CHC NEWS

For Community Health Councils

October 1981 No 70

Chaos ahead!

Reorganisation could wreak havoc with CHCs - and CHC NEWS may lose its grant

Rumours were rife at last month's annual general meeting of the Association of CHCs about what will actually happen to CHCs during the change-over next spring from area to district health authorities. Delegates at the meeting in Aberystwyth — who came from 184 CHCs — had heard whispers that CHCs might be completely disbanded on 31 March, CHC staff might have to reapply for their jobs, CHCs' memberships might be drastically reduced. And from the platform itself delegates were told that *CHC NEWS*' future funding is now in doubt.

During debate on an emergency resolution about the future of CHCs many delegates voiced great concern about the question-marks still hanging over CHCs. Naomi Honigsbaum of Kensington-Chelsea- Westminster (NW) CHC could not understand the purpose of a smaller membership when office and staff costs still have to be met and Emrys Roberts of South Gwent stressed the difficulties it would mean for rota visiting. Dag Saunders of Salop CHC had been told that it would take two months for CHCs to be set up again after reorganisation day, 31 March — and that during that period DHAs would be taking many important decisions.

Retiring chairman Rod Griffiths stressed the importance of a smooth change-over next spring. He then broke the news that the DHSS had just let him know that ministers are reconsidering the funding arrangements for *CHC NEWS*, which at present gets a block grant from the department. Delegates immediately responded with praise for the magazine, and a paragraph supporting it was added to the resolution.

The emergency resolution was passed unanimously. It calls for CHCs to have the right to adequate consultation with the DHSS and the Welsh Office when local health services are being altered; for the role of CHCs in helping the public with problems about the NHS to "continue undiminished"; for CHCs to have an "adequate" level of membership; for the right of CHCs to "shadow" DHAs as they prepare to take over responsibility: and for CHC staff to have job security and support from the authorities during reorganisation.

Earlier Rod Griffiths had read out a letter from the then junior health minister Sir George Young wishing the meeting "great success" and promising that an announcement of the Government's decisions on the role and membership of CHCs would be made shortly after the reassembly of Parliament later this month. The only advance news was that ACHCEW would definitely continue — because of the "decisive vote of confidence" in it by CHCs.

Fewer resolutions were taken this year than last so that there would be time for afternoon workshops and a guest speaker. Probably the most contentious motion was a composite from South Hammersmith and East Berkshire CHCs which deplored expenditure on "war officers" (planners for the aftermath of nuclear war) and urged the Government to transfer the money to one of the most under-funded services in the NHS. A number of speakers believed that the purpose of the expenditure was to make people believe that they can survive nuclear war — "a callous cosmetic exercise" as Judith Thomas of Leeds Western put it. Others, such as Joan Hughes of South Warwickshire, thought it irresponsible to refuse to support measures to deal with an appalling situation. The vote was finally 102-45 in favour of the resolution.

The AGM rejected a motion from South Gwent CHC calling for an in-depth study into inequalities in NHS provision between different nations and regions in Britain. Opposing the motion, John Austin-Walker, new vice-chairman of ACHCEW, said that the real problem is not inequalities *between* nations and regions but *within* them. Delegates went on to carry "very substantially" a motion urging the implementation of the Black Report's recommendations — including extra funding from the Government where necessary and a special development programme in the most deprived areas.

Cuts in the collection of statistics were

Continued on page four

New ACHCEW chairman D M Thomas (right) with retiring chairman, Rod Griffiths

INSIDE...

Your letters

Debendox dangers still there

Mrs Catherine Tricker, member Debendox Action Group Committee, 47, Mildred Avenue, Watford, Herts.

A report in the *British Medical Journal* (11 July 1981, page 99) defends the continued use of Debendox in pregnancy. Of the 22,357 pregnancies involved in this study for which Debenox was not prescribed, 2% of these resulted in malformed births, while only 1.3% of the 620 pregnancies for which Debendox had been prescribed resulted in malformed births. These figures are used to justify the drug's safety.

However, we are of the opinion that the ingestion of Debendox within the first eight weeks of pregnancy increases the risk of a malformed birth by at least five in 1000. It can be seen that 227 mothers in this study took Debendox within the first eight weeks of pregnancy, of which six delivered babies with one of the recognised malformations. Six out of 227 represents an incidence of 2.64% or an increase in risk of 0.64% over the 2% occurring among those who did not take the drug. This increase would represent 6.4 babies in 1000, which is quite consistent with our estimation of a risk of at least five in 1000. Other studies investigating the malformation rate for Debendox users also point to a peaking of damage around the eighth gestational week, which suggests that contrary to the conclusions reached in this report, Debendox does have some "appreciable teratogenic potential". We maintain that in a drug so widely prescribed, even such a low level of risk should be regarded as dangerous.

Phones, lifts and sticks

J Fryer, Secretary, Scunthorpe CHC

Through the local press, Scunthorpe CHC has been asking the public for ideas which would help disabled people. Three of the most helpful suggestions have been:

- More public phones —accessible by wheelchair and with push-button Braille dialling and a volume aid for the hard of hearing.
- Lift controls in public buildings should be able to be reached by people in wheelchairs.
- Perhaps the most controversial idea was to use dayglow material on sticks used by physically handicapped people. In time these may command the same respect as the white stick used by the blind. This would be particularly useful in busy streets and would tell the ablebodied that the person crossing with the stick needed more room or perhaps some help.

Perhaps CHCs will promote these suggestions to mark the International Year of the Disabled in a positive and constructive way.

Ed: People who are both deaf and blind can carry red-and-white striped sticks to show that they have an additional hearing handicap.

Recalling mental patients

Larry Gostin, Legal Director, Mind, 22 Harley Street, London W1

I read Mr Schreiber's letter *(CHC NEWS 68)* with some interest. Your readers may be interested to know that the new circular (HN (80) 44) for the recall of mental patients to hospital was forced upon the Government by a recent case before the European Commission of Human Rights. The case has now been referred to the European Court, and a decision is expected in the autumn. As one of the co-representatives for the patient before the court, Mind had responsibility for negotiating the contents of the new circular with the UK Government. We felt then, and still do, that time limits should be introduced so that a patient has to be informed of the reasons for his recall within 24 hours and given a "speedy" right of appeal.

What interests me is that it appears from Mr Schreiber's letter that even near relatives are not informed that a recall is taking place. If this is true, it is important for the future proceedings of this and other cases in Europe. Accordingly I would be grateful to hear the views of CHCs about the practices and procedures used for the recall of patients.

Infantile hypercalcaemia

Lady Cooper, IHC Parents Association, 37, Mulberry Green, Old Harlow, Essex CM17 OEY

One of the rarer conditions which can cause brain damage is infantile hypercalcaemia, or IHC as it is becoming known. Though the condition varies considerably in the degree of severity, the brain damage that it leaves produces a very definite and characteristic sort of mentality, which makes IHC children stand out as a separate group even amongst other backward children.

Some of the problems for parents of these children are — they sleep little, they are exceedingly hyperactive when young and they talk a great deal, which all makes a parent's life very tiring. Their comparatively high verbal ability gives an impression of being more intelligent and adult than they really are. This leads to more being expected of them than they can manage, resulting in frustration and sometimes tantrums, as they are in fact emotionally very immature.

One source of comfort is that IHC children do seem to have some sort of affinity for each other, and now a parents' association has been formed with the aim of putting parents in touch with each other for mutual help and discussion. A research foundation has also been started with the aim of getting more doctors interested in IHC and achieving earlier recognition of the condition. If anyone knows of an IHC child or would like more information, please get in touch.

Praise for *CHC NEWS*

Miss J W Wilcock, Secretary, Bradford CHC

I am writing on behalf of this CHC to support the views about *CHC NEWS* expressed by Mrs Laurie Millward in *CHC NEWS 64*, page two.

Our members also feel that *CHC NEWS* provides a variety of useful and interesting information and, as a comparatively new secretary, I have on many occasions found it to be an invaluable source of reference.

Unwanted pregnancies

B C Sneddon, 61 Selsden Road, West Norwood, London SE27

As many members of CHCs are aware, the number of unwanted pregnancies ending in abortions in this country has nearly doubled in the past decade and there is now an abortion in Britain every 3½ minutes, according to the Society for the Protection of Unborn Children.

What is needed is for CHCs to advise teenagers and others about the grave emotional and psychological side-effects resulting from pre-marital intercourse, abortion and unwanted pregnancy; and to support the view that these are contributing to the dissolution of the family unit in our society.

Wanted

We often publish letters from readers asking other readers for help of one kind or another. In future such requests will be published in shortened form, as shown below, in this special "Wanted" section of the Letters page.

Evidence that a disproportionate number of elderly people and people who visit their doctors more than the average patient are removed by GPs from their lists and have to be assigned by the FPC to other doctors.
– Weston CHC

Information about measures taken by health authorities to try to reduce the problem of people on the waiting list failing to notify the hospital that they cannot take up an admission offer, and to try to ensure maximum possible take-up of offers of hospital admission.
– South Gwent CHC

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Comment

The Association of CHCs has survived the Government's scrutiny, but now the spotlight has been turned onto *CHC NEWS*. Rumours were buzzing on day one of the association's AGM, and by day two delegates were expressing their anxieties forcefully within the meeting itself. Eventually the DHSS contingent sent a note to the platform, confirming that "the Department wishes to discuss arrangements for the future of *CHC NEWS* including the possibility of putting it onto a subscription basis".

The AGM then passed a motion of support which described *CHC NEWS* as "a valuable means of communication and education for CHC members", and told the DHSS bluntly that "the invaluable work of *CHC NEWS* and its staff should be continued and where possible expanded under the present arrangements".

The intensity of support for this magazine amongst CHCs will come as little surprise to the DHSS, because we asked CHCs about this in our *CHCs at work: 1980* survey and submitted the results to the Department as part of the "role and membership" consultation. Of the 195 CHC secretaries who completed the questionnaire, 55% said their members found the magazine "very useful", and a further 38% described it as "quite useful". Had the Department wished to find out what CHCs think about our funding basis it could have raised this as part of the consultation process.

The idea that *CHC NEWS* should be paid for by individual CHCs on a subscription basis raises very complex questions. Presumably there is no intention to withhold the magazine from CHCs that do not belong to ACHCEW, so *CHC NEWS* would need a separate subscription system. Would the information service, which is almost inextricably linked with the magazine, still be available to non-subscribing CHCs and to non-CHC enquirers?

Would CHCs have to find the sub from their existing budgets, or would regions be advised to make an additional allowance where necessary as has been the case with the association's sub?

If all CHCs subscribed the cost of the magazine per CHC in 1982/3 could be in the region of £420, and to ask CHCs to impose upon themselves a cut of this size in their funding for local activities would be to place them in a very cruel dilemma. Even if the Department did agree to make the *CHC NEWS* sub an optional extra, there would still be some CHCs that would choose not to subscribe, and within those CHCs there would probably be individual members who would have found the magazine extremely useful.

What would be the exact formula on which subs would be calculated? A flat-rate payment or an amount dependant on the number of CHC members? And finally, has anyone considered what proportion of the magazine's energy all this would deflect into elaborate paperwork and chasing up "debtors"? No wonder ACHCEW has already written to the DHSS pointing out that "the existing means of funding is undoubtedly less complicated and in effect less costly than the possible alternatives".

We would encourage individual CHCs to make their views on this known — directly to the Secretary of State and perhaps also through local MPs.

Health News

New moves on alternative finance for the NHS

The Government has set up a working party to look at alternative ways of funding health services. Using the findings of DHSS studies into the way health care is financed in other Western countries, it will consider "a range of possible proposals for improvement".

The working party will consist of representatives from the DHSS, the Treasury and Health Departments of Wales, Scotland and Northern Ireland. It will have two "specialist advisers" — both with considerable experience of the private health care sector.

The working party will report to ministers some time early in 1982. They will decide what schemes, if any, are to be pursued. The DHSS says there will eventually be "full consultation" on whatever the Government proposes.

Meanwhile a group of people concerned about the growth of private health care and wanting to promote the interests of the NHS, have set up a steering group called NHS Unlimited. They hope it will co-ordinate knowledge of private health services — in particular, private hospitals — and provide information and advice for those who want to challenge local private developments.

A number of CHCs are involved in NHS Unlimited and all CHC secretaries have been contacted to find out the extent of private hospitals in their districts. The joint secretaries are Marcia Saunders of Islington CHC and Jacqueline Kelly of South Camden CHC. The chairman is Frank Dobson, MP.

First, train your GP

General practice doctors' first priority should be good communication with their patients. And the main grumble about doctors is that they fail to communicate. This is what the Oxford regional organiser for general practice training has been told by more than 70 CHCs who accepted his invitation to say what they thought about general practice and about GPs.

Doctors wishing to become general practitioners have to complete a special post-graduate training course. The Oxford region is rethinking its training programme and wanted to take account of the patients' point of view. CHCs commented on three broad questions — the priorities for GPs, what is most appreciated in good practices, and the main grumbles.

GPs should be accessible, sympathetic and "willing to take time to explain with clarity the nature of the patient's condition", said the CHCs. GPs' co-operation with primary health care teams is high on the CHCs' list of what matters, and the councils also stressed the importance of GPs' participating in preventive medicine and health education.

An appointments system which is flexible and efficient is something patients appreciate, as well as a kind and obliging receptionist who does not obstruct access to the doctor. CHCs also highlighted a good "out-of-hours" service as a hallmark of good general practice.

The three main areas of complaint mirror the priorities already listed, such as the doctors being cursory, overbearing and uninterested as well as being too eager to dish out pills. The Association of CHCs' co-ordinating summary of the CHCs' views also complains about some doctors' "ignorance of special problems or alternative services; insensitivity to anxieties; unwillingness to visit patients".

CHCs' comments are still coming in to the Association and a more detailed analysis of the evidence will be made by ACHCEW in due course.

CHC surveys in the West Midlands

Although all but two of the 22 CHCs in the West Midlands have conducted surveys or have plans to do so, CHCs there seem to have very mixed feelings about the process of surveying. Judy Berry, an officer at the West Midlands RHA, has compiled a list of the surveys which have been done and has interviewed all CHC secretaries in the region.

Judy Berry's report is food for thought. A number of CHC secretaries expressed their personal interest in conducting surveys, but reported that their council members were not enthusiastic. Members felt that research was too expensive and time-consuming. Some argued that there is no need to find out public opinion as CHCs already represent the public, and some said surveys were not part of CHCs' job.

Other CHCs, and not exclusively those with easy access to help from universities

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Health News

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and polytechnics, have carried out surveys as a routine part of their functioning — using a wide range of methods. In an encouraging discussion of the problems of survey research, Judy Berry points out that small-scale surveys can be done quite easily and can still be useful.

One factor which may make the West Midlands CHCs untypical in their survey work is their unique RHA research committee which holds a budget of £10,000 for CHCs who then have to apply for research funds. Some CHCs find the application procedure off-putting.

* *A review of studies and information projects undertaken by CHCs in the West Midlands* by Judy Berry (West Midlands RHA, 1981).

Health care surveys

Modern forms of practice organisation are not isolating GPs from their patients, according to a survey (1) carried out for the UK Health Departments by the Office of Population Censuses and Surveys.

About 4700 people aged 16 and over were questioned about most kinds of primary health care, and one striking feature was that the growth of group practices, health centres and appointment systems is not causing patients to feel that their doctors are less approachable, nor making their journeys to the surgery more difficult. Most elderly people found it easy to get their GP to make a home visit, but 20% of people with children under five reported difficulty. People in social classes four and five were less likely than others to use the ophthalmic, dental and chiropody services.

The DHSS has also published three study reports on hospital and community care (2), as promised in the priorities handbook *Care in action*. The studies show that elderly people are being given a higher priority within general acute hospital care, and that the growth in geriatric services will not be able to absorb more than a proportion of the increased load which will fall on the acute sector as a result of demographic change.

1. *Access to primary health care*, HMSO £12.50

2. *Acute hospital sector*, DHSS £4.15; *The respective roles of the general acute and geriatric sectors in care of the elderly hospital patient*, DHSS £1.35; and *Community care*, DHSS £3.85.

The new Secretary of State

The Rt Hon Norman Fowler has replaced Patrick Jenkin as Secretary of State for Social Services, in Mrs Thatcher's Cabinet reshuffle. Mr Fowler, previously Secretary of State for Transport, was Home Affairs Correspondent of The Times *from 1966 to 1970, entered Parliament as MP for Nottingham South in 1970, became MP for Sutton Coldfield at the February 1974 election, and was chief social services spokesman for the Conservative opposition during 1975/76. He is 43. While at Transport he introduced legislation to sell off parts of the nationalised transport industries.*

Teeth 'n gums

New Social Services Secretary Norman Fowler has cautiously welcomed a proposal for a voluntary scheme enabling dentists to be paid on a regular basis for maintaining the "dental fitness" of young children — in the same way that GPs are responsible for the health care of their patients.

This scheme — on a "capitation" basis so that dentists would be paid for each child in their care rather than by item of service performed — is one of the suggestions of the Dental Strategy Review Group* which was set up last year by Mr Fowler's predecessor. The scheme would initially be for children under six but would eventually cover those up to 16. Mr Fowler sees an "attraction" in the suggestion and the Government will be considering it.

The Review Group points to a slight improvement in the state of the nation's teeth — especially children's teeth. It says that "the time is right for a change in emphasis within the service from being essentially reparative to preventive" — and prevention must be aimed at children because dental decay is mainly a disease of youth. It calls for more and better dental health education, regular use of fluoride toothpaste, the elimination of sugar from children's medicines, fluoridation on a national scale and the continuation of research into dental vaccine.

For adults, the Review Group can see no ready alternative to the present payment for item of service system that dentists operate — although it suggests introducing a system in which the patient pays a proportion of the charge rather than fixed fees.

The Group says that the emphasis on prevention should result in the need for less treatment and more delegation to auxiliary staff. It therefore recommends a reduction of at least 10% in the dental student intake and an expanded role for dental hygienists.

If the capitation system for children is generally accepted by family dentists, the Group believes that the Community Dental Service will be able to switch its focus from children in general to patients with special needs — the handicapped and the elderly.

**Towards better dental health — guidelines for the future* £1.35 from DHSS, Canons Park, Government Buildings, Honeypot Lane, Stanmore HA7 1AY.

Continued from page one
vehemently opposed by many delegates. Dennis Timms of City and Hackney CHC said these cuts were "a direct attack on our democratic rights — if you reduce data you reduce the ability to criticise".

By a narrow margin, the AGM called for a ban on young children travelling in the front of cars. It supported compulsory seat-belt wearing for anyone in the front seats.

Despite some confusion about the evidence, delegates supported East Cumbria's motion that the anti-nausea drug Debendox should be suspended until there have been full investigations into its possible effect on the foetus. The AGM also called for authorities to fulfill their obligations to make public buildings accessible for the disabled, for the Government to provide extra funds for services for the elderly and for a simplification — and extension — of the categories of people exempt from NHS charges. It regretted the abolition of the Children's Committee.

Delegates rejected a constitutional amendment to reduce the size of the standing committee. They agreed that in future, working groups discussing issues during the AGM would be allowed to send resolutions to the AGM.

Six of the seven AGM workshops came up with resolutions and it was agreed that this year these would be referred back to CHCs for discussion. The workshops covered ethnic minorites and the NHS, planning for primary care, the NHS complaints machinery, effective rota visiting, mental handcap, information, and the future of the NHS.

Guest speaker Renee Short MP started her speech reassuring CHCs that they were "really very powerful" — and that the Parliamentary Social Services Committee, which she chairs, is "a very strong ally" for CHCs. She described the way the committee works and said she would welcome suggestions from CHCs for areas of investigation.

As well as the "official" business of the AGM, delegates were able to attend a seminar on publicity led by Eileen Ware of The Volunteer Centre. There were two showings of the Yorkshire CHCs' film, *CHCs - What's that?* and on the second evening of the AGM delegates were taken by bus into the town centre for an evening of Welsh music and dancing organised by Ceredigion District Council.

This AGM saw the final appearance of Rod Griffiths as Chairman of ACHCEW. CHCs' appreciation of his work over the last two years was evident in the standing ovation he was given. The new chairman is Dan Merlin Thomas of Cardiff CHC. He was elected unopposed after John Austin-Walker of Bexley CHC stood down and was elected vice-chairman instead. The treasurer is still Eric Thomas whose recommendation that the subscription to the Association remain £250 was welcomed. Next year's AGM will be held in Coventry on 24-25 June.

Feeling special or just a number ?

*by Jo Garcia**

The years since CHCs were established have witnessed a growing consumer interest in the quality of maternity care. Some CHCs have set up committees concerned with maternal and child health. Many CHCs have produced reports on maternity care, usually presenting the findings of surveys of consumer attitudes. This article presents an overview of the results of 18 such surveys, representing the views about antenatal care of over 3500 women around the country.

In the majority of CHC survey reports there is, rightly, considerable emphasis on local problems and the comparison of different facilities available to the population covered by the survey. Women's opinions about the quality of care can vary quite strikingly from one hospital or clinic to another. The aspects of care which I have chosen to highlight do not show any uniform pattern across the country, but I have tried to draw some general conclusions from the varied findings.

CHC surveys provide useful information about antenatal care which is not available from other sources. Where there is local anxiety about mothers not coming for antenatal care early enough in their pregnancies, the surveys often show up the extent to which this happens. Some surveys show that better procedures for referral by the GP or for giving hospital appointments could reduce the number of women who have their first visit to the clinic later than is recommended. The surveys are particularly useful in describing the local pattern of consultation and referral and highlighting causes of delay.

The CHCs' work reveals the practical problems that women face when they attend antenatal clinics. A visit to the hospital clinic takes longer on average than a visit to the woman's general practitioner surgery. And although the cost of travel was not systematically investigated in these surveys, several of the mothers interviewed mentioned it as a problem. Long journeys on public transport towards the end of a pregnancy can be exhausting, especially if there are other children. Many mothers emphasised the difficulty of caring for their young children during clinic visits. In many places, those who run antenatal clinics have tried to make them more hospitable for children but the findings of a local study can give a valuable boost to this process.

The booking system and waiting times in clinics have been a prominent feature of consumer dissatisfaction. Many clinics still operate a block-booking appointment system which tends to demoralise mothers. Knowing that dozens of other mothers all have the same "appointment" is very discouraging. In one survey of clinic waiting times it was found that more than half of the women interviewed arrived at least ten minutes earlier than their appointment and a fifth arrived at least 25 minutes earlier — all hoping to beat the system. Very few arrived late.

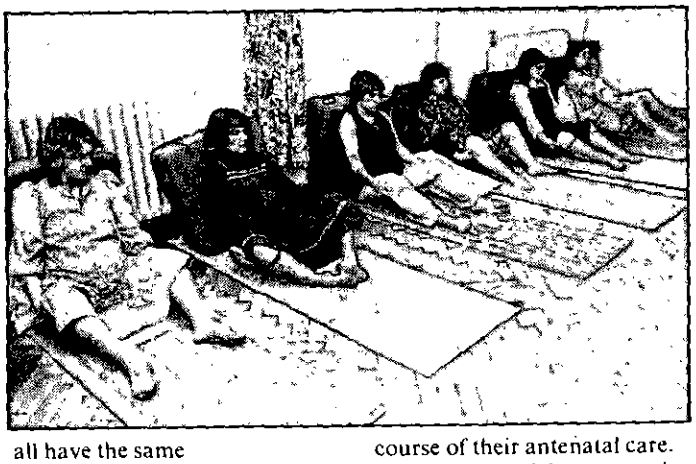

Photo: Maria Bartha

These surveys clearly demonstrate the long waiting times, especially at clinics in hospitals. The waiting time tends to be fragmented and of an unpredictable nature. This makes it difficult to get into conversation, or read, or even go to the toilet, "for fear of missing a turn". New attenders may not have the clinic system explained to them and so may be forgotten, or worry in case they have been, without knowing who to ask. It is clear from the reports that the organisation of the clinic often contributed to women's impressions that those providing the antenatal care did not respect their needs and feelings.

How far does the care given live up to women's needs and expectations? Many surveys asked questions about women's satisfaction with the personal aspects of their care, often focussing on communication with staff. The tendency for women to see different midwives and doctors at each hospital visit may have an adverse effect on good communications. Most mothers (but not all) prefer to see the same faces during the course of their antenatal care. The surveys which compared hospital and GP antenatal care show that more women feel that the personal care is good and that doctors and midwives are good at explaining things at GP antenatal visits. Midwives visiting at home emerge in an even more favourable light in answers to these questions. Two surveys which asked comparable questions of women using different hospital antenatal clinics show that the proportion who rated their treatment as a person as "very good" ranged from 56% to 81%. From the many questions answered on this subject, and from the comments quoted in these reports, the ideal of being treated as a person emerges very strongly. It's hard to come to terms with being "just a number" when you are meant to be "feeling special".

The extent to which women are free to choose the place of birth is explored in some of these surveys (although choice about antenatal care is not). In three surveys which give details about choice of place of birth, around half the women said they had had no choice. Of course, for many women, choice may be limited by clear-cut medical priorities.

The surveys sometimes deal with particular groups of women. As several CHCs' reports point out, women who need to be admitted to hospital because of pregnancy complications may miss the opportunities for discussion presented by antenatal classes and clinics. Hospital staff may not be aware of this gap, which can affect quite a lot of women.

Women from ethnic minorities also have special needs in antenatal care. Several reports suggest ways of coping with language difficulties and express the need for sensitivity in dealing with the stricter standards of modesty of women from the Indian sub-continent. The specific needs of women from ethnic minorities can only be tackled successfully by taking local conditions into account, but more published surveys of their views and details of schemes designed to give better care for them would be useful.

In summary, five points emerge:

- CHC surveys give valuable information about local needs.
- Women face considerable practical difficulties in attending antenatal clinics.
- Many women prefer the personal care that they get from a GP or midwife.
- Pregnant women like to be treated as people.
- More information is required to identify the special needs of certain groups of women.

A longer version of this article, including details of the surveys is available from Jo Garcia, NPEU, Radcliffe Infirmary, Oxford 0X2 6HE.

CHC NEWS will later publish a second article, covering CHC surveys of care at birth and after. In a third article, Jo Garcia will look at the lessons to be learnt about survey methods.

Jo Garcia works at the National Perinatal Epidemiology Unit, Oxford.

WHO'S TAKING OVER?

By next year England's 90 area health authorities will have been replaced by 193 district health authorities. Multi-district areas and area management teams will have disappeared, and about 3100 DHA members will have taken over responsibility from the 2300 or so AHA members who were previously in charge.

When the NHS was last reorganised, in 1974, a complex structure involving three "tiers" of management responsibility (region, area and district) was introduced. The view that this structure was too cumbersome quickly became widespread, and in 1978 the Royal Commission on the NHS recommended that in most places there should only be a single tier of management responsibility below region (1).

In 1979 the consultative paper *Patients first* suggested the removal of the area tier, and in 1980 the Government set out a detailed plan to implement this (2). Former Social Services Secretary Patrick Jenkin has described the new reorganisation as "part of the Government's broad strategy to reduce the burden of government, to create a simpler administration and to give more local autonomy."

"There may be advantage in appointing as DHA members those with previous CHC experience"

It is the members of an authority, not its administrators, who have the ultimate responsibility for deciding NHS policies and priorities at local level, and for some CHCs the changes next year could provide a valuable opportunity to improve contact with health authority members. Detailed guidance on the role of DHA members and the conduct of DHA business was issued by the DHSS in June (3), and would repay close inspection by CHCs.

The circular lays down that DHAs will normally consist of 16 members, plus a chairman appointed by the Secretary of State. The regional health authority (RHA) will appoint a hospital consultant, a GP, a nurse (or midwife or health visitor) and a university medical school nominee. The relevant local authorities will appoint four members, or exceptionally a larger number. The RHA will fill the remaining seats, normally eight, by appointing other members who the circular describes as "generalists".

RHAs should already have asked CHCs to nominate suitable people for DHA membership, and the circular notes that there "may be advantage" in appointing people with CHC experience. But existing CHC members must resign if they are appointed to a DHA, because of a legal bar on dual membership. At the time of writing, 16 people with CHC experience have already been appointed as DHA chairmen.

DHA members should normally live or work in the district, and should have between two and four days a month available for the work of the authority. RHAs should try to achieve a "reasonable balance" of DHA members, in terms of geography, age, sex, race, personal background and particular health interests. Appointment of people aged over 65 "should be regarded as exceptional". Local authorities are asked to bear in mind the advantages of appointing members of their committees which have links with the NHS, such as social services, housing and education.

Within the framework of national and regional priorities, says the circular, "it is the members' task, on the advice of their officers, to devise a sensible formulation and application of policy to local conditions. They will need to take into account the views of the public in their district, as expressed formally by CHCs, local authority or other interests and through members' own knowledge and judgement of local aspirations and needs".

Members are responsible for the full range of services provided direct by their authority, for "the integrated planning, provision and development of primary care and other community health services," for making available teaching facilities, and for "ensuring that there is satisfactory collaboration and joint planning with local authority services, through joint consultative machinery agreed locally".

"It is the responsibility of members to review, and where necessary challenge, proposals put forward by its DMT; and to make effective arrangements for the implementation of proposals approved by the authority. Members should, therefore, satisfy themselves that sufficient background information about all the options available accompanies proposals to enable them to make informed judgements ...

"It is not the members' role to intervene in day-to-day operational management but rather to stand back in order to take policy and strategic decisions. Nevertheless, they need enough information to make informed decisions and to assess the quality of services provided. This knowledge of operational services may be acquired in a number of ways. Visiting by members has a crucial role. How visiting is arranged will vary in accordance with local circumstances and no central blueprint can be laid down. But members should avoid the twin extremes of constant unannounced inquisitional visits on the one hand and a routine pattern of visiting which concentrates on trivia on the other ...

"The flow of information and comment between DHAs and CHCs will help to keep the public informed about local health services"

"No member is appointed to represent a sectional or personal interest. It is important that members contribute in a constructive as well as a questioning way to the whole work of an authority, avoiding the temptation to concentrate on matters of particular personal interest. The views of individual members with specialised knowledge and experience will, of course, be particularly valued on relevant issues; the decisions of the authority are, however, at all times corporate and collective. Members must, therefore, be prepared to recognise not only the duty of the authority to reach decisions but also the corporate responsibility of the members for those decisions once taken".

DHA meetings will be covered by the Public Bodies (Admission to Meetings) Act 1960, and so must normally be open to the press and general public. The Act gives DHAs the right to exclude press and public when confidential matters are to be discussed, but "it is however a general precept of public life that public bodies should not invoke the Act lightly, with a presumption in favour of open and public discussions wherever possible. By these means the flow of information and comment between DHAs and, for example, CHCs, will help to keep the public informed about local health services".

CHCs' observer status at meetings of their health authority will continue. "Observers will have the same right as members of the authority to speak during meetings but will not vote. Observers will not be automatically excluded from those parts of the DHA meetings or committee meetings which are not open to the press or the public. However, there may be some confidential matters, eg some personnel matters, which DHAs will from time to time need to discuss when it would not be appropriate for the CHC observers to be present. DHAs will, therefore, have the right to ask the CHC observers to leave the meeting during the discussion of such matters although the Secretary of State hopes that these circumstances, except for the discussion of personnel items, will be exceptional ...

"CHC observers should receive all papers to be discussed by DHAs, except those which the authority wishes to discuss without CHC observers being present. The observers should normally be free to discuss DHA papers

with their CHCs although such discussions should be held, when appropriate, without the press and public being present. DHAs may like to indicate to CHCs which papers, in their view, should be treated in this way. This arrangement for a CHC observer to attend DHA meetings should in no way impair the independent standing of CHCs but it will ensure that their voice is clearly heard at the point of decision making."

Previous guidance which restricted the formation of health authority committees and sub-committees has been cancelled, and it will be "open to DHAs to establish committees as they see fit". Such committees are not generally covered by the Public Bodies (Admission to Meetings) Act, and so are not normally open to the public. The circular advises that "issues of major significance or of substantial public interest should not be remitted to committees for executive decision", and warns that it will be important to guard against "any diminution of the public's knowledge of the authority's affairs".

Observer status for CHCs "will ensure that their voice is clearly heard at the point of decision making"

In Wales a two-tier structure of Welsh Office and AHAs is being retained, based on existing area boundaries except in the case of the Dyfed health area, which is to be divided into smaller health authorities (4). Although the new authorities will still be called AHAs, the Welsh Office has pointed out that they will be "broadly similar" to the English DHAs "in terms of resources deployed and population served". The Welsh Office says it will be issuing guidance on health authority membership, similar to that for England, in the near future.

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1. *Report of the Royal Commission on the NHS*, HMSO 1979. Chapter 20.
2. Circular HC(80)3, *Health service development: Structure and management*, July 1980.
3. Circular HC(81)6, *Health services management: The membership of DHAs*, May 1981.
4. *The structure and management of the NHS in Wales*, HMSO July 1980, Welsh Office circular WHC(81)8, *Health service development: Structure and management.*

Book reviews

General practice revisited

by Ann Cartwright and Robert Anderson, Tavistock, £11.50.

This book reports a nationwide survey of patients and their doctors in 1977 and compares the results with those of a similar study done in 1964. It concludes that the failure to uncover improvements which had been expected in 1964 is disappointing, but finds a somewhat increased willingness of patients to criticise doctors. It suggests deterioration of aspects of the service, such as doctors' attitudes to "trivial" consultations, their attitude to the "social" side of the work and home visiting.

To CHCs, however, the value of the book is that it provides a national backcloth against which to view local services. A CHC can survey local opinion and compare the results with national figures, or, conversely, can investigate locally problem areas highlighted in the book. Negotiations for improvement might succeed if services are seen to be relatively poor.

CHC readers' prejudices about standards of service are likely to be reinforced. Anecdotal evidence about which doctors are good and which are not are sustained by numerous reported correlations. For example:

- Members of the Royal College of General Practitioners considered relatively few consultations trivial, inappropriate or unnecessary.
- Doctors who enjoy their work are more likely to make home visits.
- Doctors who use a deputising service are less likely than others to regard it as appropriate for patients to consult them about family problems.
- Patients were less satisfied with doctors who qualified in Asia (especially regarding communication and examining) than with others.

The authors recognise that the decimal-point accuracy of their results will be affected by selected response. The 67% response amongst GPs seems biased towards groups providing better service, and as patients were sampled from the electoral register, one can expect that mobile people, the illiterate etc, will be under-represented. But accepting these limitations, this book remains a useful campaigning tool.

Martyn Smith
Secretary,
West Birmingham CHC

You and your heart

by Paul Kezdi, Pelican, £1.75.

This is not an alarmist book. A brief statement on the Great Killer, heart disease, is got out of the way and is followed by a clear description of the workings of this marvellous pump, the heart. There is an account of the diseases of the heart and the current research into them. Exciting news on the research front concerns a new strain of rats which spontaneously develop high blood pressure.

The bulk of the book concerns prevention, which can be practised by every human being, once they know how. It is rarely heredity alone that causes heart disease, but the combined influence of many other factors, which can be controlled. Even age is not so much a risk as early ageing, which with determination can be delayed. Stress and frustration are not the real risk factors — it is the excesses they lead to — heavy drinking, eating and smoking and lack of physical activity.

Once you have modified your present eating habits, you will thoroughly enjoy your new heart-saver meals and regular exercise. There is advice on how to relax, lists of animal fat-free diets and current weights. Finally, should prevention fail, there is a chapter on how to live enjoyably after a heart attack.

Margaret Campbell
Oxford CHC

The impending crisis of old age — a challenge to ingenuity

edited by R F A Shegog, Nuffield Provincial Hospitals Trust and Oxford University Press, £10.50.

Of books on the elderly there would seem to be no end, and the weariness of the flesh when confronted with the seemingly intractable problems that CHC special interest groups on the elderly experience can have a stultifying effect on their deliberations. It is good, therefore, to find a book on the old that revives the spirit, and could well inspire some ingenuity amongst CHC members and secretaries.

What CHCs discover, time and again, are the gaps in the care system. As the book says, existing resources are often considerable; it is in their collaborative deployment where the various systems fail to deliver. The group that produced this book of essays and recommendations believes the best way forward is for central Government to work out "a model partnership agreement" with health, social services, housing, and the voluntary and private sectors, which would be aimed at the level of the new DHAs. Amen to that, although this approach is not the present Government's style. But it could be a worthwhile task for CHC working parties. There is enough substantiated material in the book, particularly in Part IV and the annexes to chapters 12 and 14, to stimulate council members to bring on to the agenda of districts the concept of "partnership" at grassroots, where it really matters.

Two quibbles. Firstly, no prize is offered for the first reader to spot the solitary reference to CHCs in the text. Secondly, if you are old, and poor, and lonely, and living in Leeds today, there is nothing "impending" about the crisis of old age.

Jack Hallas
Lecturer in Health Policy Studies,
Nuffield Centre for Health Service Studies,
University of Leeds.

Books received

Hard-to-help families by Maureen E Lahiff (HM & M Publishers Ltd £3.95).

Give us the chance — sport and physical recreation with mentally handicapped people by Kay Latto (Disabled Living Foundation £9.50 inc post).

Just me — a songbook for children by Jean Turnbull and Steve Storr (King's Fund Books £5.00).

On the state of the public health for the year 1979 — the annual report of the chief medical officer at the DHSS (HMSO £6).

CAMPAIGNING FOR BETTER HEALTH

*by John Dennis, Peter Draper and Linda Marks, Unit for the Study of Health Policy**

Photos: Raissa Page

In recent years the word prevention has been voiced by many, not least by those working in the health and social services. The need for greater interest in the prevention of accidents and illness has also been stressed in various government publications, for example in *Prevention and health: Everybody's business* (DHSS 1977). In 1979 the Royal Commission on the NHS regretted "that more emphasis has not been placed in the past on the preventive role of the NHS. This must change if there are to be substantial improvements in health in the future". Indeed, there is scarcely a health authority document whose introductory paragraphs do not reiterate a commitment to prevention.

This article reviews some key past events and current trends in prevention. It will argue for a renaissance of the "public health" approach to prevention and will consider the contribution that CHCs might make to the new public health.

The public health movement in the UK was a response to the toll of disease and death which accompanied the accelerating industrialisation and urbanisation of early nineteenth-century England. Diseases such as tuberculosis, typhus and cholera spread in urban areas, where much of the rapidly expanding population lived in back-to-back housing and worked long hours in ill-ventilated factories. There was little clean water; and excrement was left to decompose in the streets until the heaps were large enough to make their removal a profitable business. Such conditions developed at a time of chaotic local administration and minimal state invovement, allowing short-sighted commercial interests and social irresponsibility a free rein. Public expenditure was not a priority, and more than half of what was spent was allocated to military departments (1).

Such laissez-faire policies were modified over the period from the 1830s to the 1870s. The "sanitary maps" devised by the social epidemiologists had demonstrated that death and disease were highest in overcrowded cities(2). Certain administrators of the new and centralised public services (such as those provided under the amended Poor Law of 1834), groups of doctors familiar with the conditions of the large towns, and societies such as the Health of Towns Association, struggled against vested interests and chaotic administrative procedures in the interests of public health and welfare.

The voice of prevention

The first medical officer of health (MOH) was appointed in Liverpool in 1847. From the time of the Public Health Act 1848 — and especially after the "Great" Public Health Act of 1875 — an MOH was usually appointed as adviser to each local board of health. They were amongst those who helped spread the "sanitary idea" of ridding the towns and cities of "atmospheric impurities" and "noxious substances" which were considered the source of disease.

In practice, this involved the provision of adequate drainage and clean water, and the reduction of atmospheric pollution and overcrowding — concerns which were not shared by most of the local landlords, manufacturers or traders — nor indeed by the bulk of the medical profession, who accused the reformers of "sanitary quackery".

By the time of the Public Health Act 1875, which codified and rationalised all the previous sanitary laws, improvements in health had been shown to depend largely on public ownership of the distribution of water, better local administration, and the power of prosecution over those who flouted the demands of sanitary science. By the end of the century, adult mortality was in sharp decline. This was due not to advances in medicine, but to improved nutrition and better laws and services governing the environment — in other words to public health measures (3).

Although MOHs retained control over environmental services until 1974, when their work was reorganised as community medicine — though *dis*organised would be a better description — an increasing proportion of time was devoted to the administration of treatment as well as preventive services. This process began in the late nineteenth century, when health visiting was organised by the MOH. With the NHS Act 1946, the supervision and organisation of services such as district nursing, home help and other treatment and care services assumed priority. The administration of treatment rather than preventive services has similarly preoccupied community physicians since the 1974 reorganisation. In addition, from the late nineteenth century onwards, the post of MOH gradually lost its prestige and high salary, and most doctors have concentrated on curative medicine. The public health approach to prevention had lost many of its independent practitioners.

The state of the art

There are many reasons for the increased interest in prevention — from the sometimes-reasonable-sometimes-silly desire to save money to the belief that now, as in the nineteenth century, the risks to health are largely a product of the environment people have constructed. Common to both is an awareness of the increasing cost and diminishing returns of a highly technological and "mainly treatment" approach to health. For those whose concern is the health of the public, what "preventive options" are now available?

It's perhaps best to start with the common distinction that is made between *primary, secondary* and *tertiary* prevention. *Primary* prevention seeks to prevent diseases or accidents from ever occurring — examples range from immunisation and ante-natal services to fire regulations. *Secondary* prevention tries to detect disease in the earliest stages and while it is still treatable. Screening for cervical cancer falls into this category, for example. *Tertiary* prevention attempts to prevent deterioration in established diseases or disabilities — the prevention of avoidable deformity in rheumatoid arthritis, for example.

The NHS is clearly concerned with all three types of prevention. Unfortunately, however, the international development of hospital-based technological medicine, which has broadly coincided with the lifespan of the NHS, has distracted public and professional attention from prevention towards the idea that progress in health is achieved primarily through treatment. The areas of the NHS which are concerned with primary prevention particularly need to be extended and strengthened.

It is the concept of "primary prevention" that we would therefore like to discuss further. Three different approaches towards primary prevention can be distinguished by looking at *levels of intervention.* First is the *biomedical* level — eg immunisation services. Second is the *health education* level of intervention. This involves the transmission of information and efforts to modify attitudes or behaviour, typically through an individualistic approach. Personal health services incorporate one or both of these levels. Third is the *environmental* level of intervention, the modern equivalent of the nineteenth century approach to public health.

Those who criticise the health educational approach for preaching to the victims of a horrible environment ("victim blaming") claim that it has also served to *distract* attention from the influence of the environment in promoting disease — or health. Two Canadian writers, Labonte and Penfold, suggest that health education programmes "in rendering health and disease a matter largely determined by individual behaviour patterns, have thrown a thick smokescreen over a host of factors which are far more influential in creating illness: poverty, sexual inequality, racism, occupational hazards and industrially-created environmental pollution". Turning to smoking and alcohol abuse, they continue "this does not mean that we should stop telling the truth about cigarettes and alcohol but it does hint that perhaps the way we say it needs to be more socially critical. We need to become more honest about the political and economic reality of the alcohol and tobacco industries and less quick to place all the blame for life-style diseases on the individual"(4).

Modifying the social, cultural and economic environment is, of course, a very different task from tackling the physical, chemical or biological environment. As the Black Report *Inequalities in health* has reminded us, the implications for health (and therefore for prevention) of the three variables income, social class, and occupation are enormous (see *CHC NEWS 59* pages 6-7). Yet relatively little effort is expended in trying to improve *significantly* the position of the less-well-off members of our societies.

Many of the health issues arising from the social and economic environment concern the effects of *policies.* Some relate to trading or commercial practices — taxes on alcohol and Common Market subsidies for tobacco growing, for example, have health consequences. Others relate to basic economic, social and political issues — is *any* level of nuclear arms expenditure, unemployment/under-employment, or advertising of unhealthy products, morally justifiable or socially acceptable? One way of acting on the social and economic environment (and thereby facilitating the processes whereby health can become more important in policy deliberations), is by providing health education about the social and economic structures and processes which affect health. We have dubbed this "Type 3 Health Education" (5).

There is little provision within the NHS for the development of the modern equivalent of the "social epidemiology and intervention" adopted by the public health pioneers. While some may recognise that agricultural, transport, energy and employment policies, for example, are partly health policies, typically there is neither the time nor the "organisational space" to broaden the conventional and lethally restricted definition of what affects health. At its best, the term *health promotion* encompasses this broader definition of health. It includes the notion of "positive health" — health that is more than the absence of disease — and as such is in tune with the World Health Organization's definition of health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Some critics contend that such a definition is idealistic but we believe that the distinction between the mere absence of disease and the presence of health is an

Continued on next page

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Campaigning for better health

Continued from previous page

important one. The distinction can be illustrated briefly in the field of mental health. While it is now clear that some psychiatric disorders such as depression can be prevented, it is also clear that a fundamental difference exists between individuals who are merely *coping* and individuals who are *thriving*. In the same way, while a child may not suffer from *nutritional deficiences* that is not to say that the child is *well nourished*.

If such ideas — the relevance of the social and economic environment, the influence of public policies and an expanded definition of health — are accepted as important, in which ways could CHCs best contribute to the new public health?

CHCs and health promotion

Locally, CHCs know the problems of trying to develop effective means of communication with their own communities. They issue leaflets, hold public meetings, talk to a wide range of local voluntary bodies and so on. Yet such techniques are all too often used only in relation to emotive issues like hospital closures. There is a great need for local radio and newspapers to disseminate information and to foster action on local health promotion issues. Have CHCs tried hard enough to get coverage, for example, on how that local traffic management scheme, play space or housing could be improved? How many have established a working group that concentrates on prevention or health promotion? So long as the NHS has a commitment to prevention — which it does under the 1946 Act — it is formally justifiable for CHCs to foster the interests of their local population in such ways.

CHCs reacted strongly against the suggestion in the Government's consultative paper on role and membership that they could not have "a role in the formulation of policies at national level". Many others agree that it is *essential* they should do so, whether through the Association of CHCs or other means. National and Common Market issues daily impinge on local populations, and if CHCs do not point out the health implications how can the health interests of the population be other than *nominally* represented at DHSS level? CHCs can collaborate with other people and organisations — whether community physicians, health education officers, community groups or others — to ensure that a forum exists for the discussion of how agricultural, economic and a host of other policies affect health. The development of better links between the relevant national associations is one obvious means to this end.

In attempting to contribute to health promotion, new members of CHCs will almost certainly encounter the games which opponents of prevention like to play. It is as well that they are forewarned. The three most common are *Ostrich's Bluff, the Utopian Heresy* and *the Puritan Smear*. Ostrich's Bluff consists of someone saying "There is no evidence" (of the health effects of dietary fibre, or lead in petrol, for example) while at the same time failing to mention that they have not read the dozens of relevant reports — assuming they even knew those reports existed! The Utopian Heresy operates by exaggeration, "You can't prevent everything and take all the risks out of life", and the Puritan Smear works by appeals to short-sighted hedonism, "They're taking away all our pleasures". While some individualistic, victim-blaming health education does indeed display a puritanical edge, what we have termed the third type of health education properly focuses attention on the environment in which choices are made.

In conclusion, it must be admitted that prevention (or community care for that matter), is argued for on many different grounds. We do so simply because it is normally preferable to avoid premature death and always better to avoid unnecessary suffering. *That is not to say that prevention should be emphasised at the expense of treatment and care services.* The preventable problems outlined in the Black Report and elsewhere must be tackled, but the casualties already produced still need help. What is required are modest but *extra* and *different* resources for prevention. While extra Government expenditure may seem impossible at the moment, the pendulum of political opinion about economic policy is rapidly changing direction. The case for prevention needs regular re-stating, whether in relation to illness or in relation to street violence or nuclear proliferation. Prevention is too important and too neglected for CHCs not to play their part.

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3. See for example *The role of medicine*, by T McKeown. Nuffield Provincial Hospitals Trust, 1976.
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Healthline

Patients' records and the police

What access do the police have to information about patients?

The British Medical Association's *Handbook of medical ethics* says that a doctor "must preserve secrecy on all he knows". There are five exceptions to this — two of which are relevant to this question. They are when a court has ordered disclosure, and when the doctor has an "overriding duty to society" — this is left to the doctor's own conscience to decide and he or she must be able to justify the decision.

Some newspapers have recently carried reports of *administrators* letting the police have access to medical records. If this has happened it is contrary to the advice of the National Association of Health Authorities — and goes against guidelines recently drawn up by the BMA and the Association of Chief Police Officers. These stress that "police officers should liaise directly with doctors concerning matters involving the release of information about patients, and not through medical administrators". When police do request information they must give full reasons and "no police officer should give the impression that he has a legally enforceable right to compel disclosure".

Control over private hospitals

Yet another private hospital is being built nearby and we're worried that it's going to attract staff away from the NHS. Is there any way of controlling the number of private hospitals in an area?

According to the Health Services Act 1980 (which amended the HS Act 1976) private hospital developments with 120 beds or more cannot go ahead without the authorisation of the Secretary of State for Social Services. And if they are in an area designated under Section 12a of the amended 1976 Act, the Secretary of State has to authorise *any* private developments. Areas are deemed designated if the Secretary of State has accepted a representation from the relevant health authority that further private development would "significantly prejudice" the NHS.

Obviously all private hospital developments are subject to the normal local authority planning controls.

Appeals against the Ombudsman

How does one appeal against the decision of the Health Service Ombudsman?

There is no appeal in the legal sense. You can complain to your MP who could then take your case to the parliamentary select committee — the Social Services Committee — or ask a parliamentary question on it.

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.

JOINT £INANCE bridging the gap

In the second of two articles on joint finance, Tim Booth looks at obstacles to collaboration between health and local authorities, and what CHCs can do to smooth the way.

Joint finance is part of a complex system of links between health and local authorities. These have been developed to meet the duty placed on them by the NHS Reorganisation Act 1973 to co-operate in order "to secure and advance the health and welfare of the people of England and Wales". This collaboration is pursued within a framework of working arrangements which also includes the co-terminosity of boundaries, cross-membership of the AHA, the interchange of staff, the appointment of specialist liaision officers, and joint consultation through joint consultative committees (JCCs) and joint care planning teams (JCPTs).

As the Royal Commission on the NHS observed, the success of these arrangements has been variable. Yet it would be a mistake to attribute their failings simply to the attitudes of those charged with making them work. The problems of collaboration are rooted in important differences between health and local authorities in their organisation and in their ways of working.

Obstacles to collaboration

An appreciation of these differences is crucial to any understanding of the obstacles to collaboration — and so to the difficulties of joint financing. Broadly, they may be summarised under four headings.

Political. The NHS is administered by health authorities acting as agents for the Secretary of State. Local authorities, however, hold powers and responsibilities in their own right. Unlike the NHS local government is directly politically accountable and the responsiveness of local government officers to political influences and constraints can present problems in relations with their NHS counterparts.

Financial. The NHS is financed directly by central government whereas local authority spending is met partly by the Exchequer through the Rate Support Grant, partly from rates and partly from income from sales, fees and charges. The planning and control of expenditure in the NHS is primarily a managerial function exercised through the NHS planning system, whereas in local government it is a political responsibility accomplished through the political process.

Organisational. The NHS is a complicated mix of medical staff in independent practice with nurses, administrators and other related occupations, in a series of separate but parallel managerial hierarchies. Social services are generally organised in a single managerial hierarchy. These differences can present problems of communication.

Professional. The NHS is dominated by the culture of professional medicine, with its focus on the individual. By contrast, social workers tend to display a broader awareness of the social context in which the problems they encounter arise. These differences of outlook and approach can make it difficult to sustain the consensus on which collaboration depends.

One of the main stumbling blocks to closer co-operation has been each side's ignorance of how the other manages its affairs.

If CHCs want to make a positive contribution to joint planning, and to the use of joint finance, they must complement their understanding of the NHS with a sound knowledge of the way local government works.

by Tim Booth, Lecturer in Social Policy, University of Sheffield

Tunnel vision

These differences between the health and social services also foster a kind of insularity or "tunnel vision" which predisposes both members and officers to look at problems only from the perspective of their own organisational interests and responsibilities.

A Crossroads Care attendant scheme in Braintree, funded through joint finance

Photo: Dena Ashbolt

The resulting conflicts are most apparent on issues involving the transfer of patients and clients — and hence the transfer of costs and expenditure — from one authority to another. Here it is often professional concerns, financial pressures and political considerations, rather than social needs, which seem to dictate the outcome of joint planning.

In this context, CHCs have an important part to play in ensuring that the needs of service-users do not lose out to the interests of service-providers when joint finance is being allocated.

Spur to innovation

Joint finance has been seen as a way of encouraging innovation and experiment in services. Because it is not tied to traditional spending heads within social services budgets, it can be used to support novel ideas. For example — in Calderdale a night care scheme for elderly or terminally ill people living at home, a mental illness crisis intervention service in Tower Hamlets, ten "Crossroads" care attendant schemes around the country, and in Manchester the attachment of a specialist social worker to work with women failing to turn up for ante-natal care.

However there is little evidence that the innovative potential of joint finance has been widely exploited. Both councillors and officials are inclined to see its use in terms of "more of the same".

CHCs could make a big contribution here as a source of new ideas and imaginative proposals for meeting needs and improving services.

JCC representation

In order to play their full part in joint financing, CHCs must be able to make their voice heard. In those areas where membership is denied them at present, *CHCs must strive for representation on the JCC.* The only barriers are the secretive and self-serving instincts of the statutory authorities. Only in this way will CHCs be equipped adequately to perform the important task of monitoring how joint finance is spent in their areas.

Generic prescribing

by Dr J D Williamson, Member, Barnsley CHC

Photo: Liz Heron

In their bid to achieve savings in the drugs bill many CHCs have espoused the concept of generic prescribing. They argue that if all doctors were to prescribe by using the simple chemical names of drugs, rather than using the pharmaceutical companies' brand names, the savings to the NHS would be immense. But doctors stick to their branded favourites.

The reasons for this are less complicated than you might think. Once the GP is used to prescribing one particular selection of medicines, for the sake of speed or because he knows them well, it is very difficult to persuade him to use others. It is not through malevolence or through ignorance that the doctor's habits remain unchanged, but simply because they *are* habits.

A similar situation has arisen in the past with the labelling of medicines. The mandarins thought it would be a good idea for patients to know what tablets they were on, so GPs were asked to indicate their agreement that the pharmacist could label the drugs by writing "NP" after each prescription. But doctors forgot. The net result was that a prescription form was produced with NP printed on it, and unless this was crossed out the pharmacist was expected to dispense the medicines with names attached.

Surely the same thing could be done for generic prescribing, with a similar set of Latin abbreviations inscribed for all to see? Where these were not removed the generic equivalent of whatever the doctor had prescribed could be dispensed with his full approval. Is it difficult? No, of course it is not. The only people who might object to it are the drug companies.

All of us in CHCs want the drug bill down. As a GP I would welcome greater use of generic prescribing, but I also recognise the limitations. The first of these is bio-availability. About five years ago it was recognised that not all tablets containing the heart drug Digoxin had the same effect on given individuals. It transpired that although each of the preparations had the same dose of active ingredient, some released a different proportion of this into the bloodstream. The reasons for this were legion, but the concept of the bio-availability of a substance — the ease with which it is made available within the patient's body— was born.

According to the experts bio-availability has ceased to be a problem, since it is now under scrutiny and the properties of the binding compounds used in all medicines are closely assessed. But there may be another problem associated with binding compounds. Put quite simply, if patients can be allergic to pollen or to eggs, which many are, why can they not be allergic to the binding compound of any medicine they take? The miniscule amount of active ingredient in any tablet requires a "carriage" and if this is truly inert then there is no problem. But if it interferes with the absorption or release of the active ingredient, or if it stimulates allergies in some people, then there is a significant problem.

The fact is that if you are dealing with patients on a long-term basis you cannot afford to have your monitoring process confused by not knowing which binding compounds their tablets contain. It is critical to know exactly what the patient is getting all of the time. That is the single fundamental argument in favour of branded preparations.

Another problem is that some patients prefer one particular drug. Several years ago patients were coming in asking for the contraceptive Eugynon instead of Ovran. I could not understand why, since the only difference between these two compounds is that the former is made in Germany, and the other in Britain. My patients pointed out that while they might be *chemically* identical, Eugynon was sugar-coated and

What's the food like?

By W G Favager, Secretary, Wirral Southern CHC and Harold S Fletcher, Chairman, Catering Committee, Wirral Southern CHC

The emergence of community health councils brought a fresh and independent approach to every aspect of health care — not least to the contentious subject of hospital catering.

The importance of hospital catering has always been recognised by Wirral Southern CHC as a vital link in patients' treatment and recovery. Therefore, early in 1975, the CHC formed a catering committee which has since made numerous visits to the kitchens in order to see patients' meals prepared, cooked and plated.

When measuring the standard of catering service at our large acute hospital, Clatterbridge, we took account of the fact that it has approximately 1000 beds on a 67 acre site, with all the inherent complexities, diversity of age, taste and service and dietetic problems which such a hospital poses to kitchen staff. Nevertheless, we believed that many improvements could be effected merely by a better understanding by hospital staff of the almost herculean and complex task confronting the catering department before, during and after every mealtime.

We eventually decided to produce a report for submission to the area health authority. Ten months later the AHA responded, claiming that the catering committee's decisions were based upon observations and discussions with patients on two particular dates only. This statement is wholly inaccurate. The report was the culmination of five years' regular visiting to the kitchens and patients in the hospital and from its inception the catering committee has continually had occasion to criticise various aspects of the catering facilities in the hospitals in the Southern district. All these criticisms have been referred to the appropriate officers for attention — though experience has shown that very little improvement has been achieved.

In our report we stated that there were too many delays from the time trolleys are loaded and leave the kitchens and their arrival on the wards. There were reasons for this, all of which were highlighted by the catering committee. We have in fact witnessed congestion due to unauthorised and bad parking of vehicles at unloading points, and there were many occasions when, for possibly quite valid reasons, ward staff delayed the unloading of

did not leave a nasty taste in the mouth.

The best way of managing fever is tepid sponging and paediatric aspirin or paracetamol. The cheapest forms of the latter, the generic preparations, taste horrible. One of the more expensive versions, Calpol, tastes delightful, and I have never yet met a child who refuses the prescription.

Psychiatrists have frequently found that yellow, blue or green tablets make people feel better a lot quicker than red or purple ones. All colours have a better effect than white tablets. But generic prescriptions are more often than not white tablets!

Finally there is the problem of prescription-writing itself. The average GP is fed up with writing, and it is quite natural for him to seek ways of cutting this down. If it can be done by prescribing branded, rather than generic names; which do you think he would choose? If you had to choose between alpha-methyldopa and Aldomet, which would you choose? What about cefuroxime sodium versus Zinacef? Or chenodeoxycholic acid versus Chendol?

The answer to the drug bill is not scrapping branded prescriptions. It is sensible prescribing. Where continuing medication is indicated there will always be a place for branded medicine. Nearly two-thirds of the GP's work, though, is in acute crisis medicine, and it is here that generic prescribing comes into its own. What CHCs can do is to persuade the powers-that-be to investigate the "generic equivalent permissable" prescription form. At least that way we will not be moving towards a head-on conflict with the medical profession.

All-day visiting

by Angela Alder, Secretary, West Essex and District CHC

Along with the majority of CHCs in 1974/75, our visits to health service establishments often meant 16 or more members touring en masse around various departments and wards.

The usual format of these early visits was coffee and discussion with the consultant(s), senior nursing staff and administrators, followed by a quick tour of the chosen department. The very nature of these arrangements meant that there was little contact with patients or opportunity to obtain their views of the service they were receiving — nor was there much chance of talking to ward or department staff.

Initially however, this method did serve several useful purposes: it enabled members to become familiar with services within the district, it helped to foster good relationships between NHS staff and CHC members and it was a useful means of putting the CHC on the map.

As our role developed, we felt the need to change our style of visiting and to gear it more to the work of our special interest groups. Visiting with smaller groups was more satisfactory from the members' viewpoint but it still did not fully satisfy our criteria for effective visiting.

Then an area enquiry into a complaint led us to undertake a 14-hour long ward observation, with individual members joining me at different times during the day. It was out of this very useful experience that our present pattern of visiting evolved.

Now our visiting day is divided into two-hour shifts, with members starting at 8am and ending at 10pm. I am in attendance for the whole 14 hours (apart from short meal breaks). We spend our time talking to the patients and their relatives, the nurses and the other staff who come onto the ward. The time goes incredibly quickly.

At first the staff, especially the nurses, were rather suspicious about our motives, thinking that we were there to find fault with them or their ward. However, visiting the ward beforehand to draw up a "profile" of it and to meet some of the staff has dispelled that feeling and I emphasise that we are there to observe the "patient's day".

We visited the long-stay wards first and now we are going to the acute ones. Visits are planned a year in advance, with seven members being nominated for each monthly visit. Participating members talk freely to patients, visitors and staff, and then write a brief report on their impressions. The whole day's picture is put together with a summary from myself of any recommendations or observations. This is then discussed in our regular meeting with the district management team.

What are the advantages of this type of visiting?

- Employed members or those with family ties are able to visit at a time to suit themselves;
- There is no disruption in the ward routine as one member leaves and another takes over;
- Members acquire a more realistic appreciation of the in-patient's day;
- The CHC presence throughout 14 hours ensures continuity of observation;
- Staff and patients are made more aware of the CHC's existence and learn what we can do to help them.

Many improvements for patients have resulted directly from this form of visiting — these include the installation of an extractor fan in a psychogeriatric day room, agreement by a consultant that geriatric patients need not sit by their beds during ward rounds, a three months' trial for personalised TV sets and a mothers' room in a children's ward.

Reviewing our various methods of visiting over the years, we have found that day-long visits meet our criteria for "in-depth" visiting very well, but they do demand a regular commitment from members and staff that some CHCs might find too much to sustain. We do occasionally experience difficulties in finding members to cover some of the sessions and in chasing up visit reports, but overall the process is enlightening and rewarding.

Finally, we are grateful to both our district management team which has encouraged and supported us in all our visits, and to NE Thames RHA which has welcomed this particular method of visiting.

Photo: Liz Heron

trolleys too long after their arrival.

There is no doubt the standard of catering at Clatterbridge has improved considerably since the introduction of the plated meal service and menu choice, but initially the menu cards proved difficult for patients to complete. For example, out of 83 menu cards examined by the catering committee on one visit, only three were properly completed. We were of the opinion that the menu cards were a complete failure, and that a more simplified format should be introduced. Whatever savings were envisaged in cutting down food waste by the introduction of a plated meal service and menu choice, were being dissipated in the failure of patients and nursing staff to complete the menu card.

The most common complaint at the hospital was that soup, which is served at both lunch and supper, was invariably cold. The metal soup bowls and lids were not heated as they would become too hot for staff to handle, and spill.

Our report has, in fact, produced many welcome changes. There is now in use a more simplified menu card, greater attention is paid to the wishes of the patient in regard to portion sizes and individual containers with lids have been purchased for the conveyance of soup to prevent spillage and reduce heat loss in transit.

The AHA contended that the report should have been the subject of prior discussion with officers before conclusive judgements were made, but the catering committee members believe that their function is to undertake impartial investigations into facilities affecting the patients — any prior discussion with officers might tend to colour their judgement and freedom of expression.

Inevitably, it was claimed that a number of the items referred to by the catering committee were basically management issues and the prerogative of the management concerned, but we emphasised that criticism of any NHS facility or lack of it must inevitably, if taken to its logical conclusion, be a criticism of management.

Parliament

The age of retirement

The Social Services Committee is to carry out an inquiry on "The age of retirement". It expects to consider possible changes in retirement ages or the introduction of a more flexible system. Written evidence should be sent to the Clerk to the Social Services Committee at St Stephen's House, Victoria Embankment, London SW1, by the end of November.

Cannabis

Clinical trials of cannabis are in progress in the UK to test its value in controlling the side-effects of cancer chemotherapy. It is not commercially marketed as a medicine and is subject to restrictions under the Misuse of Drugs Act (Lewis Carter-Jones, Eccles, 31 July).

Official criticism of the DHSS

In its latest review of the DHSS's expenditure plans* the Social Services Committee has voiced concern about aspects of the department's performance.

The Committee is worried about the £25m "efficiency cut" which is being deducted from the NHS budget on the assumption that authorities will save £25m by eliminating waste. The DHSS has not been able to measure the savings from increased efficiency, and the Committee asks whether authorities will end up economising by cutting services. It goes on to express concern about the lack of rigorous criteria for monitoring efficiency and quality in the NHS.

The Government is sternly criticised for its confident assertions last year that £100m could be recouped from new charges. The Committee says it ought to check out the feasibility of policy changes, such as charges for sight tests, before incorporating them into expenditure planning.

Criticism of the department's lack of information is the theme running through all the areas discussed — personal social services, the NHS and social security. The Committee will "watch with particular interest" the effects of the cuts to the DHSS's statistical services.

Finally the Committee stresses the enormous financial toll of unemployment — the direct cost to the Government of an unemployed man with a non-working wife and two children was an average of £500 per month in 1980. And an estimated 250,000 low-paid jobs could be provided for the unemployed for a net cost of £56m — less than ½% of 1980 social security expenditure. (**Third report from the Social Services Committee 1980-81, Vol I*, 324-I, HMSO £2.30).

NHS blood for sale

Discussions between the DHSS, the NHS and pharmaceutical companies are to take place over the possible sale of by-products of NHS blood donations which have been used in the manufacture of therapeutic and diagnostic products. These by-products would be those not needed by the NHS. Health minister Dr Vaughan "is sure that the majority of blood donors would wish the maximum use to be made of their donations" and says that the income from the sale "will directly benefit the NHS" (Robert McCrindle, Brentwood and Ongar, 31 July).

Fluoride

The Government's present policy is to encourage area health authorities to fluoridate water — it has no plans for legislation to make fluoridation compulsory and believes it should be done with the consent of those concerned. So far only 9% of the British population receives fluoridated water, although 85 out of 90 AHAs have decided in favour of it.

Meanwhile the Government is looking "with interest" at other ways of counteracting tooth decay and has provided over £540,000 for research into vaccination (J W Rooker, Birmingham, Perry Bar, 30 July).

Grants for insulating tanks

From November, the elderly, the disabled, the chronically sick, families with children under 16, pregnant women and the long-term unemployed, who are also getting suplementary benefit, will be able to claim a grant to help pay for insulation of hot water cylinders (Keith Best, Anglesey, 2 June).

IMMEDIATE CARE

by Ron Bailey, Editor, BASICS Journal

Each year on our roads 6500 people are killed and 350,000 are seriously injured. Prompt medical attention can help reduce these terrible figures. At any accident the lack of correct care in the critical period of twenty minutes following the accident can mean unnecessary loss of life or the chances of complete recovery being lessened. This care should be started as soon as possible and involves pain relief, prevention of blood loss, blood plasma transfusions, getting breathing going and dealing with obvious and suspected broken limbs.

The value and importance being placed on immediate care is reflected in the growth of the immediate care movement in the United Kingdom. In 1967 Dr Ken Easton, a general practitioner in Catterick, North Yorkshire, formed the first immediate care scheme. Today 71 of these schemes are in operation, involving 1200 doctors. Ten schemes are based on hospitals but the rest consist of GPs and cover roughly one third of the country. Immediate care is defined as "the provision of skilled medical help at the site of an accident or other medical emergency or in transit". The schemes include doctors who have organised themselves to provide immediate care in co-operation with nurses, police, fire, and ambulance services, hospital flying squads and mobile coronary care, intensive and resuscitation units.

We are fortunate to have in this country one of the finest ambulance services in the world and the skill and dedication of the ambulance crew undoubtedly help in the treatment of the injured. Yet at many

Photo: East Anglian Daily Times

accidents the clinical expertise of a doctor can be so important. Also, particularly in the more remote rural areas, the time needed for an ambulance to get to the scene and then to the nearest hospital is an extra problem. Surveys have shown that in urban areas the time taken to reach hospital was ten minutes from the time of the accident and in rural areas 50 minutes.

Most of the immediate care schemes are organised so that the participating doctors cover a compact local area. The schemes are voluntary organisations which rely on raising money through public support to equip their doctors with life-saving equipment and radio communication systems. The doctors work closely with the three emergency services and most schemes link with the ambulance service for call-out. Provision of immediate care is a team effort and most schemes would stress this wholeheartedly.

The national co-ordination of immediate care is focussed on BASICS (British Association for Immediate Care). Its executive council is elected from representatives of immediate care schemes and its pioneer, Dr Easton, is its chairman. The council is constantly looking into ways of improving all aspects of immediate care and promoting co-operation between all those involved.

The existence of these schemes must be of comfort to many accident victims. Evaluation of their work has not yet reached a sophisticated level but undoubtedly through the efforts of the dedicated participating doctors it can be said that prompt immediate care has saved many lives and certainly has improved the rate of recovery of many patients. Indeed the psychological aspect of having a doctor tending the injured at an accident speaks for itself.

For more information, contact Ron Bailey, c/o Health Department, Elm Street, Ipswich, Suffolk IP1 1HB.

Scanner

Terminal care

Last year Barry Lunt carried out a survey of services for the care of terminally ill cancer patients, and has now produced what he believes to be the "most comprehensive picture presently available". He gives a detailed analysis of services in England, Wales and Scotland and lists all the different schemes. The report is available from Terminal Cancer Care Report, Community Medicine, South Academic Block, Southampton General Hospital, Tremona Road, Southampton SO9 4XY. £2.50 inc post (pay to University of Southampton).

Failing faculties

Dementia is based on brain cell loss and a new guide from Mind explains that a normal brain loses 100,000 nerve cells every day — none of which are replaced. Even so, our brains should last for a life span of 110 years — it is only those people who lose more cells than the average who end up suffering from dementia. The booklet describes the difficulties that sufferers face and the ways in which they, and those who care for them, can be helped. *Coping with caring — a guide to identifying and supporting an elderly person with dementia* by Brian Lodge is available from Mind Bookshop, 155 Woodhouse Lane, Leeds LS2 (£1.60 inc post). And Age Concern has produced a leaflet on how to deal with a more widespread but related problem *Forgetfulness in elderly persons.* 25p inc post from Age Concern Greater London, 54 Knatchbull Road, London SE5 9QY.

Everything you always wanted to know about FPCs

Family practitioner services and their administration is a deceptively dry title for a guide which many CHC staff — and members — might find useful. It summarises the work and duties of family practitioner committees, the structure of the different services they co-ordinate and the way they relate to other health service bodies. £2.75 inc post from The Institute of Health Service Administrators, 75 Portland Place, London W1N 4AN.

Private patients on the increase

The total number of people covered by private health insurance in 1980 was 3,577,000 — about 6.4% of the population. According to figures collected at the request of the DHSS, this is a rise of 812,000 people compared to 1979, mainly due to an increase in the number of individual subscribers to insurance schemes (as opposed to companies buying health care for their employees) *Provident Schemes Statistics 1980* (£3 inc. post) from Lee Donaldson Associates, 21-24 Bury Street, London SW1

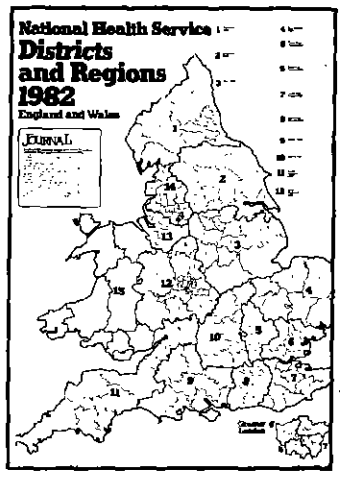
Holiday care service

Aims to promote the development of facilities for "elderly, disabled and disadvantaged people" and to act as an information bank on holidays and financial help. Contact Sue Finch, Holiday Care Service, 2 Old Bank Chambers, Station Road, Horley, Surrey RH6 9HW (Tel: 029 34 74535).

Ethnic switchboard

A telephone service has been set up in London for ethnic minority groups, statutory agencies and individuals. It will give advice and information about health care and cultural events and will arrange emergency interpreting in Cantonese, Spanish and all Asian languages. It has been set up by the Community Health Group for Ethnic Minorities which is a voluntary organisation aiming to develop awareness about the health and social problems arising out of migration. The group runs "Centre Link", an information and resource centre at 28 Churchfield Road, London W3 6EB. The switchboard on 01-993 6119 is open to callers every weekday from 7pm-11pm and Saturday 9am-9pm. It is free to individuals but a charge is made to statutory agencies.

Restructuring map



The magazine Health and Social Service Journal *has been quick off the mark in producing a map of England and Wales showing all the new districts. If the Government announces any substantial boundary changes in the next few months the HSSJ says it will sent out amending stickers to those who have purchased the map. It costs £1.50 inc post from Restructuring Map, HSSJ, 4 Little Essex Street, London, WC2R 3LF.*

Inspecting nursing homes

Health authorities must now visit all nursing homes at least twice a year. A new circular, HC (81)8, *Registration and inspection of private nursing homes and mental nursing homes (including hospitals)* lays down rules and guidelines and changes in previous legislation. It says that CHCs "do not have any general remit to visit or inspect private hospitals or nursing homes"—except for registered premises where NHS patients receive services under contractual arrangements. CHCs should have the same rights of access to these places as they do to NHS premises. The equivalent Welsh circular is WHC(81)6.

Times Health Supplement

Will be launched soon by Times Newspapers. From Friday 30 October, it will appear weekly, covering a broad range of health policy issues and news. A statement from THS says the paper "hopes to extend the common ground between health professionals and the public they serve". The editor will be Jill Turner.

Maurice Naylor

Has been appointed Director of the National Association of Health Authorities. He is the former regional administrator of the Trent RHA.

Reports in brief

Psychiatric rehabilitation by Roger Morgan and John Cheadle £4.95 from National Schizophrenia Fellowship, 79, Victoria Road, Surbiton, Surrey KT6 4NS.

Mentally handicapped people and the police sets out the Judges Rules for questioning mentally handicapped people. From Mencap Bookshop, 123 Golden Lane, London EC1 (send an s.a.e.).

Getting around: the barriers to access for disabled people £2.50 from National Consumer Council, 18 Queen Anne's Gate, London SW1H 9AA.

1980 Index of Health Circulars, notices and other guidance material lists all the DHSS bumf — £1.10 from DHSS (Leaflets) PO Box 21, Stanmore, Middlesex HA7 1AY.

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 3: Sunderland CHC Secretary: Mrs Belle Wilson.
Page 4: Lincolnshire North CHC Chairman: Mrs Marion Groves.
Page 6: South Hammersmith CHC Chairman: Roy Hall.
Page 7: North East Essex CHC Chairman: James Sutherland.
Page 8: Eastbourne CHC Secretary: Mrs Pamela Asquith.
Page 10: Southampton and South West Hampshire CHC 31 Shirley Road, Southampton SO1 3EW Tel: unchanged.
Page 11: Southmead CHC Chairman: David Large.
Page 16: Ogwr CHC Chairman: Harry Davis.
Page 17: Ynys Mon-Anglesey CHC Chairman: Coun. R I Owen.
Page 20: Falkirk LHC Chairman: W G Harris. Secretary: Mrs Anne Robson.

News from CHCs

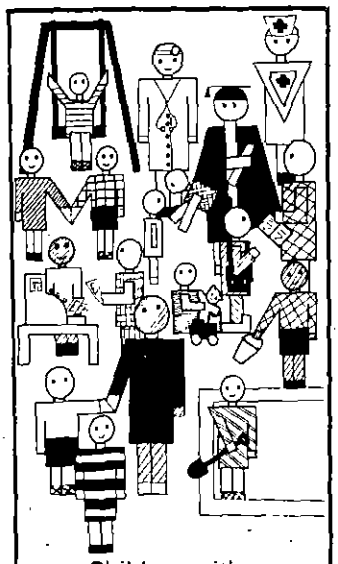
☐ Many children go right through school without ever having a medical check, according to a detailed survey of head teachers' views by **Medway CHC**. Only 10% of the teachers said that they could get satisfactory advice and action from the school medical service when children had health problems. And a quarter of the primary schools had not had a visit from the school dental service for over six years. The CHC argues that the school medical service is a "unique opportunity for observation, intervention and health education that is not available at any other time in a child's life", and argues that there is an urgent need to improve health screening in schools. The survey covers general health checks, nutrition, eye-tests, dental checks, health education and the psychiatric services.

☐ *A man whose wife died at Chapel Allerton Hospital, Leeds in 1976, has paid tribute to former chairman of* **Leeds Eastern CHC**, *Leslie Rosen, for his support and perseverance. Leeds Area Health Authority has made a £15,000 out-of-court settlement for damages to Mr Charles Lee of Bradford, whose wife's death sparked off a virtual strike of anaesthetists and led to two enquiries. Mr Lee said that without Mr Rosen's help in publicising the case, and lobbying MPs and ministers, he would not have been able to pursue the case and the matter might have been forgotten.*

☐ When the TV film *Silent Minority* was shown, **Exeter CHC** issued a statement reassuring local people that the district's hospitals for the mentally handicapped were not like those in the film. CHC member Mr Howard visited the hospitals with a newspaper reporter and photographer. Although some hospital nurses and members of the local society for the mentally handicapped attacked the CHC's statement as "whitewash", Mr Howard defended the council's action. "I'd be the last to say we're complacent about our hospitals and I'm happy in the knowledge that the DMT regard me as a thorn in their flesh. But I was also anxious that local parents should see the film in the right way".

St Lawrence's Hospital, Caterham was one of the hospitals featured in the TV film *Silent Minority.*. The hospital's patients come from all over London and **Croydon CHC** which has visited St Lawrence's more than any other hospital in its district, is considering inviting other London CHCs to discuss the problems of discharging long-stay patients into the community. Commenting on the film, Croydon CHC secretary Gloria Crosby said, "We know that people are sometimes restrained and I don't think that should happen, but what is the alternative — drugs? The film didn't show any of the good things which go on at the hospital such as therapy and the new bungalows. Of course there is under-staffing, but the film gave a false picture and we are concerned about staff morale. Top management is pretty good, and though the buildings are terrible, I wouldn't say St Lawrence's is a terrible hospital".

☐ **Soho and Marylebone CHC** (as Kensington-Chelsea-Westminster NE CHC likes to be known) caused quite a stir with its "GP availability survey", conducted by telephone. A researcher, "disguised" as a young mother with two children, phoned 41 practices as if seeking to register. The CHC then claimed that over a third of the practices in London's West End "are refusing to accept local families for treatment" and condemned the Medical Practices Committee for restricting the number of GPs in the area. The Local Medical Committee accused the CHC of using underhand methods, but acting CHC secretary Geoffrey Ellam argued that there was no other way to get a straight answer from some GPs.



Children with Special Needs

☐ *On behalf of the joint care planning team,* **Newcastle CHC** *has co-ordinated the publication of a booklet,* Children with special needs. *Graphic design students at Newcastle Polytechnic designed the book and CHC project officer Gillian Downey compiled the information for parents of handicapped children. The book covers help before school, schooling, leaving school, practical help, health services, social services, welfare benefits, short-term care, holidays and voluntary organisations.*

☐ A spate of maternity booklets and guides have recently been published. **East Dorset CHC** has written "a guide to action to be taken and help available for an unplanned pregnancy". **Redbridge CHC** and **Waltham Forest CHC** have combined to publish *Having a baby?* giving details of local maternity services.

Edinburgh Local Health Council has compiled a very detailed profile of the city's maternity units and their policies. Back in Waltham Forest again, the CHC has published a follow-up to its earlier survey of maternity services. This contained 43 recommendations and in *Second time around*, the CHC assesses the management response and weighs up the improvements made and new problems which have arisen.

☐ To dispel fears and misunderstandings **Gloucester** and **Cheltenham** CHCs held two public meetings for people living in the areas where two units for mentally handicapped people are to be built. AHA staff explained about the units at both of the well-attended meetings which were organised by the CHCs after they had criticised the AHA's lack of communication with local residents. The CHCs reckon that this kind of AHA/CHC "joint effort" is very beneficial.

☐ **North Camden** is to have a domiciliary care team for terminally ill patients living at home — due in part to pressure from the CHC which is very interested in the care of the dying and has been able to have considerable influence on the district planning team sub-group looking into terminal care. The CHC would eventually like to see a hospice serving Camden and the surrounding areas but is pleased that funds have been found for the home care team.

☐ **City and Hackney CHC** have produced *The state of the health services in City and Hackney health district.* This is a major review of local services, and the main issues that have concerned the CHC over the last six years. Topics covered include social conditions, finance, the single homeless, GP services, NHS users' rights, maternity services, ethnic minorities and community health workers.

☐ **Bolton CHC**'*s first newsletter has been a sell-out success. CHC members put copies through letterboxes, handed them out in supermarkets, and gave away more than 4000 at a street fair. The CHC also sent bundles to church groups, trade unions, and the health education department. A public relations firm was paid £660 to write the stories, design a newspaper style and print 8000 copies. Because the papers went like hot cakes, an extra 8000 had to be printed. "In fact we wrote it all ourselves and I'm confident that we can cut the cost by a third in future," said CHC secretary June Corner. "No matter how much time publicity takes, the success of CHCs depends on how well we get across to a wider public."*