CHC NEWS

For Community Health Councils November 1981 No 71

PROTECTING THE PATIENTS

A code of conduct to protect patients against the worst effects of industrial action in the NHS has been drawn up by the Trades Union Congress. The code forms part of a report on industrial relations in the NHS (1), produced by a working party set up two years ago by the TUC's Health Services Committee.

The code's seven points are:

- Any action which restricts services to patients due to an industrial dispute should be consistent with respect for human life, safety and dignity.
- In the event of an industrial dispute it will be a matter for each union or unions to consider the action that is necessary in the light of the circumstances of the dispute.
- For the duration of an industrial dispute, the union(s) involved should make arrangements in advance and with due notice, in consultation and, preferably, by agreement, with the employer, or appropriate senior members of staff, for the maintenance by their members of supplies and services essential to maintain emergency services and services to high-dependency patients.
- Emergency services are those which directly involve the life, limb or ultimate safety of a patient, for example 999, renal dialysis, terminal discharges, maternity, radiotherapy, or serious accident patients.
- High-dependency patients are those whose life, limb or ultimate safety might be at serious risk without the maintenance of services, for example children, severely mentally handicapped people or elderly patients.
- No services should be reduced to a level where satisfactory cover cannot be maintained in respect of emergency and high-dependency patients. In particular, delivery and distribution of drugs, food, oxygen and fuel should not be impeded.
- Unions may wish to give additional and more detailed advice on instructions to their members appropriate to the particular circumstances of the dispute.

Photo: John Sturrock/Report

Says the TUC: "We are recommending this code to our members because we believe that responsible trade union activity must include respect for human life and the prevention of suffering by sick people, who are in no way responsible for the actions that caused the breakdown of negotiations and the precipitation of industrial action".

Staff taking industrial action will be expected to follow the code provided local management does nothing to "exacerbate and inflame" the situation. The report pointedly requests the withdrawal of DHSS circular HC(79)20, *If industrial relations break down* (see *CHC NEWS 50* page three for details). "We believe that our code of practice will fully protect patients and allow the long-term preservation of good industrial relations. The withdrawal of the circular can help to guarantee that this will happen", says the TUC.

The new code is only one aspect of a 250-page report which also describes in detail how negotiating has evolved in the NHS, how pay is determined, how the Whitley Council system operates and how local disputes are settled. Amongst the appendices is a useful acount of the cash limits system: how it works, what its drawbacks are, and how it could be improved.

1. *Improving industrial relations in the NHS*, £6.60 inc post from the TUC, Congress House, Great Russell Street, London WC1.

"Don't tell us about side-effects" says drug safety watchdog

Reports of drug side-effects from CHCs, pressure groups and individual members of the public could be fed into a computer and used to improve existing methods of monitoring drug safety, according to an imaginative new plan devised by the Association of CHCs.

But the ACHCEW scheme has been turned down flat by the Committee on Safety of Medicines, the Government's own drug safety "watchdog".

The CSM already operates the much-criticised "yellow card" system, under which reports of drug side-effects from GPs are analysed using a computer. But it insists that side-effect reports from lay people would have to be individually investigated by medical experts before such information would be worth feeding into the computer.

Former ACHCEW chairman Dr Rod Griffiths has written to the CSM telling it that, as a former GP, he is surprised to hear that it cannot adapt its procedures to accept information from non-medical sources. The suggestion that each lay report would need expert follow-up before it could be accepted betrays "a clinical rather than a statistical approach to the problem", he argues. "It might well be that reports from laymen would be less precise, but this does not

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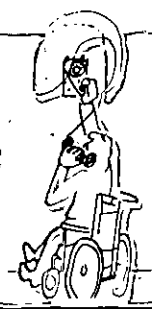
INSIDE ...



Your letters

Getting there

John Stevens, Secretary, West Berkshire CHC

There is a gap in the arrangements for assisting patients with fares for attending hospital. This has been drawn to our attention recently by patients who attend group therapy sessions at a psychiatric hospital which is 15 miles from Reading and a considerable distance from the other centres of population it serves. It seems that patients receiving supplementary benefit can be given financial help, but others cannot.

One patient is paid invalidity benefit and has no other source of income except child benefit for his son. He attends the psychiatric hospital each day but is uncertain how much longer he can continue to do so without help. Daily group therapy has enabled him to reduce his medication to a negligible amount and has prevented his admission as an inpatient. If he was to cease group therapy he could well regress, and apart from the consequent problems for him and his family the cost to the NHS would increase.

Information from other CHCs which have encountered similar problems would be helpful in presenting a case to the DHSS. It is no good financing NHS facilities if patients cannot readily get to them.

Ed: DHSS leaflet H11, "Your hospital fares", makes it clear that outpatients who find it hard to pay their fares to hospital because they have low incomes are eligible for financial help — so perhaps there has been a local misinterpretation of the rules in this case.

The missing amendment

David Johnson, Secretary, Dudley CHC

Motion 17 at the Association of CHCs' recent annual general meeting concerned the drug Debendox. Delegates were informed that although the conference order paper stated that this motion was with the permission of conference to be withdrawn, the original movers of the motion, East Cumbria CHC, now wished to debate the matter. However, what was unknown to conference was that at least one amendment to motion 17 had been sent to ACHCEW. Because East Cumbria had sought permission to withdraw the motion, this amendment was not considered by the standing committee and was not printed on the order paper.

I pointed this out to the conference, and it became clear from the other speakers that our amendment would have received considerable support. After a brief discussion with ACHCEW's secretary, Mike Gerrard, I believe the chairman was advised to refer the motion back to the standing committee. My council believes that it was wrong to ignore this advice, and the 36 abstentions on the constitutional issue involved support this view.

The field is now open next year for all CHCs which do not wish their motions to be the subject of possible amendments simply to apply to withdraw their motions, and then at the last minute to change their minds. Suppose a CHC putting forward a change to ACHCEW's constitution had adopted this procedural device of rescinded withdrawal. If the standing committee had been seeking to amend the motion, would it have allowed the debate to proceed?

Allergy to anaesthetics

Philip Marsh, Secretary, Central Nottinghamshire CHC

We have recently been approached by a lady who is very anxious about how to alert hospital staff to the fact that she and her family are allergic to certain anaesthetics. Her daughter died at the age of 14 due to a reaction against an anaesthetic, and subsequently the lady and her family were advised that they should themselves provide some sort of warning to hospital staff about this problem, by obtaining medallions from the Medic Alert organisation.

At the moment it is the responsibility of the individual to take the trouble to obtain such medallions. There are two types of medallion with different designs, provided by different organisations, and this may confuse medical and nursing staff. The lady concerned believes that it should be the responsibility of the NHS to run a scheme whereby patients at risk are easily identifiable, and it should not be the role of charitable organisations to provide such a service. I should be pleased to hear from other CHCs about this — have they received similar comments, and do they see this as an issue that should be tackled?

The pill and under-16s

Joan Oldfield, Member, Northallerton District CHC

As a member of my CHC's children's study group I have been asked to write to you in the strongest possible terms about the prescribing by GPs and doctors associated with family planning clinics of the contraceptive pill (and other drugs) to children under 16, without the knowledge or permission of their parents or guardians. While the GP may be aware of the family background and circumstances, this is not always the case with family planning clinics, which do not normally have any records of a child's medical history. Such decisions can then only be made on the evidence of the child alone.

We consider it essential that *any* doctor prescribing the contraceptive pill to children under 16 should be legally required to consult with the parents or guardians before doing so.

Choice of support hose

Mrs Marjorie Page, 87 Gomersal Lane, Gomersal, Cleckheaton, West Yorkshire

For many years now I have been obliged to wear support hose, on the advice of my doctor. If I wear support stockings I can get them on prescription at a reduced charge, but not so support tights. Yet most women under the age of sixty are accustomed to wear tights.

To my mind tights are far more efficient and comfortable, as they support the whole leg and thigh. It seems to me that this is a rule made by men, who have no experience of support hose. The last pair I bought cost me £3.49.

I feel that this matter should be brought before CHCs at national and local level, and that women like me should be able to choose either tights or stockings — on prescription.

CHCs could help educate MPs about the health service

Graham Girvan, Secretary, Bexley CHC

"Unfortunately we know neither the impact of cuts in particular authorities nor the cause or effects of increased expenditure in others". This statement appeared in the recent report of the House of Commons Social Services Committee.

It would appear that the Committee is not given all the information that it requires to be able to give considered opinions and views on the efficiency and effects of DHSS policies and actions.

CHCs are used to difficulties and delays in obtaining information, sometimes it is not known what information is available. However it is of grave concern to realise that a committee of MPs, who are ultimately responsible for the funding and establishment of national priorities, have the same difficulties as some of us. How good are our links with our local MPs, do we keep them informed of the effects that national policies are having on local health services?

How often do MPs approach CHCs for information and consumer opinion? CHCs can help to fill the gaps that other sources can't!

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

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Comment

Last month's centre-spread article on prevention marks the beginning of a shift of emphasis for *CHC NEWS*. From now on we want to pay rather more attention to the various aspects of prevention and health education, so that CHCs will be better equipped to take up these issues locally if they so choose. Perhaps we should have said this is last month's Comment — but more urgent matters intervened!

We know of course that many CHCs are already alert and active on this front. They have held meetings on prevention, run special health education events for children, and campaigned alongside anti-smoking groups. They have investigated health authority provision of school health services and health education for the general public, and have suggested much-needed improvements.

Helping people to use the NHS wisely is an important part of health education, so all those CHCs which have produced handbooks, guides and leaflets about NHS services have also been making a valuable contribution. So too have those CHCs which have nudged their health authorities into doing this job — provided that the end-product was not written in "officialese".

Some CHCs have mounted sustained, large-scale campaigns within their districts, working closely with local newspapers, radio and TV to generate a great deal of publicity — both for prevention and for the CHCs themselves. Portsmouth and SE Hants' *Help yourself to better health* campaign and East Cumbria's *Feed right, feel right* are amongst the examples that spring to mind. We recently discovered that North Bedfordshire CHC has a sub-committee with the specific task of promoting health education, and it may be that other CHCs also structure their working group activities in this way.

But we must be careful not to paint too glowing a picture. Ever since CHCs began they have been exhorted by governments to take an interest in prevention, but many have held back. Some have had reservations about doing health education work themselves — seeing it simply as one of the services which should be provided by health authorities, while CHCs get on with discovering and transmitting the "consumer view". Other CHCs may have been put off by the puritanical tone of many of the health education messages currently available, and by the tendency within health education to ignore the enormous forces within our society which continually press people willy-nilly towards unhealthy life-styles.

The vested interests which maintain these pressures operate well beyond the confines of the NHS, and CHCs will be unable to influence developments much unless they are prepared to speak out about occupational and environmental heath, about housing, and about government policies on such things as food and transport. In doing this they will inevitably be criticised for straying outside their official remit — but a more valid cause for concern would be the danger that some CHCs might over-stretch their resources to the point where they begin to skimp on their central tasks within the NHS.

CHCs will not allow that to happen, but many will be convinced of the need to trace back the causes of ill-health to their social roots. Once people truly understand what is making them ill, and why, prevention will begin to be given the priority it really deserves.

Health News

New legal barrier on access to records

Patients in court cases where medical negligence is being alleged may find it even more difficult to get to see their hospital records when a new Act of Parliament comes into force on 1 January.

Sections 33 and 34 of the Supreme Court Act 1981 (HMSO £6.35) still permit the High Court to order disclosure of medical records "to the applicant", but the new Act

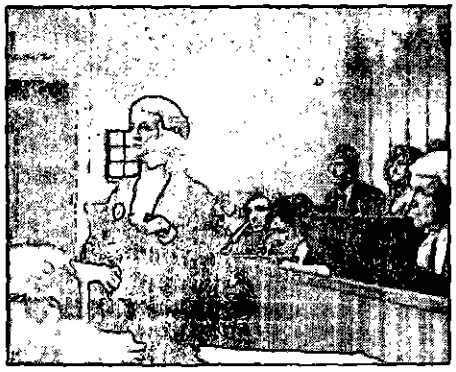

Photo: Granada TV

also gives the court three alternative ways of ordering disclosure:

❶ To the applicant's legal advisers,

❷ To the applicant's legal advisers and any medical or other professional adviser of the applicant, or

❸ If the applicant has no legal adviser, to any medical or other professional adviser of the applicant.

The court can attach particular conditions to these alternative forms of disclosure, and any of the three alternatives could be used to prevent patients themselves getting a look in.

The High Court has had the power to order disclosure of hospital records to patients alleging personal injuries even since the Administration of Justice Act 1970 became law, but this right of patients only became clear in 1978, when the House of Lords overturned earlier decisions of the English Court of Appeal (see *CHC NEWS 33* page three).

Patient transport

The structure of ambulance services will be virtually unchanged during the first year of reorganisation says Health Minister Dr Vaughan.

He announced this following the publication of the Naylor report on patient transport (1). This recommends that existing ambulance service management arrangements "should be disturbed as little as possible".

The Government broadly accepts this recommendation (2) for the period immediately after reorganisation next April. It proposes no change in either the London or metropolitan services or the existing single-district services and it says that multi-district services should be retained as whole services — following decisions about which authority is to be responsible for their management.

However after reorganisation has "settled in" the Government wants authorities to undertake a review of whether the arrangements "represent the right long-term solution".

The Naylor report also looks at the wider issues involved in ambulance provision — should accident and emergency services be separated from routine patient transport services in a two tier system? The report cites studies which show that in general a flexible single tier system is more efficient and economical than two tiers. It "accepts that there is a case for experiments particularly in urban areas" about separating the services. However it strongly rules out total separation by giving the management of one service to the district and the other to the region.

The report recommends that the ambulance service should in future be responsible for meeting the transport needs of patients "requiring transportation to hospital as a result of accident, emergency or serious illness", and of patients "who suffer from a physical or mental illness, disability or condition who in the opinion of a doctor (or other authorised health care professional) would thereby be precluded from making their own way to or from necessary treatment or diagnosis without such transport".

Concern is expressed for patients who do not come into these categories. The report suggests that DHAs be encouraged to collaborate with local authorities in developing community transport services and the DHSS is asked to review and improve the system of helping those on low

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Health News

Continued from prevous page

incomes with travel expenses.

The DHSS is asking for comments on the "wider issues" in the report by the end of September 1982.

1. *Patient transport services* — a report of the NHS working party chaired by Mr Maurice Naylor. £3.50 inc post from Public Relations Office, Trent RHA, Fulwood House, Old Fulwood Road, Sheffield S10 3TH.
2. Health notice HN(81)28.

Slicker statistics

If the recommendations of a DHSS working party are accepted the NHS should eventually get an improved and streamlined information gathering system.

The working party — better known as the Korner Committee — says that in most cases its recommendations are "a compromise between what is desirable, what is feasible, and what is affordable". They will provide the minimum information "without which" says one of the committee's secretariat, Dr Mason, "a district cannot pretend it is monitoring effectively".

The committee calls for a single patient information system covering all patients who use a hospital bed and all specialties. A minimum list of standard items should be completed on all these patients. An annual census should be carried out on all patients who have been in mental illness/mental handicap units or hospitals for a year or more and on all formal ("sectioned") patients.

The committee would like to see detailed statistics collected around maternity — in a single integrated system. Some of the information required — such as the date of the first ante-natal assessment, details about acceleration of labour, drugs given during labour, use of forceps — would go some way to satisfying the CHCs who responded to the National Perinatal Epidemiology Unit's call for comments on the Korner Committee's draft recommendations (see *CHC NEWS 69* page four).

At present there is no nationally available information about the allocation and use of operating theatres — the committee recommends that every district collect statistics on this for the regions to send to the DHSS. A similar recommendation is made for information about all day care facilities in every district.

The committee's report has been sent to a number of national bodies (including the Association of CHCs) for comment by 31 December 1981. When it has received these comments and the results of pilot trials of the proposed system which are being held in four districts, the committee will produce a final report for the Secretary of State with a timetable for implementation.

Forum for the disabled

In July representatives of organisations of disabled people met and agreed to set up the British Council of Organisations of Disabled People.

The purpose of the council is to provide a forum for the free exchange of information, ideas and views about disabled people. Twenty national organisations set up a steering committee which is holding an inaugural conference on 7 November.

More information about the BCODP from Frances Hasler, Spinal Injuries Association, 5 Crowndale Road, London NW1. Tel: 01-388 6840.

MPs voice their concern about NHS management

Deep concern about the growth in numbers of NHS management staff has been expressed in the latest report from the House of Commons Committee of Public Accounts (1). The commmittee consists of 14 MPs, and its report is based on evidence provided by health department witnesses during four days of cross-examination.

Between 1971 and 1979 administrative and clerical (A and C) staff increased by 45% in England and Wales, as against a general growth of 22% in staff numbers, partly because of the 1974 reorganisation of the NHS. In 1976 the DHSS set targets for reducing the proportion of English NHS spending taken up by management costs, and between then and 1979 the staff groups covered by these targets shrank by 5.6%. However, 55% of all A and C staff were not covered by the targets, and their numbers increased by almost 12% over the same period. The staff groups in the uncontrolled area are defined as "operational staff", providing clerical and secretarial support to doctors, nurses and other professionals.

The Committee of Public Accounts notes the Government's intention to squeeze NHS management costs by a further £30m during the 1982 reorganisation, but remains unconvinced that A and C staff cannot be used still more efficiently. "While we note DHSS's broad view that adequate control over manpower can be achieved mainly by cash limits, we recommend that DHSS and the Welsh Office should explore the feasibility of employing more detailed controls and targets for such operational staff. Otherwise resources, while still within cash limits, may distort the medical/non-medical balance".

The report says it is "quite unsatisfactory", given that the NHS is a labour-intensive organisation over thirty years old, that the DHSS does not have fully up-to-date manpower information and has not yet established what information it needs for overall control purposes.

The report also considers delays in the commissioning of new hospitals, which in 1980 had led to nine new hospitals in England standing partly empty because of insufficient funds to meet their running costs. The DHSS told the committee that it takes up to 15 years to plan and commission a hospital, and so the hospitals in question "had been planned in the 1960s when the prospects for growth had been very different from current prospects".

The committee says any failure to use a completed hospital is a "major waste of public resources", and recommends that the present arrangements for financing the revenue consequences of capital schemes should be reconsidered. When new hospitals are opened, pressure from local communities to retain the older hospitals as well as their replacements should be resisted, and the agreement of CHCs on this should be sought at the outset of any new hospital scheme.

1. *Financial control and accountability in the NHS*, Seventeenth report from the Committee of Public Accounts, House of Commons Paper 255, HMSO £7.25.

"Don't tell us about side-effects"

Continued from page one

mean that the information is useless, simply that more needs to be collected before much notice is taken".

In his letter Dr Griffiths warns that the credibility of the CSM is now at stake, and implies that unless serious consideration is given to the ACHCEW scheme CHCs will increasingly give their support to pressure groups campaigning against particular drugs.

"If CHCs had a procedure by which they could report side-effects to you they would feel much more confident about the conclusions you draw in relation to the safety of drugs. While you steadfastly ignore information from lay sources, it makes it all too easy for those who say that the committee is dominated to its detriment by medical and pharmaceutical interests."

But nothing in this lengthy correspondence seems to have cut any ice with the CSM. In a letter dated 14 October, CSM secretary Zoe Spencer has told Dr Griffiths that a meeting to discuss the ACHCEW scheme would not be useful — partly because it is "not practicable within present resources" for the CSM even to consider the scheme, and partly because of the Government's policy that monitoring of drugs is not a function of CHCs.

Dr Griffiths says the CSM's response is unsatisfactory, and he will be contacting the committee again about the ACHCEW scheme. He believes that reporting of drug side-effects is not covered by GPs' terms of service, and this could be one reason why so few serious side-effects are reported through the "yellow card" system. He will be telling the CSM that the only alternative to a lay reporting scheme would be to make the reporting of side-effects part of the terms of service, so that failure to report would become grounds for a complaint against the GP concerned.

Access in the High Street

Getting there

"Dropped kerbs are essential for many wheelchair users and a help to older people with shopping trolleys and to people with prams or pushchairs; however they are too often ... poorly sited and executed ..."

Assistance

"Each shop should have a policy of assistance ... covering for example:

- **Direct staff assistance in entering, selecting goods and leaving.**
- **Clear signs**
- **Clear information on assistance and facilities available**
- **Gaining attention — both inside and outside**
- **Packing and carry-out service**
- **Seating."**

Counters

"Height is very important — inaccessible counters, because too high, inconvenience those in wheelchairs, or with limited arm reach and use, or those for whom it is important to be able to communicate at the same level."

If disabled people are to live happily in the community they must be able to get out and about independently and use "high street" facilities on their own — shops, banks, post offices and telephones. Much work has been put into devising adaptations and aids for disabled people in their homes but there is also a great need for supermarkets and shops to think of their disabled customers.

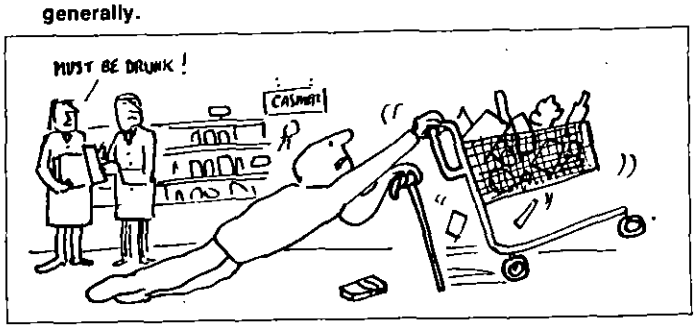
As its main contribution to the International Year of Disabled People the Centre on Environment for the Handicapped has produced *Access in the high street – advice on how to make shopping more manageable for disabled people* (1). This is an illustrated guide to the problems facing disabled people in getting to the shops and when they arrive. It also gives detailed suggestions for improvements. The problems are brought to life in interviews with a young blind woman, a physically handicapped couple in their early 30s, a very elderly couple and a middle-aged couple who both suffer from cerebral palsy.

CEH says that high street premises are continually being altered and modernised and "there is tremendous scope in this process for the modifications — often simple and inexpensive if the awareness and intentions are there at the start — that will make shops manageable for a greater proportion of the population". Many people — not just the disabled — would benefit: mothers with prams or pushchairs, pregnant women, elderly people. The improvements would "make sound human and commercial sense". We include here some of the points that CEH make in their booklet.

Another useful set of notes on how to improve public access for the disabled has been produced by the Committee on Restrictions against Disabled People (2). It also suggests ways local organisations can help, and gives a list of access groups around the country.

Problems with parking

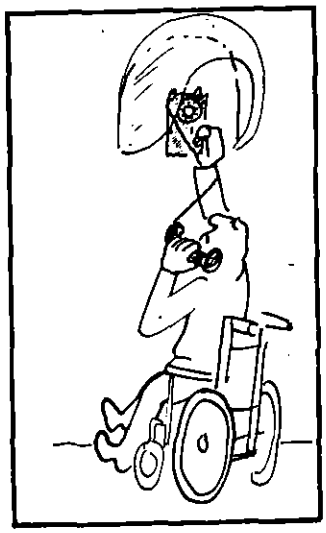
- **Long distances from reserved spaces to shops.**
- **Special provision often occupied by non-disabled users.**
- **Yellow lines restrict convenient bulk shopping and choice generally.**



Baskets and trolleys

"Baskets, especially those developed to suit wheelchairs, are valuable as are trolleys which are shallow and wider than the standard model; some shoppers will rely on the trolley itself for support while going round the shops ..."

Telephones in shops



"Welcomed by those who may need to call someone to collect them; preferably accessible to wheelchair users, at reasonably low height, at the least with a fold-down seat for old people, and with some acoustic privacy."

Supermarket checkouts

"Ideally all checkouts should be wide enough to allow a wheelchair to pass through; in practice at least one must be provided and clearly indicated, otherwise shoppers face the embarrassment of having to retrace their route to the entrance/exit, often disrupting the flow in the process".

Photos: George Goff. Cartoons: Louis Hellman/CEH

References

1. *Access in the high street* from CEH, 126 Albert Street, London NW1 7NF. 50p inc post for one copy, 25p for subsequent copies.
2. *Improving access for disabled people*. Write for copies to John Stanford, RADAR, 25 Mortimer Street, London W1N 8AB.

Child health services...

Photo: Raissa Page

TOO IMPORTANT TO LEAVE TO CHANCE

*by Peg Belson**

In next year's reorganisation of the NHS the posts of Specialist in Community Medicine (Child Health) and Area Nurse (Child Health) are to be abolished. The Children's Committee — set up in 1978 as a voice for children, with direct access to the Secretary of State for Social Services — has already been closed down by the Government. This year's annual general meeting of the Association of CHCs agreed unanimously "to take all possible steps, including pressure on HM Government, to ensure that each district health authority has a policy for children and a named representative with paediatric experience to act as an advocate for services for children".

Recent correspondence about the future administration of child health services had made it clear that, while the Secretary of State shares the concern that a suitably qualified doctor should be responsible for these services in each of the new authorities, the DHSS does not intend to lay down any statutory responsibility for child health services. Guidance to regional health authorities and to the new DHAs (1) says that in relation to child health services there should continue to be "named and appropriately qualified individuals who would have among their responsibilities on behalf of one or more DHAs" all the tasks described in an existing circular on child health services issued at the time of the last NHS reorganisation(2). For the NHS these tasks include:

- The organisation and planning of integrated health services for children, which includes establishing guidelines for service planning, involvement in district health care planning teams and providing information on child health services.
- The development and organisation of immunisation services and of health surveillance for the pre-school child.
- Liaison with health education departments, to provide advice on education relating to children's health and development.
- The planning and integration of child mental health services.
- The establishing of research programmes relating to child health (perhaps to seek out the inadequacies highlighted in the Black and Short Reports!)
- Supervising the work of clinical medical officers and senior clinical medical officers.
- Involvement in the multidisciplinary co-ordination of services for the under-fives.
- Provision of the medical input to adoption and fostering services, and adequate medical supervision — particularly psychiatric — to residential children's homes.

It's quite a tall order.

The National Association for the Welfare of Children in Hospital (NAWCH) has asked RHAs to ensure that these responsibilities will be appropriately undertaken, and has received a diversity of responses. In view of the DHSS instruction that districts should decide on their own management arrangements, some authorities have decided not to offer any advice on possible appointments or management structures. Others see their role as advising and debating while leaving the final decision to the district.

Some regions think that there should be community physicians with prime responsibility for child health services though not necessarily an exclusive remit, others that one community physician with special child care interests could be shared between districts, while at least four regions would prefer community physicians not to have a specific designation. Some regions think that the matter may be partly determined in any case by the present shortage of suitably qualified community physicians, though senior clinical medical officers could take over the management and organisation of child health services.

Comment on this proposal from within the service makes it clear that most senior clinical medical officers have considerable experience in developmental paediatrics, educational medicine and preventive child health. However, if they are to undertake advisory and executive functions in relation to the preventive and school health service, they should have the necessary experience in community medicine as well and should be of independent status. Concern has been expressed by some education authorities at the disappearance of the named community specialist with designated responsibility for the provision of the school health service and advice on health policy.

Based on the proposals of the Court Report (3) another approach put forward has been the establishment in each health district of an integrated child health department. This would be a designated unit of management, the remit of which would be the overall health care of all children. It would be multi-professional, encompassing all the hospital medical and nursing staff involved with children, the "named and appropriately qualified individual" responsible for organising child health services, and members of other professions such as psychologists, social workers and therapists. Such an arrangement would be a single voice for children, and this might well make it easier to identify and meet their needs. Children, after all, probably make up a quarter of a district's population.

A better balance of funding

For local authorities the main tasks are:

- The day-to-day management of the school health service, eg visits to schools, advice to teachers, provision of speech therapy etc.
- Advice to education departments on policy and on individual children, eg those with special needs.
- The organisation and staffing of the school health service.
- The provision of information about the school health service.
- Co-ordination between the health authorities and education and social services departments on child health matters, eg child abuse.

* *Peg Belson is a founder member of the National Association for the Welfare of Children in Hospital, and until recently was chairman of Kensington, Chelsea and Westminster (South) CHC. She is now a member of the "shadow" Victoria DHA.*

between acute and community services might make a reality of the frequently-repeated but little-implemented DHSS policy that whenever possible children should be treated in their own homes, under the care of their family doctor, with hospital and social services support as necessary. It also might facilitate the *Care in action* (4) policy that acutely ill children in hospital should be gathered together in a comprehensive children's department in the care of paediatricians and suitably qualified nurses — a policy first put forward in 1971. Yet today 40% of children are still to be found in adult wards, separate provision for accident and emergency is minimal, and psychiatric services for children and particularly for adolescents are very limited. Parents are still prevented from being with their children during a stressful hospital experience, sometimes for as long as 40 hours — a day and two long nights for a child who may have no sense of time!

Children's health services are too important to leave to chance. CHCs should ensure that their new DHAs are alerted to the need for a stated policy for children and an advocate for children's services. Such a policy and such an advocate become even more essential with the disappearance of the Children's Committee, with its focus on the developmental needs of children and its role in policy advocacy. It is to be hoped that it will be succeeded by an independent voice for children that can press for the development of policies and services to meet the needs of children and their parents.

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1. *Health service development: Structure and management.* DHSS circular HC(80)8, paragraph 20.
2. *Child health services,* circular HRC(74)5.
3. *Fit for the future.* The report of the Committee on Child Health Services (the Court Report), HMSO 1976.
4. *Care in action.* A handbook of policies and priorities for the health and personal social services in England, HMSO 1981.

Further reading

Who is to follow the Specialist in Community Medicine (Child Health)? by AM Jepson. Community Medicine, Vol 3, No 3.

What is a children's ward? A summary of DHSS reports and recommendations. Price 65p inc post from NAWCH, Exton House, 7 Exton Street, London SE1 8UE.

Book reviews

A dictionary of operations

by Dr Andrew Stanway, Granada £2.50

This is what it sounds like—an A to Z of operations. From abortions to removing warts, Dr Stanway describes simply what the operation is, why it may be necessary and what happens while it is going on. He also tells us about procedures and investigations such as amniocentesis and enemas. In the introductory chapters there is general guidance about going into hospital — what to take in, and who's who in the hierarchy. Might be a useful reference book for CHC offices.

Overcoming depression

by Dr Andrew Stanway, Hamlyn Paperbacks £1.50

This book comes from the same prolific author as the one above. Another layperson's guide — this time to depression. It gives clear, practical descriptions of different types of depression — their origins (as far as they are known), what sufferers and their friends and relatives can expect, and what kinds of help are available. The book has a sympathetic and down to earth approach to depression which would probably make it a worthwhile read either for those who are involved with someone suffering from depression — or sufferers themselves.

The nurse and the welfare state

edited by Jean Gaffin, HM & M publishers, £4.75

The title of this book may wrongly put off non-nurse readers — only the last of the nine chapters specifically concerns nurses. The others set the whole scene in which the NHS functions, covering also the history and background of the welfare state, social policy and a useful summary of major social security and tax benefits today.

Extracts from all major NHS reports are quoted, from Beveridge to the Royal Commission on the NHS and there is a good index, list of relevant addresses and essential reading. The editor recognises the accuracy of the conclusions of the Black Report and suggests that nurses, working with deprived families can ensure the proper take-up of benefits.

The book was interesting and should be prescribed reading for new CHC secretaries — despite an error stating that a few CHC members are appointed by the *area* health authority!

Joy Gunter
Secretary, Dewsbury CHC

STOP — a guide to non-smoking

Penguin Books, 95p

The ladykillers

by Bobbie Jacobson, Pluto Press, £1.95

There is nothing really new in these books except Ms Jacobson's belief that smoking is another male plot (her book is subtitled *Why smoking is a feminist issue*). What then is male smoking?

They tell us, again, that smoking is likely to damage one's health in some very unpleasant ways and is

Photo: Maria Bartha

thoroughly anti-social because it can also affect other people's health. They mention ways of stopping but contradict each other on whether or not a new method is dangerous.

The Penguin book, which looks like a cigarette packet, was produced by a group which includes smokers "some of whom were trying to give up" — an honest but not very propitious opening. One of their most telling points is the table showing the costs of smoking (at April '81 prices) for periods up to ten years. DHSS, please copy onto large posters?

The acid tests of both books must be their ability to persuade the smoking reader to jack it in. For me they have so far failed despite the jolt when I first read them. I remain a guilt-ridden smoker looking for a painless method of stopping. There is little comfort in being told by Ms Jacobson that it is harder for women than men to give up and that it will only happen when the time is right.

PS My spouse read the Penguin book, had a fearful cough a few weeks later and stopped smoking.

Juliet Mattinson
Secretary, East Berkshire CHC

The handbook of medical ethics

British Medical Association, Tavistock Square, London WC1H 9JP (£3 to non-members, £1 to members)

The new edition of the BMA's medical ethics guide gives new advice to doctors who may face tricky decisions about matters such as giving contraceptives to under-16s, treating Jehovah's Witnesses, terminal illness and death, and health screening.

The BMA advises doctors to make every effort to persuade a girl under 16 who wants contraceptives to tell her parents. If she refuses and the doctor is satisfied that she has the "mental maturity to understand the possible consequences of her action", the prescription can go ahead. The handbook warns that a doctor's decision not to prescribe "does not absolve him from keeping the interview confidential".

There is a new section on Jehovah's Witnesses whose beliefs lead them to refuse consent to blood transfusions. The doctor should explain the risk of operations or other procedures without transfusion and if the Witness still refuses, must decide whether to go ahead. If the doctor decides not to proceed, the patient must be referred to another doctor who *is* willing to take the risks. Even in emergencies, the patient's right to decline blood must be respected, though the doctor, may not decline to treat. In the case of children, the handbook offers doctors the choice of ignoring the parental refusal of consent, or making the Witnesses' child a ward of court.

The ethics of "presymptomatic screening" involve a dilemma: "screening would reveal many sick persons who do not at present seek medical help". Doctors wishing to carry out screening programmes are advised to make sure that individuals in a given population wish to know whether they have the disease for which screening is proposed".

FLUORIDATION

*by Neil Jenkins, Professor of Oral Physiology, University of Newcastle upon Tyne**

Fluoridation is fundamentally a scientific issue, raising two questions: Does it reduce tooth decay effectively, and is it safe? Unfortunately fluoridation has become a political issue, with the "pros" and "antis" polarised into rigid positions. There is very little real debate between the two sides.

Figure 1 summarises the results from 95 artificial fluoridation schemes in 20 countries — virtually all the schemes in which results have been recorded. The reduction in *caries* (ie tooth decay) in the deciduous (ie "milk") teeth was 40-50% in 21 schemes, and for permanent teeth the reduction was 50-60% in 30 schemes. Four results gave only 20-30% reduction, but in 14 schemes the reduction was over 70%.

The important conclusion is that an average reduction of about 50% can be

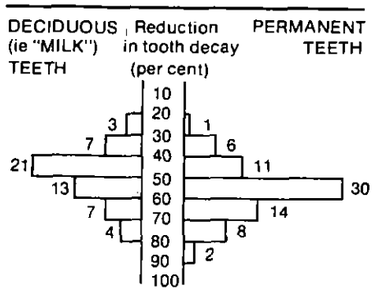

Figure 1. This summarises the results of 95 fluoridation schemes. The figures at the ends of the horizontal bars show how many schemes produced the percentage reduction in tooth decay indicated in the central vertical column. For example, taking the bar marked "30" on the right, this means that decay of permanent teeth was reduced by 50-60% in 30 schemes.

expected, though a few schemes may for a variety of reasons give considerably higher or lower effects. It is impossible to judge the value of fluoridation by looking at only one scheme. The effects of artificial fluoridation and of natural fluoride (F) at one part per million (ppm) are very similar.

In mature adults teeth may be extracted for reasons other than caries, eg because of gum disease or following accidents, and this makes the measurement of caries more difficult. Figure 2 shows the result of a study (1) which allowed for these

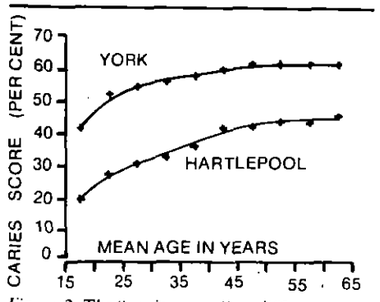

Figure 2. The "caries score" at different ages in Hartlepool (two parts per million of F) and York (no F). Caries score means the percentage of teeth which are decayed, or have been filled or extracted because of decay. Note that there is virtually no increase in caries after the age of 45, and that the effect of F is still present between the ages of 45 and 65.

difficulties, carried out in Hartlepool, where until recently there were 2ppm of F in the drinking water. A marked reduction in caries, continuing through to age 60-65, was found. This confirms evidence from other countries that F has a lifelong effect in reducing caries, although this has not yet been adequately investigated in the UK in an area with the optimum F concentration of 1ppm.

Some critics point out that F only delays caries rather than preventing it. But slowly-developing cavities are more likely to be filled in time to avoid extractions, and as the development of new caries falls to almost zero after age 40-45 (see Figure 2), a cavity postponed may never happen at all.

"Natural" versus "artificial"

F can be shown to reduce caries in areas where it is present naturally in drinking water, such as Hartlepool, but a common objection to fluoridation is based on the belief that F added artificially is somehow "different". One version of this argument is that calcium fluoride occurs naturally in water whereas it is *sodium* fluoride that is added at the waterworks. This is meaningless, because at concentrations of 1ppm both these salts are almost completely *ionised*, ie split into electrically-charged atomic particles called *ions*. Calcium fluoride splits into calcium ions and F ions, and sodium fluoride into sodium ions and F ions. In both cases the F exists only as a separate ion, and all F ions are identical irrespective of their source.

Another objection, which needs to be taken rather more seriously, is that natural F usually (but not invariably) occurs in "hard" water, whereas F can be added artificially to any water. However there is agreement from theoretical chemistry, animal experiments and dental research that the biological actions of F are not significantly different in hard or soft water.

There is, however, a difference between the effects of boiling on hard and soft water containing F. On concentrating hard water to less than one third of its original volume, some of the dissolved F becomes solid again, so that the concentration of the remaining dissolved F never rises much above 3ppm. But with *soft* water the concentration of F may become much higher, although when reduced to a small volume by boiling the water is usually so discoloured that it is most unlikely to be used for drinking. I have meaured the concentration of F in samples from the kettles of forgetful elderly people, who might repeatedly have left the water boiling for long times, but the highest concentration I have found is 1.3ppm — not much above the original 1ppm. This confirms the unimportance in practice of this effect. There are therefore no known grounds for saying that the biological effects of F added at the waterworks are any different from those of F which is present naturally.

Another common objection to fluoridation is that high F intake can cause *mottling* — the formation of white, chalky spots or patches on some teeth. People's teeth are only vulnerable to F-induced mottling while they are still developing, ie up to the age of eight. In severe cases, for instance when the water contains more than 2ppm F, the white spots may acquire an unsightly yellow-brown stain some years after the teeth emerge, but at 1ppm F the marks are few in number, small and unobtrusive, and do not become stained.

Many other factors (eg infections or blows to the jaw before the teeth emerge) may cause similar marks on the teeth (called *idiopathic* mottling) which are frequently confused with the effects of F. Children growing up in areas with 1ppm F in the water actually have less idiopathic mottling than those in areas without F, because F prevents many of these idiopathic white patches. F at 1ppm is too low to produce significant mottling, reduces idiopathic mottling and greatly reduces caries, which explains why 1ppm is regarded as the optimum concentration for artificial fluoridation schemes.

When photographs of 100 teeth, 50 from an F area (Anglesey) and 50 from a non-F area (Leeds) were shown in random order to groups of dentists and laymen, they were unable to distinguish the F from the non-F teeth. This confirms that at 1ppm mottling caused by F is of no aesthetic significance.

Safety of fluoridation

F is one of the many substances like iron, copper, vitamin A and oxygen, which are valuable or essential at one level of intake but poisonous at much higher intakes. F is also present in tea and some foods, so the question that arises is whether total intake of F from all sources ever reaches a harmful level in an area with 1ppm F in the water. Until recently, numerous comparisons of public health statistics in F and non-F areas in several countries gave no suggestion that mortality from any major disease is higher in F areas, although there is a trend for heart disease to be *lower*.

Recently, however, two US biochemists called Yiamouyiannis and Burk have stated that the rise in mortality from cancer has increased in ten US cities since they fluoridated, in comparison with US cities without F (2). They believe they can show the same effect in the UK, by comparing Birmingham, which became fluoridated in 1964, with Manchester, which is unfluoridated (3).

These figures have been carefully scrutinised by eminent epidemiologists, and by statisticians qualified to detect changes in cancer mortality, who point out that insufficient account has been taken of the age, sex and race structure of the populations under study, and of the changes in these factors which have occurred since fluoridation (4). When these factors are allowed for, the increase in cancer mortality in the US F-towns was 3% *less* than in the non-F towns. The claim that the higher rate of increase in cancer in Birmingham than in Manchester is due to F is invalid for several reasons, the most striking being that cancer has increased more rapidly in several British cities without F than in Birmingham. No other survey has suggested a link between F and cancer.

Effects of excessive fluoride

People known to be taking excessive F have been studied in many parts of the world. In tropical climates water intake tends to be higher, and in areas with 10ppm or so of F in the drinking water these two factors can combine to produce F intakes of more than 20 milligrams per day. The earliest harmful effect of such high intakes has been found to be pain and stiffness in the joints and a thickening of the bones. These would seem to be the symptoms to be looked for in studies of the safety of lifelong F intake, rather than looking for increases in the death rates from serious diseases. This is obviously difficult because no statistics are kept of these minor complaints. They are difficult to quantify, and most elderly people suffer from them to some extent.

I have carried out a survey by questionnaire on the incidence of painful joints among 400 women over 60, half of them long-term residents in Hartlepool (2ppm F) and half in Redcar (no F). This showed no difference between the two groups, even though some of the Hartlepool women were heavy tea drinkers. Tea in Hartlepool would be expected to average 3ppm F.

Thorough medical checks have been carried out on two populations with high F intakes. The first survey was carried out in a town in Texas where the water contained 8ppm F, on 116 people whose F intake would have been 12-16 milligrams per day, assuming a water intake of 1½-2 litres daily in that hot climate. The other population consisted of the workers in an aluminium factory in Fort William, Scotland, who were exposed to fumes containing F. Their average daily urinary excretion was nine milligrams of F, so allowing for loss through sweat and storage in bone their daily F intake was also about 12-16 milligrams.

The general health of both groups was satisfactory but 10-15% of the Texan population and 25% of those exposed at Fort William were shown by X-rays to have the very first stages of bone thickening, though this was not accompanied by pain or any other symptoms. It could therefore be cautiously concluded that prolonged intake of 12-16 milligrams of F per day is the threshold below which no harm can result, except for mottling.

How does this compare with the intake in a town with 1ppm F in the drinking water? I have studied this in some detail in Newcastle, which was fluoridated in 1968. The highest F intake that I found was in a

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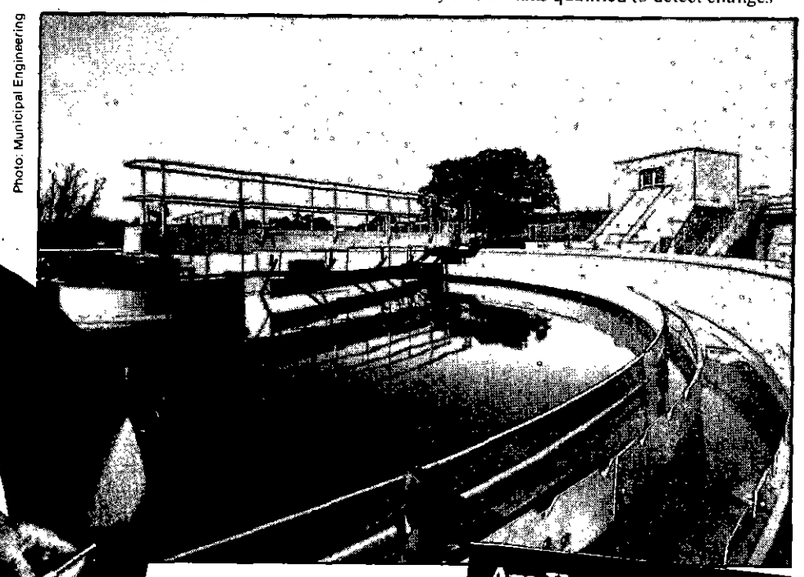
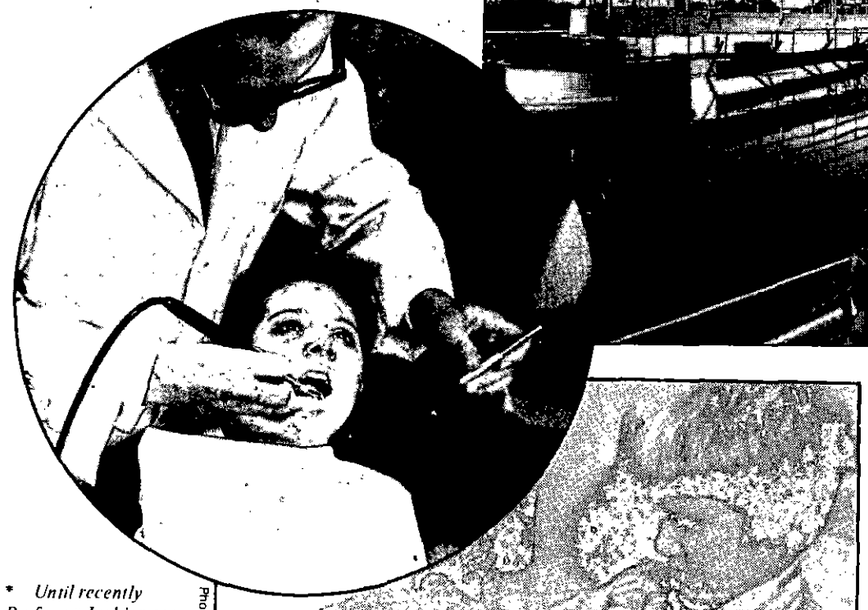


Photo: Municipal Engineering



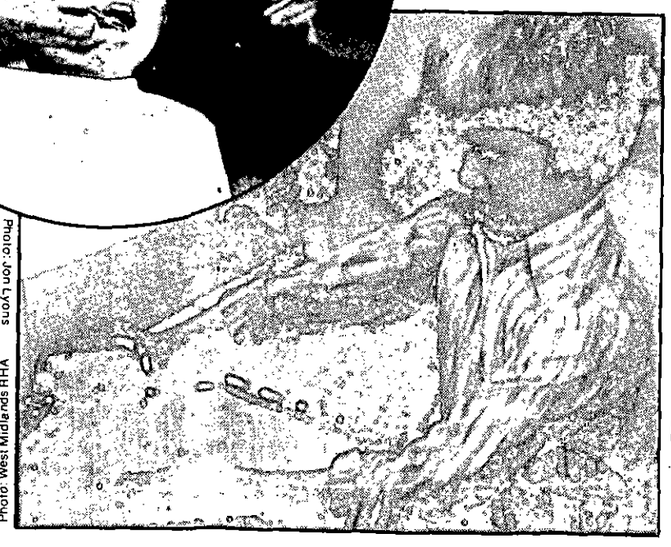


Photo: West Midlands RHA

Photo: Jon Lyons

Above: One of a series of pro-fluoride posters produced by the US government.

* *Until recently Professor Jenkins was Chairman of Newcastle CHC, and Chairman of The Fluoridation Society.*

FLUORIDATION

Continued from previous page

man who drank 22 cups of tea a day, and washed them down with four pints of Newcastle beer. Tea in Newcastle contained 1.1 to 4.3 ppm F, depending on how it was made. This man was taking in about nine milligrams a day — safely below the threshold. In the other Newcastle people I studied, with more usual intakes of tea and other fluids, F intake varied from two to five milligrams daily, well below the potential danger level.

Allergy to fluoride

It has been suggested that some people are hypersensitive (loosely described as "allergic") to concentrations of F that have no undesirable effect on the general population. A US doctor called George Waldbott, and another doctor in the Netherlands, have described a variety of extremely vague and unspecific symptoms in over 100 patients, which they state *quickly improve if the patients drink F-free* water (5). The two doctors state that they have confirmed the existence of this condition by "double-blind" tests, in which neither the patients nor the experimenters know whether they are receiving the substance being tested, but the experimental design of these tests was unsatisfactory. The patients were given three unlabelled bottles of water, one containing 1000ppm F, and instructed to take one tablespoon daily for one week from each bottle in turn, and report their symptoms. Administration of small doses of 1000 ppm F is not a reliable guide to the possible effects of 1ppm F in the drinking water.

Evidence in Britain for allergy to F is restricted to accounts of individual cases, and where tests have been planned the results have been indecisive or the patients have been unwilling to submit to them. If allergy to F exists then allergy to tea must exist, and as Britain has been a tea-drinking nation for centuries it would be expected that this would have been detected long ago. Only four cases appear ever to have been reported, and as two of these patients were also allergic to coffee and one to tomatoes (which do not contain F) F cannot be the culprit. A few cases of allergy to fluoridated toothpastes have been reported, but in at

least some of them it was the flavouring agent rather than the 1000 ppm F they contain which was responsible.

The existence of F-hypersensitivity remains scientifically unconfirmed, but if it does exist it must be extremely rare or it would have been detected by now. It would not in any case be a serious bar to fluoridation, as the supply of F-free water to a few patients could be arranged. The search for people who might be hypersensitive to 1ppm F should continue and if any are found it is most important that they should be subjected to proper tests, to establish whether the symptoms they describe really are produced by F.

Looked at as a whole, the evidence suggests that the undoubted dental benefits of fluoridation — the reduction of toothache and the saving of teeth — far outweigh the hypothetical risk of any harmful effects to a tiny minority.

Fluoridation and freedom

Some people argue that fluoridation interferes with the freedom of the individual to choose what he does or does not take into his body, in food and medicine. But this freedom no longer exists, because almost every food we eat in modern society contains additives, mostly unknown to the consumer. Unlike F, many of these additives are artificial, synthetic substances introduced for commercial rather than health reasons. It is of course quite impossible to exclude F from our bodies altogether, as it is present to some extent in all water supplies and many foods. In any case, the very existence of our society depends on the willingness of its members to sacrifice some of their freedom for the benefit of others. Modern medicine considers it unethical to withhold any procedure known to prevent or cure disease, and on this view it is the opponents of fluoridation who are behaving unethically.

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3. An open letter to Sir Emmanuel Kaye MP, dated 22 October 1979.
4. *Fluoridation of water supplies and cancer–a possible association*, by P D Oldham and D J Newell. Applied Statistics, Volume 16, 1977, pages 125-135.
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Parliament

Cervical collars, support tights, disposable syringes

The drug tariff is the DHSS list of medicines and other items available on prescription. The British Medical Association has asked the Department to consider including neck support collars in the tariff and the arguments are being looked at again. Until there is a British Standard specification for support tights the Department will not make any available on prescription. Neither will Ministers agree to "diverting £10 million from other NHS priorities" to make disposable needles and syringes available on general prescription. (Dr Roger Thomas, Carmarthen, 20 July)

Pay beds in NHS hospitals

The numbers of pay beds in NHS hospitals is as follows:

27 July 1979	2617*
27 July 1980	2402
27 July 1981	2408*

*41 extra pay beds have been authorised for use by emergency private patients when other private beds are occupied (Ernie Ross, Dundee West, 27 July).

Development Team for the Mentally Handicapped

The Government is satisfied with the balance of membership of the Team — out of 82 members, seven are parents of mentally handicapped children. The rest of the Team consists of consultant psychiatrists (11), consultant paediatricians (2), nurses (20), psychologists (12), social workers (16), speech therapists (1), physiotherapists (1), NHS administrators (8). There are also four special advisers (Lewis Carter-Jones Eccles, 5 June).

Anti-epileptic drug warning

The Committee on Safety of Medicines has reviewed the safety record of the anti-epileptic drug, sodium valproate, which is marketed as Epilim. It has advised that the drug's data sheet be amended, to include additional warnings about possible side-effects — blood disorders, liver failure, and acute pancreatitis (John Morris, Aberavon, 27 July).

Doctors' language proficiency

Doctors who are nationals of Common Market countries or who qualified in the EEC, will have to satisfy NHS employers of their proficiency in English. The standards required will be similar to those applied by the General Medical Council which tests the language proficiency of non-EEC foreign doctors wishing to practise in the UK (Dr Roger Thomas, Carmarthen, 31 July).

Children in care

The estimated cost to local authorities of maintaining a child in care in 1979/80 was £3429 (Charles Irving, Cheltenham, 20 July).

Income from social security

In 1978 and 1979, taken together, 12% of gross household income in England and 16% in Wales came from social security benefits. These figures exclude short-term (less than 13 weeks) payments for sickness and unemployment, but include all pensioner households (Dafydd Wigley, Caernarvon, 16 June).

What hope for the inner city?

*by Robert Davies, Chairman, Soho and Marylebone CHC**

We do not need any more reports to remind us of inadequate health services for inner city communities suffering poorer health. But after four years of special inner city initiatives, closely watched by some CHCs, we should be asking what has been achieved and what are the lessons for us all. After the violent scars of the summer, what hope has the Secretary of State for the Environment, Michael Heseltine, offered in his latest Merseyside package, announced last month?

It is notable that the inner cities programme, launched by the Labour Government in 1977, should survive the change in government so much intact. The programme brought aid to selected cities — 29 inner city partnership and programme authorities — and had three aims:

- To tackle the underlying economic problems of decline;
- To ensure a critical review of main programmes, policies and expenditure to achieve a "bending" of programmes over a decade in favour of the inner areas; and
- To promote joint action between departments, agencies and the wider community.

Additional resources came via an enhanced central government urban programme scheduled to increase each year. The programme now runs at some £225m a year, of which the partnerships get over £85m.

It was well recognised that primary care and community services were relatively poor and access to health care needed positive promotion. Traditional patterns and levels of provision could be re-examined in both health and social services. New projects could be initiated, particularly in the partnership areas where urban programme cash was available for area health authorities. Because the health service is subject to less direct political control than local government, CHCs had a crucial role to play in ensuring that AHAs responded quickly to this challenge.

There is no complete picture of what happened. A rough analysis of partnership programmes indicates wide variations in action and imagination. The bulk of the several million pounds channelled to AHAs from the urban programme went on one-off capital schemes, mainly hospital provision. Some expenditure went to health centres and clinics; authorities covering Hackney, Islington and Lambeth gave early priority to community services.

Whilst the programme survived a change in government, new priorities had an impact on the social component of inner area programmes. Remarkably, the level of urban programme resources was not cut as a whole — although the gradual growth planned by the Labour government was abandoned in favour of level-pegging. Fewer new initiatives were possible and greater emphasis was placed on capital spending rather than the crucial revenue expenditure. Michael Heseltine's latest Merseyside package reflects an unabating trend — the emphasis is on tackling the economic "cause". Whilst that is of course a clear priority, no attempt has been made to strike a balance between it and other considerations, for instance the call from local voluntary groups for more support.

If the urban programme grant was the icing, then the cake itself, the main programmes of local government expenditure, was cut from planned targets. The health service suffered a double blow from strict cash limits and the impact of increased VAT.

Cash is not the only ingredient of quality. A great deal can be achieved through shifts in policy and approach as well as resources. As it turned out, policies were not to get the microscope treatment. The new preoccupation became the task of spending the urban programme grant. With few exceptions, chief officers and professional interests defended their territory against the questioning eye. Key ministries, including the DHSS, did not share the Department of the Environment's enthusiasm for inner city policy. By the time the financial straightjacket was laced, it seemed unlikely that policies would be reviewed unless enlightened administrators, members and CHCs were unusually determined.

The programme is not without achievements, such as the unprecedented activity of voluntary groups. In the first three years of the programme over £50 million-worth of new community projects were launched and a few areas saw much improved relations between city council and community. CHCs' performance varied, although they are geared to represent a consumer voice in planning and local provision.

Some such as Central Manchester, Central Birmingham and City and Hackney and St Thomas's in London were involved from the start. Others were notably low-key and possibly missed an opportunity to inject an urgent health dimension into the programme or create a channel of communication for those who did. Some CHCs failed to identify the health dimensions of many inner city problems, such as housing and employment; and gave greater attention to more specialised health issues. Where the traditional pattern was for the CHC simply to react to the health authority, and the health authority failed to make the first move, some CHCs were lost for a role.

Photo: Maria Barthe

Interesting new alliances and structures emerged. Newcastle Inner City Forum set up a health sub-group. Central Manchester CHC helped set up a group concerned with community health issues affecting minority ethnic groups. Newcastle City Council's joint working group on inner city health is a focus for collaboration between statutory and voluntary sectors including the AHA, Family Practitioner Committee and CHC. Liverpool's community physician, Alex Scott-Samuel, is a key mover behind study groups on health and unemployment.

Perhaps the most significant of local developments is the recent upsurge of community health initiatives. These vary from women's health groups and children's health clubs to a wide range of alternative health education projects and self-help schemes. This growing movement is being catalogued by Caroline Smith of the National Council for Voluntary Organisations Inner Cities Unit, who is also producing a handbook on local projects and funding sources.

Funding comes from a variety of sources including the urban programme and the Manpower Services Commission. The Leeds Comunity Health Project, with four workers from the MSC's Community Enterprise Programme, has encouraged the development of a wide range of self-help initiatives, including play schemes and groups concerned with post-natal support, women's self-defence and men's health.

Prospects for inner city health seem bleak, although valuable lessons are emerging. With the new district health authorities about to inherit this legacy, CHCs must take a more prominent role in supporting community involvement and ensuring that lessons get learned.

Robert Davies works for the National Council for Voluntary Organisations.

Is US health care a glimpse of our future?

by Cyril Beales, Member, Newham CHC

The current boom in private hospitals is heralding in the worst aspects of the United States health care system. For 33 years the British NHS has been funded by national taxation and its services are free to everyone when needed. But the NHS is being starved of cash, our great teaching hospitals are victims of reduced funding and more than 300 hospitals have closed in eight years, while rebuilding has not kept pace. Now 650,000 people are on NHS waiting lists and this is one of the reasons more people are joining private health care schemes. Last year the number of subscribers rose by 30% and 3½ million people (6.4% of the population) are now covered by private medical care.

The controversy over queue-jumping in private medicine is as old as the NHS itself, but what is new is the current expansion of the private sector and the fact that American investors have come to view private health care in Britain as a profitable proposition. This year American money accounts for half of the £100 million invested in 70 private hospitals throughout Britain. It is a tragedy to see the empty NHS hospitals in prime sites going to private bidders —whether the money comes from Britain, the United States or anywhere else — but the American involvement in the expansion of private medicine in Britain seems to bring much closer the spectre of an American-style, two-tier health care system.

America has a health service based on free enterprise. Twenty years ago it had a mixture of publicly-owned and private hospitals, but the private sector's share has been steadily growing. One company alone owns a thousand hospitals, mostly in better class areas, and is expanding at the rate of six new acquisitions from the state a year.

Doctors and hospitals are in the health business in the United States to make money and it is very big business. It may not be organised to make you healthy, but it is certainly organised to make money. The New York Stock Exchange loves it. It loves the drug companies and the equipment supply firms which are all good investments. The health insurance system guarantees that investors will get their money back.

Patients who are short of money, out of work or underinsured are likely to be treated in a public hospital. These city-owned hospitals are struggling to meet the needs of poor communities. They have a complicated registration process to find out how much patients will pay and for many patients the hospital charge is cut, but only after a means test.

The family practitioner, providing medical care on your doorstep, is being squeezed out of the American health care system. Surgeons in the United States are paid item by item for everything they provide for patients. The hospitals get their income by the same method. Health insurance guarantees payment, thus providing a financial incentive to operate whether or not it is necessary. Senate investigations have shown that there are about two million unnecessary operations performed each year and that surgeons in the States operate twice as much as their British counterparts. Investigations by Congress found that four billion dollars worth of useless surgery had been performed in 1976.

Photo: Barry Lewis/Network

All these disclosures are symptomatic of what is wrong with health care in America, and the same thing will happen here as private health care grows. Far from relieving the strain on the NHS, private hospitals are making things worse, by taking NHS-trained staff away and by dealing only with profitable, "curable" problems, leaving the NHS to cope with the chronic, long-term, old, uninsured or handicapped.

The British Government wants a thriving private sector and has made it clear that there will be no financial boost for the NHS. It has authorised health authorities to sell NHS buildings and land to private companies, to pay private hospitals to clear waiting lists and to offer blood bank and laboratory services to private hospitals.

For the first time the London Stock Exchange has followed its New York counterpart in viewing private hospitals as a profitable investment. City financiers recently raised £3 million for a hospital in Yorkshire and have found £10 million more for six other developments. They predict substantial profits.

Private health care and private health insurance always lead to two classes of care. Those with adequate insurance do very well, but for those without insurance the prospects are grim. Thus the two-class system develops. Why do we have to embark on a similar course to the United States?

SOMETHING TO BITE ON

by Dave Dean, Secretary, Basingstoke and North Hampshire CHC

During the early years of the Hampshire CHCs, our questions concerning NHS dental services and treatments tended to be dealt with by the area dental officer (ADO). Because of the type of questions we were asking, the ADO proposed a meeting between CHC representatives and the three arms of the area dental services — the hospital consultants, the community dental services and the general dental practitioners — so that better understanding could be reached.

The value of this proposal was appreciated by the four CHCs, and a joint approach to the AHA quickly brought forth the inaugural meeting, presided over by the AHA's chairman. Since 1977 these meetings have continued on a twice-yearly basis, enabling many subjects to be discussed and examined. Each CHC is represented by its chairman, vice-chairman and secretary, or by delegated members, as it chooses. Twelve members of the profession, representing the three arms of the service, are invited via their local, district and area dental committees. The ADO and the FPC administrator also attend. The usefulness of this arrangement has increased over the years, as inhibitions have gradually broken down during detailed discussions. The ADO has been able to advise about both "sides" of dental problems, and the CHCs have contributed a picture of patients' problems built up from the details of individual complaints. The dentists have showed obvious concern about the difficulties reported by patients.

The publication of a ten-year strategic plan for the NHS in Hampshire allowed an in-depth examination of the future of dental services. What effect could health education and prevention campaigns have on current practices? Would the decline in extractions continue, making gum disease the main concern of the future? Are patients aware that because of gum shrinkage full dentures should be checked every 2-3 years? These and many more items were provoked by the plan's seventy pages of text on dental services, but even more important for the CHCs was the opportunity to talk things over at first hand with the profession.

Concern expressed about particular aspects of dental services has brought some far-reaching responses. Discussions about elderly people's difficulty in obtaining dentures have resulted in the setting up of a pilot service involving two salaried dentists, both retired practitioners. One works one session a week and the other works four, in health centres, purely on dentures for the elderly. Both are employed directly by the AHA to work in the general dental service.

Rural residents' difficulties in attending urban dental surgeries have led to a research project in which a mobile dental clinic was

Shared maternity care

The best of both worlds?

*by Sara Arber**

Maternity care for most women in South West Surrey is "shared" between their general practitioner and St Luke's Hospital, Guildford, where over 90% of the babies are delivered. "Shared" antenatal care involves attending the hospital for "booking in", for an initial medical consultation, an ultra-sound scan if thought necessary, a consultation at 34 weeks, and a varying number of consultations between then and the birth in hospital. The balance of antenatal care is given by the woman's general practitioner (GP), usually in seven to ten visits. In a minority of cases the GP is responsible for the delivery in hospital. The GP also usually performs the postnatal check-up six weeks after delivery.

There are no statistics kept in this district or nationally on the proportion of births covered by "shared" care. At least 80% of GPs in Surrey are on the family practitioner committee's obstetric list, which means they undertake to provide maternity medical services. Doctors are paid £60 for complete antenatal and postnatal care without delivery and £72 if the care includes confinement. If an average practice of 2300 patients had the current birth rate of 12 per 1000 there would be 28 pregnancies per year — an additional annual income for the GP of £1680 for shared care without delivery and over £2000 for maternity services including confinements. The trend to a greater proportion of women receiving antenatal care from their GP is likely to increase across the country, because of financial pressures on the hospital service and the financial incentives for GPs to provide maternity services.

Shared maternity care has a number of advantages over hospital-only care:

- Normally a shorter distance to travel to the GP than the hospital.
- Reduced waiting time in the surgery.
- Continuity of care — this is the most important advantage. In the hospital it is less usual to see the same doctor or nurse on consecutive visits, so there is little chance of building up a personal relationship. The assembly line approach is more in evidence, with a range of different people performing specific procedures, which in the GP setting, are done by one or at most two people.

In general practice usually the same doctor is seen throughout, which encourages the development, or extension, of a personal relationship. This improves communication during pregnancy and afterwards — with the inevitable consultations for childhood illnesses. In group practices, antenatal care may be shared between partners, which loses some continuity, but has the advantage of enabling the mother to get to know more of the practice partners. This advantage is probably lost if more than three partners are involved. Shared care should enable the health visitor attached to the practice to meet each woman early on during pregnancy and give advice at this stage, rather than only at the end of the pregnancy. Getting to know the community midwife at the practice is also very valuable, since she visits at home after the birth.

These advantages of continuity help the development of trust and confidence, as well as improving communication. They are even greater with second or later births, since the primary health care team is less likely to change than the hospital staff.

However, some women receiving shared care can find themselves at a disadvantage. As an independent contractor, the GP contracts with the family practitioner committee (FPC) to provide certain services for a fee, in this case maternity medical services. There is no control whatsoever over the way in which he or she provides these services, ie whether the GP gives any advice or performs routine diagnostic tests.

A number of pregnant women have contacted my CHC distressed because of the inadequacy of the antenatal care received from their GP, but not knowing what to do about it. One woman, who was five and a half months pregnant, said that her GP had never listened for the foetal heart, asked for a urine sample to test, or checked for swelling of the ankles or fingers, and he had only examined her abdomen at some antenatal visits. She was understandably worried and was fortunate in being able to get transferred to the hospital for all her subsequent antenatal care. She would have preferred to obtain antenatal care from another GP, but it seems that once a woman has signed to say she will receive maternity services from a specific GP it is impossible to do this. Other women have complained about not being given advice or information about diet, exercise or any other aspect of self-care during pregnancy. One wonders whether a primary health care team exists at all in certain practices, when women say they did not see a health visitor or midwife until the very end of their pregnancy.

GPs who are interested generally provide an excellent service, better from the patient's point of view than if all the care had been given by the hospital. Unfortunately, there are others who are providing a poor, and sometimes potentially dangerous service.

There are no specific guidelines as to exactly what maternity services should be provided by a GP on the obstetric list and there is no procedure by which the FPC or any other organisation can control the adequacy of the service rendered. So, some women are worse off than if they had attended the hospital for all their antenatal and postnatal care. By the time they realise the problem, it is often too late or too complicated to change doctors. Women having their first baby, are especially vulnerable, since they have often had little prior contact with the doctor.

Photo: Steve Benbow/Network

It is important to find ways of improving services during pregnancy while retaining the advantages of "shared" antenatal care. We should also consider ways of integrating contraception and preconception services with the antenatal and maternity services, since these are equally important in producing healthier babies. South West Surrey CHC would welcome comments from other CHCs on these issues.

**Sara Arber is a former member of South West Surrey CHC and is now a member of the "shadow" SW Surrey DHA.*

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loaned by the AHA to a general dental practitioner, to treat his patients in a defined rural area. The need for some form of emergency dental treatment at weekends and national holidays has brought into being three emergency schemes.

Through these meetings the CHCs have obtained a much better understanding of the service and its organisation, whilst collectively we have all worked towards the reduction or elimination of service "black spots". Individual complaints against general dental practitioners are of course the province of the FPC, but we have found that pursuing them with the FPC strictly to obtain satisfaction for an individual is not in itself enough. Where complaints form a pattern, this then becomes a subject for discussion by the joint working group. By participating in the group's work the FPC can ensure that its interests are protected.

The Hampshire CHCs are convinced of the benefits of this type of meeting, but we readily admit that its success is proportionate to the genuine response of the profession. We are fortunate to have had the active cooperation of members of all the branches of the dental profession, plus encouragement from the AHA chairman. The profession is organised in a structure that lends itself to such meetings with CHCs, and most dentists are sufficiently worried about the services being provided to want to make improvements. So go ahead and try to open up what we have found to be the best channel of communication with any professional body — it will prove worth the effort!

Healthline

Can I wear two hats?

I'm a CHC member and I've just been appointed to be a member of one of the new district health authorities. Must I resign at once from the CHC?
The DHSS guidance on this is paragraph 8 of *The membership of health authorities*, Circular HC(81)6. It says:
"There may be an advantage in appointing as DHA members those with previous CHC experience. Statutorily, it is not possible to serve on a CHC and DHA concurrently. People appointed to DHA membership are required, therefore, to resign from membership of a CHC. Although the statutory restriction applies only from the date a DHA formally comes into existence, conflict of interest could arise during the "shadow" phase of a DHA's life and concurrent membership would be equally inappropriate in those circumstances."

It is important to note that the law does not require you to resign until the DHA ceases to be a shadow and becomes the real thing. But the DHSS is strongly discouraging dual membership of a CHC and a shadow DHA. While local implementation of this guidance may vary, the law itself is clear.

Ambulance service complaints

Is there a set procedure for making a complaint about the ambulance service?
No. You should write to the chief officer of the local ambulance service, giving all the relevant details.

In non-metropolitan places these are usually run by the area health authority. In cities which cover more than one area there is generally an arrangement for a city-wide service eg in London there is the London Ambulance Service (LAS) administered by SW Thames region.

The chief officer of LAS says that every complaint is fully investigated by one of his senior officers who interviews the ambulance crew and visits the complainant if further information is needed. When the investigations are completed the complainant is told of the findings, and the more serious cases — if proved — may lead to disciplinary action

Tattooing

Is it legal for a 16 year old to be tattooed? And can you give me some background information about tattooing?
The Tattooing of Minors Act 1969 makes it an offence to tattoo someone under the age of 16 — unless it is done by a doctor or at a doctor's direction. (This might be when someone has a very rare blood group or medical condition, and needs a permanent record of it.) There is a fine of £50 for a first offence and £100 for subsequent offences.

In many places anyone can set up as a tattooist, but some local authorities have passed bye-laws requiring tattooists to register with them. These authorities include the GLC, South Yorkshire, the West Midlands, and East Sussex.

Some tattooists belong to the British Tattoo Artists Federation which would welcome compulsory registration. In conjunction with Dr Noah of the Communicable Disease Surveillance Centre (CDSC) it has drawn up a code, the *Model method of hygienic tattooing* which has been sent to local authority environmental health officers. The Federation is based at 301 King Street, Fenton, Stoke on Trent, Staffs.

Following research into infections, such as hepatitis, which arise from doing tattoos in unhygienic conditions, Dr Noah has become very interested in tattooing. He feels that CHCs could have "a small but definite role to play" in ensuring that tattooists (and also acupuncturists and ear-piercers) are registered with local authorities. He is based at the CDSC, 61 Colindale Avenue, London, NW9 5EQ.

Cancer of the cervix

Can you give me some background information on the incidence of cervical cancer and the "smear" test screening programme?
The cervix is the neck of the womb. In 1979 the overall deathrate from cancer of the cervix was 82.7 per million female population. The deaths rise quite steeply with age: eg 25-29 years — 16.1; 30-34 years — 31.2; 35-39 years — 54.1; 40-44 years — 63.4; 50-54 years — 122.8. The total death rate has fallen since 1970. Age, sexual and child-bearing experience have all been identified as risk factors predisposing certain women to the cancer and it seems that women in lower income groups are at greater risk.

There seems little doubt that regular screening reduces deaths. The problem is that the screening programmes generally only reach about 60% of women and those most at risk are unaware of the screening service. The DHSS pays GPs £4.50 every time they test a woman over 35 years old and tests are also done in family planning clinics. Younger women are selectively screened.

There has been considerable debate about the age at which universal screening should begin and about the cost-effectiveness of the screening programme, weighing the benefits to individual women whose cancer might otherwise go undetected against the cost to the community of testing thousands of healthy women.

The report of a DHSS Committee on Gynaecological Cytology is on Dr Vaughan's desk, awaiting publication. The Committee considered the frequency of testing and the age at which testing should begin. A number of CHCs have taken action on their concern about the low take-up by local women of the screening service.

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.

What is Motor Neurone Disease?

by Ann Gretton, National Secretary, Motor Neurone Disease Association

Motor neurone disease, often shortened to MND, is the name given to a group of diseases in which the nerve cells controlling the muscles of movement are slowly destroyed. These nerve cells in the brain and in the spinal cord are known as *motor neurones*. With no nerves to control them the muscles gradually weaken and waste away. Muscular weakness is often seen first in the hands or the feet, and may be accompanied by twitching and cramp. With time it will spread to the arms and legs and to the throat and chest, causing difficulties with speech, swallowing and breathing. In the end there will be general immobility.

The MND Association was formed in 1979, to bring together all those people who are concerned in any way with MND. The association will endeavour to support research on all aspects of MND, and will provide a meeting ground for those doing the research, as well as the doctors and social workers who have to attend to the daily needs of the MND patient. It will also collect and distribute information on MND and its treatment, at all levels, from the advanced research specialist to the friend of a patient who just "wants to help".

But above all else, the association is concerned about the MND patient — about his or her welfare. Until the all-important question about the cause of MND has been answered and an effective treatment has been shown to be available, the first task of the association will be to try to help MND patients, their relatives and their friends in whatever way seems most appropriate. That assistance may be the provision of an "aid" to help with day-to-day living, the giving of advice on such aids, or even the provision of financial help if it is felt that there is a real need.

With the progression of such a serious disease there often comes loneliness, perhaps despair. The association feels that if it can give an opportunity for patients to come together and thus to know that other patients, and many other people, are aware of some of their problems, then those twin terrors of loneliness and despair will have little chance of taking over.

The Motor Neurone Disease Association, 7 Lorimer Avenue, Gedling, Nottingham NG4 4BS. Tel: 0602-878700

Scanner

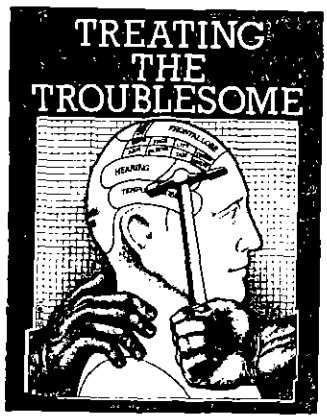
Medical negligence

A new charity, Action for the Victims of Medical Accidents, has been formed to advise and support the victims of medical accidents and to publicise the social injustices which these patients often suffer. Chairman is writer Peter Ransley, whose gruelling TV play *Minor complications* provoked a flood of requests for help. AVMA would like to work closely with CHCs, and can be contacted at 33 Dordrecht Road, London W3. Tel: 01-749 6298.

Black report summary

The Black report, *Inequalities in health*, was published by the DHSS in August 1980. It shows that despite the NHS manual workers and their families still tend to die younger and to have much worse health than professional people. While the health of the nation as a whole has improved, this class-related gap is growing. Copies of the report itself are virtually unobtainable, but a useful 24-page summary has been published by the Trades Union Congress. Copies £1.20 inc post from the TUC, Congress House, Gt Russell Street, London WC1.

Cutting it out



Treating the troublesome discusses the whole range of medical and psychiatric techniques for modifying behaviour — from psychotherapy and drugs to ECT and psychosurgery. It proposes a system of lay advocacy, for use whenever a doctor is in some doubt about a patient's ability or freedom to give informed consent to a particular form of treatment. £2.90 inc post from the Council for Science and Society, 3/4 St Andrews Hill, London EC4V 5BY.

More about medicines

Drug and Therapeutics Bulletin, published fortnightly for doctors by *Which?*, continues to be a mine of useful, consumer-oriented medical information. Recent issues have included items titled *What should we tell patients about their medicines?* and *Liquid medicines can rot sick children's teeth* (both in DTB 11 September), *When buying can cost less than the prescription charge* (25 September) and *Fluoride in toothpaste, rinses, gels and tablets* (9 October). Single copies of DTB are 85p each, from the Consumers' Association, Caxton Hill, Hertford SG13 7LZ.

Giving up smoking

Six ten-minute programmes called *So you want to stop smoking* will be shown at weekly intervals on BBC1 TV, beginning on Sunday 3 January. The series will follow the progress of three people trying to give up, and will also feature advice from experts and celebrities. Viewers who write to an address given at the end of each programme will be sent a "stop pack" produced by the Health Education Council and the Scottish Health Education Group.

Improving fire safety

Every year there are about 2000 fires in NHS hospitals, and it has been estimated that it would cost £170m at 1979 prices to bring existing hospitals up to fire certificate standards. *Fire safety in health care buildings* is the report of a conference held in Coventry a year ago, including papers on how to evaluate fire safety and make improvements through upgrading, and on fire alarm systems and staff training. £4.95 inc post from David White, Coventry AHA, Christchurch House, Greyfriars Lane, Coventry CV1 2GQ.

Depo-Provera

This 48-page report looks in depth at the injectable contraceptive Depo-Provera — its development, its use in Britain and abroad, the abuses which sometimes accompany its administration, and the arguments for and against a ban on the drug. While conceding that there is a minority of women who might find Depo useful, the report argues that these benefits are far outweighed by the need to protect the "vast majority of women all over the world who are given it regardless of their own safety or comfort or convenience".

Depo-Provera, £1.50 inc post from the Campaign Against Depo-Provera, c/o ICAS, 374 Grays Inn Road, London WC1.

Health authority members: WHC(81)7

This circular, NHS structure and management: The membership of health authorities, is the Welsh version of the English circular on DHA membership described in detail on page six of last month's *CHC NEWS*. The Regulations which the two circulars implement have now also been published — they are contained in Statutory Instrument 1981 No 933, *The NHS (Health Authorities: Membership) Regulations 1981* (HMSO £1.10).

Rubella: HN(FP)(81)34

Says GPs can now claim a fee for rubella vaccinations given to girls between their tenth and 14th birthdays. Previously the age range was *eleven* to 14.

CHC Directory: Changes

Changes to the CHC Directory are published on this page in each issue of *CHC NEWS*. Please let us know if your entry needs updating. Single copies of the directory are available free — send an A4-size self-addressed envelope and 25p in stamps.

Page 2: East Cumbria CHC Chairman: Coun. WS Whitson
Page 2: South East Cumbria CHC Chairman: Coun. Bill Stewart
Page 3: Huddersfield CHC Chairman: P Walley
Page 4: Wakefield Western CHC Chairman: Coun. J Firth
Page 4: Wakefield Western CHC Tel: Wakefield 362509
Page 4: North Derbyshire CHC Chairman: Alun Jones
Page 4: South Lincolnshire CHC Chairman: Coun. Lloyd Ramsden
Page 5: Northern Sheffield CHC Chairman: TW Shipstone
Page 5: Southern Sheffield CHC Chairman: Mrs JM Ward
Page 6: Brent CHC Secretary: Ms Marianne Craig
Page 6: KCW North West District CHC Secretary: Ms Susie Parsons
Page 7: KCW South District CHC Chairman: Mrs Mathilda Edelman
Page 7: Havering CHC Chairman: RV Rudge
Page 7: Newham CHC Chairman: Coun. Mrs Marjorie Helps
Page 8: Brighton CHC Secretary: Alan Brookes
Page 8: Eastbourne CHC Chairman: Mrs Margaret Mailer-Howat
Page 8: Medway CHC Chairman: Coun. AM North
Page 10: Southampton and South West Hampshire CHC Chairman: Mrs GE Bryant
Page 10: Swindon CHC Chairman: Mrs JM St C Coates
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Page 12: North Devon CHC Chairman: Mrs Meriel Oliver
Page 12: Torbay CHC Chairman: Mrs Pamela Gower
Page 12: Mid-Staffordshire CHC Chairman: SG Bayley
Page 13: Sandwell CHC Chairman: Martin Prestidge
Page 14: Lancaster CHC Chairman: Don Hargreaves
Page 15: Bury CHC Chairman: R Hamilton
Page 15: North Manchester CHC Chairman: Harry Foden
Page 19: South Western Regional Association of CHC Secretaries c/o Gloucester CHC, Roebuck House, 37a Brunswick Road, Gloucester GL1 1LU. Chairman: Mrs Mary Aitchison. Secretary: Mrs Judith Gill. Tel: Gloucester 413044.
Page 21: Kincardine and Deeside LHC Glen O'Dee Hospital, Corsee Road, Banchory AB3 3SA. Chairman: J Innes. Secretary: Mrs Margaret Wilson. Tel: 03302 2233 Ext 6.
Page 21: South-Eastern District (Greater Glasgow) LHC Secretary: John Rowan

News from CHCs

□ In a last-minute change of heart, Health Minister Dr Vaughan has announced that Liverpool will have a "unique" structure in the reorganised health service. Instead of the three district health authorities announced in the summer, Liverpool will have just one — which is what MPs, the city council and the CHCs had campaigned for — but there will be two "sector management teams". One of these sectors will manage all patient services.
To the delight of the two local CHCs, **Liverpool Central and Southern** and **Liverpool Eastern,** there will be two CHCs — one for each sector — "to enable the new authority to be sensitive to local needs". But both CHC secretaries are very worried about how the new structure will actually work — and they believe that local health officials share their confusion.

□ As the new DHAs grind into action behind the scenes, a number of CHCs are making approaches to them in the hope of being present when they take possibly crucial decisions in the next few months. Until April of course, neither CHCs or the press have any right to be present at the shadow DHA meetings. Reactions of the DHAs to CHCs vary. **Harrow CHC** was very pleased when its chairman, Miss Olive Hawker, was invited "out of the blue" to attend the first DHA meeting. She was made "very welcome" and invited to future meetings. On the other hand, when **Greenwich CHC** asked if it could send an observer to DHA meetings it was told that the shadow chairman would put the CHC's request to the first DHA meeting. CHC secretary May Clarke says there ought to have been guidance from the DHSS on this issue.

□ To the dismay of **Norwich CHC** it was not allowed to participate in the planning of the new regional secure unit which is going to be built locally. And when the CHC made its comments on the published plans it was told that it was too late to make alterations as planning permission was about to come through. The CHC is doubly worried about its inability to suggest changes because there is likely to be a capital shortfall on the unit of £¼m, and it would rather see a smaller unit than cuts to other regional projects to make up the difference.

□ **East Berkshire CHC** member Alistair Macnair Kay went out on call for a day with a local ambulance crew. He came back "full of admiration" for the service but was worried about the high number of abortive calls and the lack of consideration for the ambulances shown by other road users.

□ Earlier this year **South Gwent CHC** persuaded BBC Wales to make a 50 minute programme about the controversial anti-nausea drug, Debendox. The programme started with a film of local women who had taken Debendox in pregnancy and then had congenitally malformed children. It then moved on to a studio discussion. The speakers included a director of the American company producing the drug, the secretary of the Debendox Action Group and South Gwent CHC secretary Emrys Roberts to represent the "consumer".

□ *Maggie Campbell, Assistant Secretary of* **King's CHC** *is shown here talking to a member of the public at a recent "Health Day" organised to celebrate the opening of a new health clinic in West Norwood. The previous clinic had been closed last year at two day's notice after being declared unsafe. The CHC and a local women's health group then launched a public campaign for a new clinic, which eventually proved successful. The staff of the new clinic gave up their Saturday to meet their potential customers and local health groups organised events for the numerous children who turned up.*

□ "Would you like to share your underpants with someone?" When **Islington CHC** posed the question that way, the area health authority chairman agreed that personal clothing for long-stay elderly hospital patients was an important issue, and now the CHC's six year's campaigning has seen success. Someone has been appointed to liaise between the patients and the hospital laundry, to keep track of clothes and mend them. CHC chairman Betty Hudson said, "I'm sure relatives will provide clothing once they're confident that things won't get lost".

□ **Havering CHC** was surprised at the district management team's reaction to the CHC's efforts to publicise local health facilities for well women by distributing a leaflet about them. The CHC had decided to publicise the services to see whether there was a need for a special Well Woman service or if the existing provision was sufficient, as the DMT had claimed. The DMT wrote to the CHC warning it that publicity might lead to increased demand — and there might not be enough cash to pay for an expansion to meet this demand. The CHC went ahead and distributed thousands of its leaflets but has not yet heard of anyone being turned away from clinics. And in fact the CHC has now learnt that the district's latest plans actually include the possibility of setting up special Well Woman clinics.

□ A seminar on job opportunities for disabled people was **Wakefield Western CHC**'s way of marking IYDP. The audience included several disabled young people who forcefully described their problems and the attitudes they had met. The programme also attracted social workers, careers and education officers, and a sprinkling of personnel officers from local firms. Speakers included a resettlement officer from the Manpower Services Commission, who described the capital grants available to firms who need to adapt their premises in order to employ a handicapped person. An officer from Pathway, Mencap's employment scheme, talked about placing mentally handicapped people in jobs.

□ **East Glamorgan CHC** is setting the pace in its efforts to oppose the plans for closure of the 170-bed orthopaedic hospital at Rhydlafar. Although no consultation document has yet been issued, three area health authorities concerned with the hospital have agreed in principle to close it down. The East Glamorgan district is very dependent on the hospital though patients also come from Gwent and South Glamorgan. The CHC has already organised three meetings in different parts of the district and the council has made contact with the hospital staff's Rhydlafar Action Committee.

□ The problem of the growing population of elderly people on the south coast spurred **Portsmouth and South East Hants CHC** into action when it learnt that the DHSS had deferred plans to open a chiropody school in Southampton. The council wrote to the Secretary of State arguing that without the school the shortage of chiropodists would soon reach crisis proportions. Now the DHSS has promised to look at the whole issue "a little more closely".