's wheel — we are failing to honour those among them who assert that there is another way.

And we are doing more than that. By devaluing the people we have entrusted to the charge of staff, we are agreeing that the best residents can hope for is a "kindly custody". We are agreeing that if that custody becomes less than kindly, even abusive, that is only what is to be expected. We are saying, in effect, that we shrug our shoulders and accept the almost-inevitability, because fundamentally it accords with our own views. We are saying that the men and women who live on those back-wards are, when it comes down to it, simply a load of shit done up in the middle.

Further reading

1. *Asylums: Essays on the social situation of mental patients and other inmates*, by Erving Goffman. Penguin, 1971.
2. *The politics of mental handicap*, by Joanna Ryan with Frank Thomas, Penguin, 1980, £1.75.

Medical audit

by Rod Griffiths, Member, Central Birmingham CHC and Chairman, Association of Community Health Councils for England and Wales

Medical audit is now a *fashionable topic of* conversation among doctors, although the activity itself may still be restricted to "consenting adults in private". Medical audit is an American concept and was originally developed by insurance companies as a way of checking up on health spending — hence the accountancy term "audit". In Britain however it is essentially aimed at checking the quality of patient care. Doctors are encouraged to do medical audit in order to make their work more consistent and so that they can learn from their mistakes.

The concept is both simple and broad — the comparison of doctors' activity with intent. By intent we might mean a *precise statement such as* "all patients being treated with drug X should have their pulse checked once a month", which is easy to monitor. There may be a much vaguer notion for audit such as "patients should be told what is wrong with them".

The great problem is to arrive at effective definitions of activity and intent which allow them to be compared not only with each other but also between doctors and institutions. Variations in these definitions may have large effects not only on the type of audit that is undertaken but also on the conclusions that can be drawn from it. This article suggests questions that a CHC might ask about medical *audit and what the answers* might mean.

Process or outcome?

Most patients are concerned about the outcome of medical treatment (will it stop hurting, will I get better?) but results may depend on many factors outside the control of doctors. Medical audit deals with normal, everyday practice so it is difficult to artificially correct things such as the patient's medical history or social class, both of which influence the outcome of doctors' treatment. The easiest way is to concentrate on *process* (what *was done to the patient) rather* than *outcome* (what happened). Being cynical, it is easier to ensure that everyone is given the right amount of a drug than it is to be sure that it is the right drug. It is easier to ensure that everyone with a particular diagnosis is treated the same way than it is to be sure that the diagnosis is correct. Audit *of processes may be the only* practical possibility and may lead to less haphazard treatment of patients, but it does not necessarily lead to improved outcome.

Case or service?

Most audits are carried out on a case by case basis. This usually means that some sort of check list has to be established for each type of case which the doctors may see. CHCs are of course concerned about how individuals fare under treatment but they also want to know if everyone in the community is getting the best out of the service. If a better process is more time-consuming for each individual treated, the result may be that fewer patients are treated, the waiting list grows and there is more unmet need in the community. This has happened in orthopaedics since it became possible to relieve arthritis sufferers with joint replacement operations.

There are no easy answers to this problem because seeing more patients may reduce the standard of service which individuals receive. When resources are limited, audit could enable judgments to be *made about the best* compromises, provided that both the treatment processes and the volume of service are looked at together. If audit could be done in such a way that community needs are built into the audit model, one might be able to produce a better balance of care and allocation of resources. But if audit fails to take account of the people in the community who are waiting for treatment and it only monitors what happens to the people who actually get to the surgery or the hospital, there is a risk that this will lead to a concentration on fewer and fewer people to the detriment of the community as *a whole.*

What model is used?

Every audit requires a model against which reality is compared. Most commonly the model is established by the doctors themselves. If the model is too elaborate (for example, every patient who enters the surgery is to be given a range of blood tests) it will produce an artificial demand *for extra resources.* But an undemanding model may produce complacency. It is important to know how the model compares with established thinking — this may be done by comparing the treatment policy of a similar unit in another town or by consulting medical literature. Where authoritative reports are available (such as the Court report on *child health services* or the National Development Group's reports on the *mentally handicapped*) the local model should be compared with them.

Is the audit based upon selected cases?

Some degree of selection is almost inevitable. Most audit is based on cases which come to doctors and these may not be *typical of the whole* population. The audit may a also be confined to cases which require similar procedures or treatment. These two sources of selection may seem so natural to doctors that they fail to recognise that they may bias the conclusions.

Further artificial selection *may occur if the audit is carried* out over a particular time period (during the winter) or on a sample of patients (the elderly or people who are found to have stomach ulcers). When this happens the CHC *should try to establish how the* sample relates to their district and whether any differences are due to the diseases under study or some abnormality of the selection process.

The CHC will also need to know what effect the sample selection may have on other patients. Why was this *particular selection made?* Was it because there were worries about this group or perhaps because this particular doctor is interested in this disease? In either case audit could lead to change in practice and to resources being attracted away from other patients with different conditions.

Can a CHC do audit?

Doctors are naturally concerned about medical details, whereas the CHC may be more concerned about accessibility of care, waiting times or politeness — all of which are valid elements of *patient care. Ideally, doctors* and CHCs should conduct a joint exercise from which both would learn a good deal. If this is not possible the CHC should leave no doubt that it can audit the service to patients, provided that it has a clear idea of what kind of service it thinks should be available. Our CHC took the Court child health model and asked parents about their perceptions of the service, as well as what screening the children had been given and what information they had been given about immunisation*.

CHCs should encourage medical audit of processes but must be prepared to question the definitions and framework used. If local doctors are *unenthusiastic, do your own audit* by dreaming up an ideal service and asking patients if that is what happened to them.

Further reading

Looking forward to audit, Charles D Shaw, British Medical Journal 21 June 1980.

* 6/10 could do better *Central Birmingham CHC 1981*

This article is partly based on a paper given at the Royal College of Physicians conference on medical audit, 23 January 1981. For copies of the full paper, contact Rod Griffiths.

A VISIT TO RURAL PAKISTAN

by Jill Evans, Organiser, Asian Education Centre, Burton-upon-Trent and Member, South East Staffs CHC

In the winter of 1979/80 I spent four weeks looking at health services in rural Pakistan. This visit partly arose because of my growing interest in the health education of Asian women living in England.

In 1975 I had visited Pakistan to find out more about the educational background of the Pakistani schoolchildren I was teaching in the West Midlands. After that visit I was appointed organiser of the Asian Education Centre in Burton-upon-Trent. I saw my work here as being almost exclusively teaching English to women from the Indian sub-continent who had come to this country to join male relatives who were already settled and working here.

The reasons why people want to learn English determine what you teach them and I quickly discovered that for most Asian women the only time they needed to speak English was when they required medical treatment. The more I discovered about the things that women wanted to say the more interested I became in their earlier lives.

As a CHC member I have had increasing demands from the health authorities to answer queries about cultural differences and to give health education to my adult students. I am fully aware that as an Englishwoman I can only provide second-hand information but it is equally true that many Asian patients are not able, for a variety of reasons, to articulate their needs and hopes to the appropriate authorities. Until young Asians who have been brought up in this country are taking a more vocal part in community affairs, it falls to people such as myself to make representations on their behalf and be responsible for relaying information back to them.

My recent visit was partly sponsored by the West Midlands RHA's CHC Research Committee. During my stay I visited hospitals, health centres and dispensaries and interviewed doctors, nurses and government ministers and officials. I also stayed in three villages — two of which I had visited before. I have learnt some Urdu but in any case many men in Pakistan speak English and I had little difficulty in communicating. All my accommodation was arranged through friends I had known in England or on my previous visit.

I arrived at Islamabad Airport on a cold, wet December morning. The first few days of my visit were spent in the depths of a remote village. Because of the continuous rain I was unable to venture outside the one room in which all the women slept and ate and sat and talked. At night time we were joined for a few hours by the men of the family. I felt very cold in spite of the thick

DOCTOR-WATCHING

by Sue Jenkins, Secretary, Leeds Western CHC

"Does my doctor have to hold a surgery that I can get to after 5pm?" I was not sure of the answer, but the Family Practitioner Committee told me: "No".

"Oh", I thought.

A few days later I had thought a bit more, and phoned the FPC again: "Are doctors doing fewer evening surgeries?"

"Yes".

"How many fewer?"

This time it was the FPC that didn't know the answer. They don't compile information about GPs' surgeries in that form, though of course all changes in surgery hours have to be approved by the FPC. Quite how they decide on whether they approve or not remains unclear, because our FPC observer is excluded from seeing the reports of the relevant FPC sub-committee.

So the CHC decided to investigate for itself, and a particularly gallant member took home the 95-page FPC list plus the 50 pages of amendments published over a 2¼-year period. He came back, looking tired, with reams of figures which clearly showed the position regarding surgery times in March 1980 compared with those of January 1978.

Looking at surgeries open for appointments after 6pm, we found a 20% decline over the city of Leeds as a whole and a 44% decline in the less well-off South Leeds area. Saturday morning surgeries have also fallen by 23.5%.

Then we decided to collect a little more evidence on what the public thinks. Not being expert pollsters and wanting to move quickly, we simply visited shopping areas and asked people if they were in full-time work, following up with three more questions about the ease of getting to see a doctor. The most interesting result was the 18% who claimed that they lost full pay if they took time off work to see a doctor. Half the people in full-time work expressed some degree of difficulty in getting to see their doctor.

Some polytechnic students have been helping us to check these initial results with a bigger and better survey, which is particularly necessary in view of the reactions received to date from local GPs — that "the public doesn't want evening surgeries", and alternatively that "doctors would like to work longer but other health centre staff won't let them". The Area Health Authority's reaction was that the matter fell within the FPC's remit, and so far it has not pursued our suggestion that fewer evening surgeries will have an effect on the use of accident and emergency facilities.

So where do we go from here? One question that my members now wish to pursue is about the use of the city's Doctors' Deputising Service. Will there be an increasing use of this service? The FPC has to agree to the use of the DDS by doctors, and the guideline in circular HC(FP)(78)1 is that a deputising service should not care for a practitioner's patients every night.

However, we have found that it is possible that in a practice of five doctors, covering for each other on weekday nights, and each using the deputising service, the DDS could be supplying evening cover every night of the week. The FPC's records do not show whether or how often this occurs, because the application form which GPs have to complete to apply to use the deputising service does not ask for this information.

Meanwhile the questions from the public keep coming in: "For how many months in a year is my doctor allowed to use a locum?" "What is the recommended maximum number of hours for a GP to work in a local hospital?"

And so, to any doctor readers, a heartfelt message — we're sure that the majority of you are dedicated workers with high productivity, who design your service to meet the need. So what do you think the public should be saying and doing about the minority of GPs who perhaps aren't and don't? □

cotton quilts which were draped round me. Many women and children wore the same inadequate thin clothes day and night and severe coughs and colds were very common. Sharing of drinking vessels and communal smoking of the hookah were all signs to me of a lack of concern for the spreading of germs. After three days the sun came out and I was able to move on. In spite of all the discomforts my impression was of a cheerfulness engendered by the communal life which is sadly missed by Asian women in the UK.

Although knowledge in rural Pakistan about modern agricultural methods is growing, there is still very inadequate knowledge and education about health matters. This is particularly noticeable in baby and child care. I was very disturbed to see the unhygienic conditions in which many babies are born and it is not surprising that the mortality rate of mothers and babies is so high in Pakistan — a maternal mortality rate of 6.8 per 1000 live births compared to 0.1 in England and Wales and an infant mortality rate of 105 per 1000 live births compared to 14 in the UK. Soon after I returned I learnt of the deaths of two babies shortly after birth in the village I know best in Pakistan. There are no medical facilities in the village, no road to it, no electricity and no piped water or sanitation.

In the town of Mirpur I saw hopeful signs of how to tackle the problems of rural communities — although I also received a very clear picture of the difficulties of local areas obtaining central funds. The director of the Para Medical Institute, Dr Ejaz, is responsible for training field workers drawn from all over the Azad Kashmir district. He is convinced of the importance of taking students from each locality. By using supervised hostel accommodation he endeavours to give students an insight into a higher standard of living at the same time as giving basic training in everyday health problems. Dr Ejaz insists on instruction being in Urdu (the national language of Pakistan). Previously such programmes were in English because that is the language used in medical schools. Dr Ejaz gives health education lectures in local high schools, many of whose pupils come from rural areas. He believes that in Asian society people learn best from their own family members, or at least from people trusted in their own community. It seems to me that in England we might try to make more use of Asians who are prepared to work within their own groups rather than try to mount health programmes via outside agencies.

The importance of gaining women's confidence was illustrated by the experience of the "lady health visitor" in Mirpur, Mrs Saleem Aziz Chaudhry, who runs a maternity health centre. Many very poor women now attend her clinics but initially they come for food distributed by UNICEF. Only after offering that service is she able to increase the confidence of the mothers enough to seek medical help. She admitted that the family planning side of her work was mainly used by educated and professional women. All other women see their children as an essential insurance for

themselves in old age, and the high infant mortality rate encourages women to have as many children as possible.

If services provided in their homeland by their own womenfolk, with no language problems, are only being developed and used slowly, it is not surprising that the health education of immigrant communities here is taking shape so slowly. Mortality rates for Asian mothers and babies in this country suggest that Asian patients are failing to take up the available services or make best use of them.

I would like to see a deliberate attempt to encourage Asian girls in particular to take up careers in nursing and health education. And I feel sure that Dr Ejaz is on the right lines when he goes into schools with information which he wants to get back to communities outside the reach of mainstream advertising.

At the Asian Education Centre in Burton we recently organised a pilot series of parent-craft classes for Asian women. This was prepared and staffed by health visitors and a community midwife who were attached to general practices where a substantial number of patients are of Asian origin. There were six sessions covering pregnancy, childbirth (when a tape and slide pack was used), feeding by breast and bottle — including a demonstration of both methods. Diets for mothers and weaning methods for babies were discussed. In the final session they used the SE Staffs Health Education Unit's exhibition of toys and play for babies and very young children. Most important of all, an interpreter was paid to attend all the sessions ☐

A full report report of Jill Evans' visit to Pakistan is available from SE Staffs CHC.

CHC RECORDS to keep or not to keep

by Harry Baker, Secretary, Kettering and District CHC

I have been enquiring about the retention periods for CHC records and paperwork. No information was available on this from Oxford RHA, and even contact with the DHSS produced no conclusive agreement on procedure. I was advised to contact the Public Record Office (PRO) at Kew, and although they too were at first unable to confirm any definite procedure they were most helpful. Their liaison officer, Mr Knightbridge, visited our office to discuss the matter, and the PRO has now produced the following information:

1. CHC records are not subject to the provisions of the Public Records Acts. Nonetheless, in view of their close relationship to records of the NHS, which are public records, it appears appropriate to apply the procedures laid down in the Public Records Act 1958 for review of the records and the transfer of those adjudged suitable for permanent preservation to the appropriate local authority record office. The PRO, at the request of the DHSS, has agreed to advise CHCs on those procedures.

2. CHC records which appear likely to be of permanent value, and should therefore be retained by them indefinitely for the present, are:

- Minutes, with supporting papers, of CHCs.
- Minutes, with supporting papers, of CHC committees and working groups.
- Papers relating to the CHC constitution, establishment and membership.
- Papers relating to inquiries.
- Papers relating to research and projects, and
- One copy of all publications of the CHC, including annual reports.

3. Of the above categories, only papers relating to inquiries are likely to retain long-term sensitivity and therefore to merit closure to public inspection for a period longer than the normal 30-year restriction which applies to public records. All other series transferred to local record offices could be released immediately to public inspection, since CHC proceedings are held in public.

4. Classes of CHC records which are unlikely to be of permanent value, and therefore need to be retained only for so long as there is an administrative need to refer to them, are:

- General correspondence files.
- Duplicate copies of "out-letters".
- Financial records.
- Circulars, pamphlets etc from the DHSS and NHS authorities, and
- Copies of minutes and other papers of NHS authorities.

Experience to date suggests that a retention period of three years would cover the useful life of most of this material, and that some could be destroyed after only one year.

5. The committee structure of other CHCs and their methods of record-keeping may differ from those of the Kettering and District CHC, and information from some of them on these matters will be required before general guidelines concerning the retention and disposal of CHC records can be framed.

Perhaps other CHCs would like to comment on this, so that definite guidelines could be produced or an Order made by the DHSS. Interested CHCs should write direct to Mr A A H Knightbridge, Liaison Officer, Public Record Office, Kew, Richmond, Surrey, who will collate the information. ☐

Parliament

Keep off drugs!

"Monitoring of drugs is not a function of CHCs, whether or not they have medical representation, but they can advise any person contacting them about an adverse reaction to a drug to report it through the patient's doctor to the Committee on Safety of Medicines", Health Minister Dr Gerard Vaughan has told the Commons (Lewis Carter-Jones, Eccles, 14 May).

Chiropodists' register

The Government will soon be releasing proposals to "close" the profession of chiropody. Possible amendments to the Professions Supplementary to Medicine Act 1960, restricting the use of professional titles under the Act in "spheres such as chiropody" to state-registered practitioners, will be published in a DHSS consultative document (Tim Brinton, Gravesend, 5 May).

Smoking tops the prevention hit-list

Smoking-related diseases cost the NHS £115m per year at November 1979 prices, according to the best estimates available to the DHSS. Accidents at home cost £87m, alcohol-related diseases and accidents cost £50-69m, and road accidents cost £75m (of which £18m could be avoided if drivers and front-seat passengers of cars would wear their seat belts). Estimates of the cost to the NHS of obesity due to over-eating, drug-taking and accidents at work following neglect of safety precautions are not available (Arthur Lewis, Newham NW, 1 May).

Ambulance standards

There are no national criteria for the manning of ambulance stations. Standards of service have been recommended by the DHSS, but manning levels are for individual ambulance authorities to decide (Clement Freud, Isle of Ely, 27 April).

Infant mortality

In 1979 the infant mortality rate in Calderdale health area was 21.2 deaths under one year per 1000 live births as against an average of 12.8 for England and Wales. The rate in Manchester was 18.5, and in Barnsley it was 18.2 (Alf Morris, Manchester Wythenshawe, 6 April).

Vaccination against whooping cough

In England in 1971 and 1972 just over 600,000 children a year completed courses of vaccination against whooping cough, but by 1977 this figure had slumped to 192,000. In 1978 it was 199,000, and in 1979 it increased to 249,000 (Barry Sheerman, Huddersfield East, 24 March).

Teaching districts

The distinction between "teaching" and "non-teaching" health authorities will be retained in the reorganised NHS, the Government has decided, following consultations around its discussion paper *Medical teaching in the NHS* (issued with circular HN(80)40). District Health Authorities with special responsibilities for medical and dental teaching will be designated as teaching DHAs though the suffix "Teaching" will not appear in their titles (Sir David Price, Eastleigh, 6 May).

Consultants in geriatrics

In September 1980 there were 397 whole-time equivalent consultants in geriatric medicine in England and Wales. There is no DHSS staffing guideline, but professional opinion currently suggests a need for 780 whole-time equivalent consultants, rising to 800 by 1990 (Ken Eastham, Manchester Blackley, 5 May).

Therapeutic earnings

The therapeutic earnings limit for invalidity pensioners will be increased from £15 to £16.50 per week, from November this year (Jack Ashley, Stoke on Trent South, 30 April).

Fund-raising fears "are unnecessary"

Fears that DHSS circular HC(80)11 might make it more difficult for voluntary organisation to raise their own funds are unnecessary, Dr Vaughan has explained. The circular's provisions are intended to supplement and support the work of existing voluntary groups, and the Government wishes to see the range of voluntary groups extended not reduced. Following a number of discussions between Dr Vaughan and the National Council for Voluntary Organisations, a further guidance note has been issued (HC(80)11 Part II) stressing the need for health authorities to consult and work closely with local groups (Alf Morris, Manchester Wythenshawe, 1 May).

Your letters

Continued from page two

If the standard of care is to be kept up as the numbers of the old increase, the community has either got to give its services voluntarily or pay higher taxes, or to will the reduction of public expenditure in other fields. Past experience suggests that the working population is unwilling to pay higher taxes, and cutting public expenditure in other fields is never as easy as it sounds.

Inequalities in health

June Corner, Secretary, Bolton CHC

The positive approach to the Black report — *Inequalities in health* — taken in the article "Action on Black spots" (*CHC NEWS 66* page one) and by the Association of CHCs in organising a seminar for CHCs on the report is to be welcomed.

It is to be contrasted with the immediate dismissal of the report's recommendations by Social Services Secretary Patrick Jenkin when it was first published last year. As your article indicated, Mr Jenkin is continuing to give the report short shrift by claiming firstly that it fails to establish in what way health inequalities are linked to social class structure, and secondly that the claim that poor people have less access to the NHS than the better-off can be disputed. Both issues, which are clearly inter-related, are comprehensively dealt with in the report.

Chapter 4 deals exclusively with the evidence for inequality in health service availability and use. Paragraphs 4.42, 4.43 and the conclusions in chapter 6 directly deal with Mr Jenkin's claims. To give just one example:

> Class differentials in use of the various services which we have considered derive from the interaction of social and ecological factors. Differences in sheer availability and, at least to some extent, in the quality of care available in different localities provide one channel by which social inequality permeates the NHS. Reduced provision implied greater journeys, longer waiting lists, longer waiting times, difficulties in obtaining an appointment, shortage of space, and so on. A second channel is provided by the structuring of health care institutions in accordance with the values, assumptions and preferences of the sophisticated middle class "consumer". Inadequate attention may be paid to the different problems and needs of those who are less able to express themselves in acceptable terms and who suffer from a lack of command over resources both of time and money. (paragraph 4.48)

Ed: See page 16 for an account of ACHCEW's seminar on the Black report.

Problems with joint finance

Laurie Millward, Secretary, Edgware/Hendon CHC

Problems with the local working of joint finance here in Barnet — particularly in regard to the local authority's reluctance to "taper-off" (ie take up its annually increasing share of each scheme) — have led this CHC to look at the whole subject of joint finance.

In order to make any sensible suggestions we need to know more about the experiences of other areas. In particular, are other boroughs still enthusiastically taking up all available joint finance money in spite of future rate implications — or is this refusal to taper-off now a growing/fairly common problem?

Scanner

Is there an organisation for people with...?

Doctors and nurses need up-to-date information about voluntary health care support for patients and now a model scheme has been designed to meet this need. *Help for health* reports on how patients in Wessex are referred to voluntary sources of help and the demands which are made on a pilot information service which is now running in the region. *Help for health*, from Wessex Regional Library and Information Service, South Academic Block, Southampton General Hospital, Southampton SO9 4XY (£3.50 payable to Hampshire Area Health Authority).

European Social Fund

Schemes to improve job opportunities in the United Kingdom received about £135 million in 1980 from the European Social Fund. Private organisations can apply for help from this EEC fund — schemes must already have been promised local or central government support. The fund will give grants to increase jobs for disabled workers, training and retraining schemes and vocational projects for unemployed young people, according to the Department of Employment's guide. *The European Social Fund*, from the Dept of Employment, Caxton House, Tothill Street, London SW1H 9NA (free).

Job protection for the disabled

Is a report from the Low Pay Unit showing one of the dark sides of International Year of the Disabled (IYDP). Unemployment among the disabled is estimated at over 20%. Sixty per cent of unemployed disabled people have been out of work for over a year (compared to 24% of the general unemployed population).

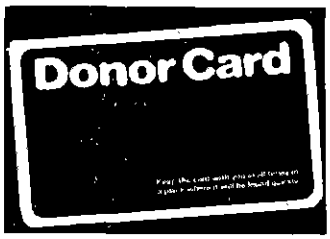
The statutory quota scheme — requiring all firms with 20 or more employees to employ 3% registered disabled people — is extremely ineffective. In 1978 63.2% of eligible employers failed to fulfil their quota obligations — many of these had been issued permits to do so, but of the 9000 or so who simply ignore the quota only six have been prosecuted since 1964. The LPU warns of moves afoot to abandon the quota altogether and calls rather for a strengthening of the system and an improvement in allowances and rehabilitation schemes for disabled people. 95p inc post from LPU, 9 Poland Street, London W1V 3DG.

Maternity language

Going to hospital to have a baby can be quite a bewildering experience even when you can understand what people are saying to you. When hospital staff are all speaking a language you don't understand, the event can become a frightening ordeal. The *Help maternity language course* has been written to help women with little or no English use the maternity and child health services. It has been tested in Leeds with pregnant Punjabi and Bangladeshi women. *Help maternity language course* from Printed Resources Unit for Continuing Education, 27 Harrogate Road, Leeds 7 (£4).

Arthritis services

Over eight million people go to their GP with rheumatic problems every year — and these problems are responsible for the annual loss of 61 million working days. Yet a new survey of the services for sufferers from rheumatism and arthritis reveals enormous regional variations in the treatment available and the waiting times for it. A key factor is the availability of specialist staff — there are over eight times as many people per consultant rheumatologist in the West Midlands as in Wessex. *People with arthritis need help and support* from the Arthritis and Rheumatism Council, 41 Eagle Street, London WC1R 4AR. 50p post free.



This is the new plastic multi-organ donor card. Potential donors can specify particular organs to be used "for transplantation" or allow any part of their body to be used "for the treatment of others". Cards and publicity material from DHSS (Leaflets), PO Box 21, Stanmore, Middlesex

The menopause

Is the latest booklet in the *Family doctor* series. It aims to give reassurance and information on issues women often ask about. For example, "Why do some women go through the menopause without any symptoms while others seem to have terrible problems?" From *Family doctor publications*, BMA House, Tavistock Sqare, London WC1H 9JP (50p plus 15p post).

Education rights

All young people have the right to full-time education, if they want it, till the age of 19 — and that includes mentally handicapped people. This is the message of a leaflet produced by MIND, the Advisory Centre for Education and the Children's Legal Centre. It explains what parents should do if local education authorities refuse to offer their mentally handicapped children a place in a school or college. For individual copies send a SAE to MIND, 22 Harley Street, London W1N 2ED, for 50 leaflets send 50p and for 100 send £1.

Well bread

We don't each as much bread as we used to but it "still has a major part to play in the diet of British people" according to a recent DHSS report. The report stresses the nutritional value of bread — even white bread — and says that people would benefit from eating more bread and less fat and sugar. Types of bread and bread-making are discussed and it makes a number of recommendations about additives and labelling. *Nutritional aspects of bread and flour* HMSO £3.90.

Nursing shortages

How acute is the shortage of trained nurses in key specialties? The Royal College of Nursing has just carried out a survey of nursing officers throughout Britain to find this out. And also to discover in which areas more trained staff are needed.

The RCN has so far analysed the results for six of the specialties — the rest will be published later. Its report bears out the frequent claim that there are widespread shortages of trained nurses, not only is such specialties as geriatric care (88% of respondents had a shortage), mental handicap (86%) and mental illness (88%) but also in operating theatres (78%), orthopaedics (56%) and accident and emergency (55%). In all these specialties respondents gave lack of available manpower as by far and away the main reason for the shortage, rather than lack of funds, accommodation or problems with transport. *Manpower availability*, £1 inc post from RCN, Henrietta Place, London W1M 0AB.

CHC Directory: Changes

The latest CHC Directory was published in November 1980. It contains details of Scottish Local Health Councils and the District Committees in Northern Ireland, as well as CHCs. Single copies of the CHC Directory are available free from *CHC NEWS* — please send a large (A4) self-addressed envelope with 25p in stamps.

Changes to the directory are published on this page — please tell us of any alterations in address, phone number, chairman or secretary of your CHC.

Page 2: Hartlepool CHC 36 Victoria Road, Hartlepool, Cleveland TS26 8DD (*temporary address*).
Page 2: South West Durham CHC Tel: Bishop Auckland 605013.
Page 3: Leeds Western CHC Chairman: Coun. Mrs Judy Thomas.
Page 5: Cambridge CHC Chairman: Mrs Sheila Gatiss.
Page 8: Brighton CHC Secretary: David Bowring.
Page 11: Southmead CHC Secretary: Mrs Susanne Davis.
Page 11: Cornwall CHC Secretary: Bruce Tidy.
Page 15: Manchester Central CHC Chairman: Miss H Merrick.
Page 16: Ogwr CHC Secretary: Paul Baker.
Page 17: Neath-Afan CHC Chairman: Miss G Jones.
Page 20: Renfrew District LHC Chairman: J Gribben.

News from CHCs

☐ The International Year of Disabled People continues to be a lively focus for CHC activity. **Aberconwy CHC** had a full week of activities which included an exhibition of aids, an afternoon of sports for disabled participants and four interdenominational church services which each centred on a different aspect of handicap. The services were broadcast on the Welsh radio network. **North Surrey CHC** ran a "consumer week", aimed at increasing awareness of the needs, abilities and aspirations of disabled people. **North East Essex CHC** and **Plymouth CHC** have also hosted an "Aids to living" exhibition. At a meeting of **Medway CHC**, members heard a talk by an ex-patient at a local mental illness hospital, who spoke about his experience of being detained under the Mental Health Act. The CHC is taking up his suggestions about inserting additional information on patients' rights into the hospital's booklet for in-patients.

☐ Visitors to Sheffield Show and patients at one of the city's health centres completed over 400 questionnaires drawn up by **Sheffield Southern CHC**. The CHC aimed to find out which areas of health care should have extra resources. Acute hospital services came out on top, followed by children's services and spending on prevention and research. Funds for the elderly and for the disabled ranked below heart transplants in popularity.

CHC secretary Harry Trent says the CHC will not be relaxing its pressure for more spending on the "cinderella services", although he considers the survey was well worth doing. "At least we can see what we're up against — we need to educate the public about the needs of the elderly, the disabled, the mentally ill and the mentally handicapped". Harry Trent also stressed that the sample was unrepresentative of the Sheffield population as a whole — with a bias towards middle class people in the 17-44 age group.

☐ A 22-5 vote by **Salop CHC** against fluoridation has resulted in a block on the fluoridation of water supplies for about 1,600,000 people. Severn Trent Water Authority will not agree to area and regional health authorities' requests for fluoridation as long as there is opposition from local CHCs. **Mid-Staffordshire CHC** has also opposed the fluoridation proposals, though **Wolverhampton CHC** has been in favour.

The decision in Salop CHC was taken after a massive "pure water" campaign. The county council and five out of six district councils were opposed. Former CHC chairman, T K Stratford commented, "If a quarter of the steam generated over this had been generated over the elderly mentally ill, we'd be living in a better society". The CHC has resolved not to put the issue on its agenda again for at least three years.

☐ When a report condemning catering standards in the new 800-bed Royal Liverpool Hospital was "leaked" to **Liverpool Central and Southern CHC**, the council did not hesitate to tell the press. The report's author, a DHSS catering adviser had found that food served to patients was of "extremely poor quality" and that on only one day in three did meals provide more than 50% of the recommended protein intake. Patients had no choice of menu, food was wasted and long-stay patients were risking malnutrition the report concluded. The adviser had reported to the hospital in August last year, but until the CHC spilt the beans, area health authority members knew nothing about it. The CHC had received complaints from patients who were relying on relatives to bring in meals for them. The AHA has now accepted the recommendations of a working-party (which included a CHC observer), calling for a choice of menu and the appointment of additional staff. "You don't help issues by covering them up", said CHC chairman, Sylvia Hikins — "especially something as important as feeding patients".

☐ **Haringey CHC** has produced a straightforward leaflet explaining how to save money on prescriptions. It lists the groups of people who are entitled to free prescriptions, how to get a free scrip and how to get a "season ticket".

☐ All prescription charges should be abolished, says the **Association of Scottish Local Health Councils**. At its annual general meeting in Stirling on 25 June, the association voted in favour of free medicines for all and unanimously condemned the Government's plans to charge overseas visitors as "socially divisive". It also heard a report of its own working-party's review of the role and function of LHCs.

The annual general meeting of the **Association of CHCs for England and Wales** will be in Aberystwyth on 17-18 September.

Brian Clough — the manager of Nottingham Forest Football Club and quite possibly the next England manager too – has agreed to star in a CHC publicity poster to be produced by the **Association of CHCs.**

☐ A boat run by GPs to take them over to the smaller of the Scilly Isles has become a focus of attention for the **Isles of Scilly CHC**. The doctors are contracted to run the medical launch and pay the pilot, but they say that the expenses paid by the DHSS are not high enough to meet the boat's running costs. The CHC is trying to get more money for the doctors.

☐ Philip Lowe, who was secretary of **Eastbourne CHC**, died on 18 May, aged 66, after a determined fight against a long illness. He became CHC secretary in 1974 and was active in the Eastbourne community. Before coming to the CHC from London, Philip Lowe had been Hospital Secretary to University College Hospital, Deputy House Governor at King's College Hospital and then senior tutor at the King's Fund College. The founding of the LINK Centre for Deafened People owes much to the fund-raising efforts of Philip Lowe — "a man who always put service before self", says neighbouring Hastings CHC secretary, Margaret Ross.

☐ When real life began to resemble a script from *Yes, Minister*, it was getting beyond a joke for **Yarmouth and Waveney CHC**. At present there are no beds for eye patients in the district and the outpatient waiting list is 60 weeks, but after a long battle, the CHC had won a promise of 12 beds in the new hospital which is due to open at the end of the year. Jubilation was short-lived as the CHC soon discovered that there were no plans to employ doctors. "What is the point of the beds if we have no consultant?" asked the CHC chairman at an AHA meeting. The CHC wants the region to pay for two ophthalmic specialists as part of the new hospital allocation.

☐ CHCs continue to show an intense interest in the Black Report — *Inequalities in health*. Members and secretaries from all over the country recently attended a seminar in Coventry on the report, which was organised by the **Association of CHCs**. One of the report's authors, Professor Peter Townsend, discussed its main themes and stressed the need for a national health strategy cutting across ministerial and departmental boundaries. Jane Streather spoke of the problems facing one-parent families — above all, poverty. And Dr Carlos Ferreyra described factors affecting the health of ethnic minorities.

Francis Pajak of **Bolton CHC** called for a special health development programme for the ten deprived areas singled out by the Black Report. Bolton is one of the CHCs involved in the campaign for extra help and funding described in *CHC NEWS 66* page one.

At the end of the day the conference passed a resolution deploring the Government's negative response to the report and asking for a Parliamentary debate on it. The Social Services Secretary was called on to press for necessary resources to provide services, and to give guidance to health authorities on the recommendations which have little or no revenue implications.