CHC NEWS

For Community Health Councils

December 1981 No 72

Social services cuts deepening

Social services directors are "fearful of the consequences for clients" in the many areas where local authorities are making cuts to social services budgets.

In a recent survey* the Association of Directors of Social Services has found that in 1981-82 social services departments in England and Wales will be suffering an overall cut of almost 0.5% in real spending compared to 1980-81 — and many of the 1980-81 budgets were a reduction over the previous year's spending. The ADSS points out that the Government itself has said that it is necessary to have 2% growth per year to *maintain* standards of social service provision, given the increasing numbers of elderly people and children in care.

The ADSS makes it clear that behind the overall figures there are considerable differences between authorities. Of the 83 (71.6%) who replied to the association's questionnaire, 44 are making real budget increases, 25 by at least 5%, seven are making no change and 31 are making real reductions — 16 of them by 5% or more. Of this last group the association says, "in the absence of substantial supplementary budgets clients of these departments will suffer very badly indeed". The authorities involved are mainly London boroughs and non-metropolitan counties.

Authorities are finding an enormous increase in the financial demands their clients place on them. In 1980-81 the cases where cash payments were needed to prevent children being received into care rose by 11.9%, and the number of cases involving payments for clothing and footwear increased by 54%. The report says that "never has poverty in material terms been such a major factor in whether people (particularly children) require to be 'in care', or can survive in the community".

The association welcomes the Government's stated policies and priorities for improving community care for the elderly, and its encouragement for preventive social work, but "wonders how the objectives can be achieved when resources are so scarce" and reductions are being made in many social services budgets. And it says the problems are compounded by the "Government-directed reduction" in the related services of housing, education and subsidised transport.

Although spending on fieldwork has risen in real terms in twice as many authorities as those in which it has been reduced, this reflects the cost of fieldwork services and there has been an overall decrease of 393 in the number of fieldwork posts. Home helps and related staff have fared better — there are now 762 more of these than there were in 1979. And a marked increase is shown in staff in homes for the mentally handicapped and day care staff for the elderly and physically handicapped. Significant reductions of staff are seen among administrative, clerical and secretarial staff and staff in day nurseries and community homes.

The survey shows "a general recognition of the important role volunteers can play". Attitudes to funding voluntary bodies in a time of financial retrenchment varied, but the average 1981-82 budget shows an increase over 1980-81 of 15.4% in its allocation to the voluntary sector. A number of authorities are developing joint ventures with voluntary groups, and there is "special mention of the value of joint funding as a means of more fully utilising the voluntary potential".

**Personal social services expenditure, staffing and activities* from ADSS, Social Services Department, Civic Centre, Newcastle upon Tyne NE1 8PA. Price £8.

Government delay worries CHCs

The Government's prolonged and worrying silence on the future of CHCs has provoked bitter criticism from the Association of CHCs. Official decisions about the role and membership of CHCs have been expected since late October, and ACHCEW chairman D M Thomas has now written to Social Services Secretary Norman Fowler expressing CHCs' "extreme concern" about the continuing delay.

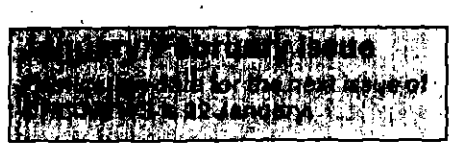
The letter highlights two matters of particular concern:

- "The gap which is growing between DHA shadow management and CHCs, so long as CHCs are not given observer status relative to them".
- "The introduction into the normal consultation procedure of an additional element of consultation, in that the Department's decisions on the role and membership of CHCs have been trawled among regional health authorities before final decisions are made, without CHCs for their association being given the same oportunity to react".

The Secretary of State is requested either to announce his decisions or to arrange an "early meeting" with ACHCEW representatives.

On 24 November, Health Minister Dr Gerard Vaughan told the House of Commons that "CHCs represent the public interest in the National Health Service locally, and not regionally or nationally. Therefore, CHCs will be linked with the new, more local, district health authorities in future. We have no plans to alter their role on complaints".

● See Comment on page three.



Your letters

Postal votes

Shirley McCarthy, Secretary, North West Herts CHC

This CHC's attention has been drawn to the fact that local Electoral Registration Officers take a narrow interpretation of the discretion they are permitted in respect of counter-signatories on a disabled person's application for a postal vote. They will not readily accept a non-medical counter-signatory.

It seems iniquitous that there is no need for a supporting counter-signature for people requesting a postal vote on the grounds that their work takes them away from their usual place of residence — whereas disabled people are required to have someone testify that they are housebound. Moreover they are subject to the Electoral Registration Officer's interpretation of the regulations. We would like to hear what the reactions of other CHCs are to this.

Open University learning materials

Sheila Kitzinger, Centre for Continuing Education, The Open University, P O Box 188, Sherwood House, Sherwood Drive, Bletchley, Milton Keynes MK3 6HW

I have just started work for the Open University on the creation of new materials on pregnancy, childbirth and new parenthood. I should be very grateful if CHC members were able to advise me on what changes should take place, the areas on which it is important to focus and even the packaging of the product.

War planning

R J F Whyte, Chairman, Harrogate CHC

I consider that your report about the Association of CHCs' AGM (*see CHC NEWS 70* page one) omits the most important part of the case made by those opposing the resolution about war planning officers.

The principal argument used against any form of planning for a war-like emergency is that the only form of war would be an all-out nuclear war in which there would be few survivors and conditions would be such that they would not be able to help anybody else. Circular (HDC(77)1) clearly states that a future war might begin with a period of non-nuclear conventional war but it is unlikely that it would continue for long without either a settlement or escalation into nuclear war. Bearing in mind the increasing devastation which nuclear war can bring, it is now even more likely that a conventional war would be settled by Washington and Moscow using their hot-line.

If that occurs there would be many thousands of wounded servicemen on the Continent requiring evacuation and urgent hospital treatment in this country. It is also likely that Britain itself would be subjected to air attacks of a conventional nature (possibly including the use of chemical, but not nuclear weapons). Such attacks would probably be on limited objectives and would occur whether Britain had nuclear weapons or not. In this case there would be tens — possibly hundreds — of thousands of seriously injured in this country, but the vast majority of the population, and the NHS, would be untouched and would be available to care for these casualties.

The resolution which was passed at the AGM was based on a false premise. As it is framed the resolution opposes all forms of contingency planning. In view of the possibility of a short conventional war, opposition to such contingency planning is difficult to understand.

What do *you* think?

G E Havelock, Chairman, Oxford Regional CHC Chairmen and Secretaries, c/o East Berkshire CHC

The Oxford Regional CHC Chairmen and Secretaries recently discussed the excessive amount of duplicating and expense that is incurred in circulating the news of the Association of CHCs' Standing Committee to every CHC after its meetings.

We came to the conclusion that the best way of making such news available to all CHC members would be through the pages of *CHC NEWS*. The presentation of ACHCEW news on two or three pages of the magazine would not only provide an excellent feature, but would also prove to the DHSS that *CHC NEWS* actively and positively relates and co-ordinates information about CHCs.

Handing over these pages to the Association would reduce the amount of work the hard-pressed ACHCEW secretariat performs in reaching every CHC with news items and would also improve the quality content of *CHC NEWS*.

Ed: We would welcome readers' comments on the idea of handing over two or three pages of CHC NEWS to ACHCEW.

Special offer for CHCs

Ivana T Cooke, 179 Valetta Road, Acton, London W3 7TA. Tel 01-749 3154

I'm setting up an agency providing cartoon illustration, writing and public relations advice and am offering a discount on these services to CHCs. I've specialised in illustration of health subjects and I've been a CHC secretary for two years and a member for four, so feel familiar with the issues!

All-day visiting

Liz Haggard, Secretary, South Nottingham CHC

For the last three years our CHC has been using an all-day visiting pattern which varies slightly from the one described by West Essex and District CHC in *CHC NEWS 70* page 13.

We also cover the ward day with a rota of members covering two or three hours each, but the members visit on their own rather than having the secretary accompany them. After the visit the members write up their experience and a week or ten days later return to the ward with their collated notes to read them through and discuss them with the ward staff. Any points which still need taking up after this informal talk-through are dealt with formally by the secretary.

We fully agree that adding all-day visiting to the existing range of CHC visiting has been much more satisfying for the members and more helpful for the hospital staff.

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Wanted

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

Information about *female* users of artificial limbs. Artificial limbs were originally, designed for soldiers, but what is suitable for a man is not necessarily suitable for a woman — they may have many problems, especially during pregnancy and whilst caring for young children. Many improvements have been made to artificial arms but legs seem almost unchanged since the 1940s. A leading surgeon and I are trying to mount a campaign to rectify the situation but we need more detailed information.

Also — information about whether it is true that Thalidomide victims will not wear their limbs because they are so uncomfortable.

— Mrs Margaret Bamford, Member, Frenchay CHC, 93 High Street, Hanham, Bristol BS15 3QG

Statistics from other CHCs about occupational therapy staffing in their local hospitals.

— Bradford CHC

CHC NEWS

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Comment

For more than two years now CHCs have lived with uncertainty about their future. In spite of a vote of confidence from the Royal Commission on the NHS, *Patients first* and its ensuing consultation period kept them wondering whether they would continue to exist at all. Once that issue had been settled, the Government's consultation paper on role and membership raised questions about the basis on which CHCs would continue. Six months after the end of this second consultation, the Secretary of State's decisions are still awaited.

Not surprisingly, CHC members and staff have become increasingly anxious during this period. The threat of abolition and the later uncertainty as to function would have been enough in themselves to cause anxiety. But a sense of frustration has been added because all this is happening at a time when the NHS is undergoing an important structural reorganisation, with relationships needing to be worked out with the district health authorities and the new management units. As the timescale for decisions has been extended again and again, so the pressure has mounted.

Early in September it became known that a draft DHSS document on the future of CHCs was circulating amongst regional health authorities. The immediate result was a resolution from the Association of CHCs' AGM, reasserting the principal points made by the majority of CHCs during the consultation earlier in the year. Since then, nothing. Rumours have travelled around, straws in the wind have been studied, and various possibilities canvassed. But from Mr Fowler there has been complete silence — he has responded neither to ACHCEW's requests for a meeting, nor to the many direct representations he has received on the subject.

It is worth remembering that CHCs were built into the NHS structure by a Conservative government, and that their job is to represent the interests of the public. That objective, which was seen to be important in 1973, is no less so in 1981. CHCs have provided a service at relatively low cost, and the number of CHC members appointed to the new DHAs testifies to the expertise they have developed. CHCs have been a sturdy champion for children and for the elderly, chronically ill and physically and mentally handicapped members of our society. Not least they are a potent source of information for MPs and for the Government itself, if properly used.

If CHCs are to stay, then they have important business to transact with DHAs, with unit management within the districts and with the newly-independent FPCs. They must be able to get down to it, and to make their contribution with some moral authority. CHC staff have the right to know where they stand. They have served their councils with outstanding diligence and with great personal commitment. Continuing uncertainty about the future is unfair and demoralising to them — particularly in regions such as Trent, where wholesale mergers and reductions in numbers are to take place.

Mr Fowler must act. The DHSS must realise that prolonging the anxiety extracts a toll which can only do harm. CHCs have been tried and tested three times in their short existence, and have proved their worth — certainly to Mr Jenkin's satisfaction. It is now up to his successor to lay down guidelines for the future, so that CHCs can get on with the work.

Health News

Heart risk at rayon factory

Workers at a factory in north Wales have been exposed to dangerously high levels of carbon disulphide gas throughout the 1970s, despite medical evidence published in 1968 linking the chemical with coronary heart disease (CHD). This disturbing allegation comes in a report from the white-collar union ASTMS (1).

The report focuses on Courtaulds' Greenfield factory at Holywell, north Wales, where carbon disulphide is used to convert cellulose into rayon fibre. Three ASTMS members there have died recently from CHD, according to the report, and figures from the Transport and General Workers Union on deaths amongst its members in the spinning and washing department show more than twice the expected death rate from CHD over a three-year period. Most of the people dying from CHD were unexpectedly young.

The 1968 evidence — subsequently confirmed by research in Finland, Norway and the USA — was co-authored by the Greenfield plant's medical officer, and was published in the *British Medical Journal*. ASTMS claims that Greenfield employees were not told about the *BMJ* paper, but Courtaulds says the findings were reported in the national and local press and were also discussed with union representatives.

The Health and Safety Executive's Threshold Limit Value (safety guideline) for carbon disulphide in air was reduced from 20 parts per million (ppm) to 10ppm last year, though the US National Institute for Occupational Safety and Health is now recommending a TLV of 1ppm. Between 1976 and 1980 management took 25,000 spot-check measurements at Greenfield, of which 92% were above 10ppm and 69% above 20ppm. Courtaulds says that it has been making a "continuing effort" to reduce employees' exposure to carbon disulphide since 1945.

Courtaulds is the biggest European manufacturer of rayon and Cellophane, and also uses carbon disulphide at factories in Grimsby, Bridgwater and Barrow-in-Furness. Other major users have factories in St Helens, Wigton, Wrexham, Bury and Fleetwood.

1. *Carbon disulphide: An investigation into heart disease at Courtaulds*, £5 inc post from ASTMS, 10 Jamestown Road, London NW1 7DT.

Avoiding heart attacks (HMSO £1.50) *is the latest in the DHSS' series of booklets on prevention and health. It gives clear advice on avoiding the risk factors — smoking, high blood pressure, overweight, too much dietary fat, stress and lack of exercise. Smoking is the biggest known risk factor, and the Health Education Council, Action on Smoking and Health and the BBC are expected to announce new anti-smoking campaigns this month.*

Independent FPCs

In the reorganised health service family practitioner committees will be granted their wish to become independent health authorities with the power to employ their own staff. Health Minister Dr Vaughan says that this is "most likely to facilitate the development of primary care services and lead to increased efficiency in the administration of the family practitioner services".

The necessary legislation cannot be introduced during the present session of Parliament so "interim arrangements" will be made. Where the FPC and DHA are coterminous, the DHA will take over the

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Health News

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AHA's functions of employing FPC staff, and where more than one DHA is coterminous with the FPC, one of the DHAs will be designated the employing agency. In the 22 cases where FPC boundaries are not coterminous with the new DHAs the FPCs will have to be reconstituted to match the DHAs. The DHSS admits this could be expensive — medical records will have to be moved — but says it will try to minimise the cost.

The British Medical Association and the Society of FPCs have welcomed the Government's decision. But Bill Darling of the National Association of Health Authorities says "this is a major step backwards from the ideal of an integrated NHS". Mike Gerrard of the Association of CHCs commented that "it won't make a great deal of difference to the public" but he would be very concerned if the FPCs remain outside the primary health care planning process.

'Shock' report

Over a quarter of the electroconvulsive therapy (ECT) clinics in Britain have "severe deficiencies", such as low standards of care, obsolete apparatus and unsuitable premises — according to a comprehensive study of ECT by the Royal College of Psychiatrists*.

About half the units giving ECT (390) were visited by RCP observers. Some 46% of the units were purpose-built or adapted for ECT but "not all of these and few others are really suitable." The observers would have been willing to have ECT themselves in 43% of the clinics and in 30% they would have accepted ECT with reluctance. But the remaining 27% had "serious deficiencies" — and this includes 16% which had "very serious shortcomings". In these clinics "ECT is given in unsuitable conditions, with a lack of respect for patients' feelings" by ill-trained, sometimes incompetent staff.

The RCP also sent a questionnaire about ECT to all its members and others who prescribe the treatment. Of the 86% (2755) who offered sufficient information for analysis, only 1% said that ECT should never be used and 87% regard it "as at least occasionally justified".

Just under half of the respondents had prescribed and/or administered ECT in the previous six months. A third of these doctors provided further details about the patients involved. Depression was the primary diagnosis in 83% of the cases. The psychiatrists considered that 87% of these improved after ECT — in comparison with a random sample of GPs who believed that only 66% of their depressive patients (comparable in other respects with the psychiatrists' ECT patients) showed improvement after ECT.

Most of the psychiatrists believed that it should be their responsibility, rather than a "multidisciplinary" panel's, to make the final decision about whether to give ECT to an unwilling patient or one unable to give valid consent. In the case of a detained patient who refused consent, 59% would give ECT after informing the next of kin and 16% would give it even if the relative also objected. Five per cent would never give ECT to an unwilling patient.

Wide regional variations in the use of ECT were found — Yorkshire uses it more than three times as much as Oxford. The RCP says the differences are "not easily explained". It rules out links with factors such as unemployment. Individual hospitals sometimes have very high rates of ECT use which may be due to the practice of particular consultants.

Social Services Secretary Norman Fowler says he shares the College's concern about deficiencies in ECT. He is especially worried about the use of obsolete equipment (all that is available in over a quarter of ECT clinics) and has announced the formation of a working group to investigate the matter and report within three months.

* *Electroconvulsive treatment in Great Britain, 1980* by John Pippard and Les Ellam, £10 inc post from Hadley Bros Ltd, The Invicta Press, Ashford, Kent.

Patients' charter on its way

The National Consumer Council's long-awaited "patients' charter" is about to be published — hopefully in March. Called *Patients' rights: A guide to rights and responsibilities of patients and doctors in the NHS*, it will be available in full report form and as a "summary" leaflet.

Copies of the summary of the guide will be sent free to every CHC member. The full report will cost £1, but will be available to CHCs at half-price. The NCC hopes that CHCs will help it to "launch" the guide by arranging local publicity.

The guide contains chapters on Becoming a patient, Choice and consent, Information, Children, Representation, Complaint and redress, and Contacts. The NCC plans to do further work on a number of related issues, including appointment systems, complaints procedures, confidentiality and NHS spending priorities.

For more information contact John Ward at the NCC, 18 Queen Anne's Gate, London SW1H 9AA. Tel: 01-222 9501.

School health service 'in peril'

The school health service may be seriously undermined by next year's NHS reorganisation, according to a report (1) from the Children's Committee. The committee was axed by the Government earlier this year, and this review of the school health service (SHS) was its final piece of work.

The report warns that "The close relationship between the health services and the education services, essential to the effective functioning of the SHS, is imperilled by the way in which the NHS is being reorganised ... Under the present system, an area health authority generally covers the same geographical and administrative area as a local education authority. The move to establish more and smaller district health authorities will mean in future that, in the main, several DHAs will need to relate to one local education authority. The new administrative units will often be too small to employ their own Specialist in Community Medicine (Child Health), who in the past has provided advice and carried executive responsibility on the health aspects of a local education authority's functions.

"There is a genuine fear that the imbalance and incompatibility in size and range of responsibilities will make it a more difficult and complicated exercise to achieve the close cooperation between the health and education authorities which is essential to the maintenance and development of the SHS. Similarly, there is anxiety that the new administrative units will be too small to employ area dental officers, who have a vital role in managing the community dental service and preventing dental disease at local level".

The Government's response to the Warnock Report on handicapped children, embodied in the new Education Bill, is also likely to cause problems, by increasing the demands made on the SHS.

The report concludes that the financial and staff resources of the SHS must be safeguarded, and that "the objective of ensuring that every school has available the expertise of a doctor and nurse qualified and experienced in educational medicine and nursing must be pursued relentlessly".

Routine medical examinations should be abandoned "in favour of more selective surveillance when appropriate and of annual health care interviews with the school nurse", and for adolescents the emphasis should be on the constant availability of SHS staff for consultation. The work of the community dental service in schools should be given a high priority, and a common element of training for teachers, doctors and nurses should be considered.

1. *The school health service: A position paper*, free from the Children's Committee, c/o The National Children's Bureau, 8 Wakley Street, London EC1. Please send a stamped addressed envelope.

Needs of the under-fives

The Children's Committee has also sent the Social Services Secretary its final advice (2) on the needs of under-fives in the family, based on responses to a discussion document which it published in January.

The committee suggests that child benefits should be inflation-proofed, and that the maternity grant should be increased "forthwith" to a realistic level. GPs, health visitors and midwives should be more active in advising families about welfare benefits, and the DHSS should publish a special leaflet to help with this. The DHSS should also commission a study of why low-income families fail to claim the benefits for which they are eligible.

2. *Submission to the Secretaries of State on the needs of the under-fives in the family* free for the Children's Committee, as above.

Reform of mental health law

WILL IT BE ENOUGH?

by Larry Gostin, Legal Director, Mind

The new Mental Health (Amendment) Bill is the culmination of seven years of campaigning to change the Mental Health Act 1959 by voluntary organisations, professional groups and health service trades unions.

The debate on new mental health legislation was initiated in 1975 with the publication of the Bullen Report and Mind's *A human condition,* volume 1. The last government published a consultative document in 1976 and a White Paper in 1978, which was debated in 1979. But it failed to introduce a bill before it left office.

The broad philosophy of the Bill is clearly to reverse the trend of granting unaccountable authority to professionals, and to increase the rights and safeguards available to detained patients.

The main provisions in the Bill which are to be welcomed are:

- Halving the periods of detention under section 26 of the Act. This means that the new period will be six months, which can be renewed for a further six months and then for periods of one year at a time. These periods are still too long as one would not expect that it would be necessary to detain patients for such inordinate periods of time — or that it would benefit them.
- For certain groups, detention in hospital will only be renewed if the person is thought "treatable", ie "treatment is likely to alleviate or prevent a deterioration in the patient's condition". This is important in order to avoid the use of hospitals as places of custodial care only. Unfortunately this provision does not apply to mentally ill or severely mentally handicapped people.
- Local authorities will have to approve the social workers who carry out mental welfare officer functions under the 1959 Act. And in future they will have to be specially trained.
- The powers of guardians under the Act are to be reduced. At present guardians are given very wide-ranging powers over mentally disordered people who do not need hospital treatment but do need supervision and control in the community.
- Automatic rights to mental health review tribunals for detained patients who have not taken the initiative to apply on their own behalf. Patients will be referred to the tribunal if they have not applied to it within the first six months of detention or have been detained for three years without a hearing.

These are the non-controversial aspects of the Bill.

The inadequacies in the Bill are due more to what it omits than to what it contains. Remarkably it does not try to comply with the recent decision against the UK Government by the European Court of Human Rights about whether a detained patient has a periodic right to have the grounds for his detention considered by a body with power to order his discharge if it considers further detention is not justified under domestic law. It is expected however, that the Government will introduce an amendment giving patients detained under section 65 (ie by a court order, possibly without a time limit) the right to apply to a tribunal with the power to discharge them.

Also missing from the Bill is reform of section 141 which diminishes the right of patients to sue anyone acting under the 1959 Act. This is a major omission and it is noteworthy that Mind has filed two further cases before the European Commission of Human Rights on this issue.

Perhaps the most controversial and important aspect of the Bill involves the right to impose treatment on unwilling patients. This is an area which badly needs reform and every effort should be made to press MPs for change. The proposals in the Bill about consent to treatment describe different categories of treatment:

- *Treatments which give rise to special concern* — those that have been described as "hazardous, irreversible or not fully established". They will only be given with the patient's consent and the agreement of an independent doctor and they will be laid down either in regulations or in a code of practice.
- *Specific items of treatment, such as medication, surgery and ECT* which are not of "special concern". These may be administered without the patient's consent if an independent doctor agrees.
- *All other forms of medical treatment* — these may be given without the patient's consent or that of an independent doctor.
- *Emergency treatment* — special rules apply.

These proposals must be of very great concern to CHCs and any other organisations concerned with the interests of consumers.

The use of a second *medical* opinion alone is a totally unacceptable safeguard. Apart from the Royal College of Psychiatrists virtually all voluntary and professional groups have always proposed a multidisciplinary second opinion on the grounds that issues of competency and consent to treatment cannot be determined solely on the basis of medical or scientific expertise, but require a lay, social and commensense judgement. The decision to impose a treatment on an unwilling adult patient requires a subjective decision about a number of diverse factors — the purpose of the treatment, possible adverse effects, and the strength and cogency of the patient's reasons for refusal.

The only safeguard which would command the confidence of patients and the public is a second opinion which was independent and multidisciplinary (including a lay element). This could be achieved by imposing such a duty on mental health review tribunals, which of course are already set up.

The Government's proposal is that the second opinion should come from a doctor selected from a panel by the Mental Health Act Commission. This is a new, independent body which the Government is proposing should be set up with a "general protective function for detained patients". Its members would be lawyers, doctors, nurses, social workers, psychologists and laymen. It would make one or two visits every year to all the 300 or so local hospitals and mental nursing homes in England and Wales where there are detained patients, and one visit every month to the four special hospitals. The idea is that members would make sure that detained patients were aware of their rights and see that hospitals were operating detention procedures properly.

But although the new commission would be multidisciplinary, it will not be the commission providing the second opinion but only a *doctor* it has nominated. A compromise would be for the commission to examine questions of consent on the same multidisciplinary basis that it would review other issues.

This is a most important area where Parliament should ensure that not only medical opinion is respected. It is a matter of very deep concern to a great many people and organisations.

The **Mental Health (Amendment) Bill** *(HMSO £3.80) was published on 11 November 1981. It is accompanied by a White Paper* **Reform of Mental Health Legislation** *Cmnd 8405 (HMSO £2.65).*

FUNDING

No Secretary of State for Social Services has asked a more fundamental question than the one posed by Patrick Jenkin before he left the Department: Is there a better way of funding the NHS?

CHC members could be forgiven for believing that fundamental reform has already begun. After all, the newspapers are full these days of new attempts to save NHS funds. The proposed new charges for foreigners are only the most obvious example. Health Minister Dr Gerard Vaughan has been peppering administrators with ideas on how to cut costs. These range from using private contractors for hospital laundry, cleaning, maintenance, security etc, to sending more NHS patients to private nursing homes.

But these exercises should not be confused with the answer to Mr Jenkin's question. All the ideas listed so far would produce only candle-end savings. The proposed new charges for foreigners, for example, are expected to produce £5m for a service which now spends £11,000m a year. Putting patients in private nursing homes would probably not save anything because the Government has proposed that the homes could charge the equivalent cost of keeping the patient in an NHS bed.

It has been estimated that the NHS spends £115m a year on treating diseases linked to tobacco, and £70m on drink-related sickness, so a richer source of funds would be to charge smokers and drinkers when the NHS treatment they require is for an illness related to their habits. But as Sir George Young has pointed out, this idea raises thorny ethical problems.

Three of the items examined and rejected by the British Medical Association this year have a familiar ring. Requiring patients to pay for the "hotel" side of hospital life (ie bed and board) was looked at as long ago as 1950. The recently released Cabinet papers for the period show that the Attlee government considered imposing a ten-shilling-a-week "hotel" charge. But Attlee's ministers rejected the idea, as did Harold Wilson's Cabinet when the idea was put to it by Barbara Castle. Consultation fees were rejected by the BMA on the grounds that they could discourage patients most at risk, and voluntary fund-raising also proved unpopular.

No doubt all these options will have been noted by the inter-departmental working party on alternative finance for the NHS, which was set up by Patrick Jenkin in July. But it will not have needed to spend much time on any of them. The Royal Commission on the NHS looked at most of them in its 1979 report, and reminded ministers of the small amounts alternative sources of revenue could raise. At that time prescription and other charges only raised about 2% of the NHS budget, and fees for private beds less than 1%. A national lottery, it was estimated, would raise less than 0.5%. Over 97% of the NHS was paid for by taxes and national insurance contributions.

by Malcolm Dean, Social Affairs Editor, The Guardian

There are only two options which would raise significant sums for the NHS: a local health tax and health insurance. A local health tax can be ruled out under this government because it would

Insurance financing

What the Royal Commission said

In 1946 it was decided to introduce an "Exchequer-financed" national health service throughout the United Kingdom — and that is what we have had ever since 1948. In 1978/79, for example, 88% of NHS finance came from general taxation, 9.5% from national insurance contributions and only 2% from prescription and other charges.

By contrast, health care elsewhere in western Europe and in north America is commonly financed through insurance schemes, and the Royal Commission on the NHS commented in some detail on this alternative method of financing the NHS in its 1979 report.

There is no standard system of health insurance, but judging by the private health insurance schemes already operating in the UK a switch to an insurance-financed scheme would involve the following major changes:

- Each patient would be charged according to the service used, and wholly or partly reimbursed by an insurance agency.
- Insurance could be undertaken either by private agencies on a commercial basis or by some form of public undertaking.
- Those covered by the insurance would have some choice about the extent of cover they purchased.
- The insurance premiums could be paid either by the individual or by his or her employer.

"People would buy health insurance

Book reviews

Family planning, sterilisation and abortion services

by Isobel Allan, Policy Studies Institute, 1/2 Castle Lane, London SW1E 6DR, £4.35 inc. post

All aspects of birth control services — contraception, sterilisation and abortion — are examined in detail in two area health authorities from both consumer and professional viewpoints. The report concludes that while family planning is a "fact of life" for the majority of women, there are deficiencies in birth control provision generally.

Attention needs to be paid, for example, to speedier abortion referral procedures, better and quicker pregnancy testing, more sterilisation and vasectomy provision (free NHS vasectomy seems the exception rather than the rule), day-care abortion facilities, young people's birth control clinics, publicity for birth control and better communication between different parts of the NHS.

This useful and timely study provides a set of guidelines for action.

Dilys Cossey, St Thomas' CHC

Conscientious objectors at work

by Virginia Beardshaw, Social Audit, 9 Poland Street, London W1, £2.95 + 30p post

After 20 major enquiries in half as many years, no one can fail to know just how horribly wrong things may go for people who live and work in mental handicap and mental illness hospitals. The danger is that abuses of property and persons, harsh handlings and humiliations, even systems which are held together by rottenness cease to appall; they can seem, through these repeated cataloguings, almost an inevitable part of our institutional models. Individual members of staff who cry out against abuse tell us otherwise. How can we doubt that they should be cherished and supported as the best protection we can offer to those in their care?

Yet as this crucially important study shows, they too can be abused. Its careful analysis of the published reports, backed by interviews and case-histories, detail a horrifying range of sanctions wielded against complainers — from effective suspension, to ostracism by colleagues, to

THE NHS

mean a loss of some control in Whitehall.

This leaves health insurance. Dr Vaughan is being urged by right-wing organisations like the Adam Smith Institute to give large tax rebates to people who decide to opt out of the NHS and take out health insurance. At present just 6% of the population are enrolled in private insurance schemes but the ASI believes that 60% would opt out by 1985 if tax concessions were made.

Ministers will be much more cautious and realistic. They are fully aware, despite the Winter of Discontent in 1978/79, of the public popularity of the NHS. Even Dr Vaughan, who has always been much more enthusiastic about private insurance schemes than Patrick Jenkin, has emphasised to the Conservative Medical Association that he does not want to dismantle the NHS.

Two officials from the DHSS began studying insurance-financed health schemes a year ago. One went to the USA and the other looked at France, Germany, Italy and Scandinavia. Their reports have not been published, but will be available to the working party. An insurance-financed NHS would help reduce the demand on public expenditure, an obvious attraction for the present government, but the disadvantages are serious. All western states are now struggling to limit health expenditure, the demands for which are infinite. The USA is now spending over 10% of its gross domestic product on health, compared to our 6%, but this has not provided the US with a better system. It has encouraged even more high-technology medicine and less attention to primary care.

The reason why expenditure tends to increase under an insurance-based system is that insurance holders have no say in how their insurance scheme is run — whereas tax-payers have the vote! Most western states look with envy at the British model, and Italy has just moved from an insurance-based scheme to a tax-funded system. Another problem with insurance schemes is that they would destroy the founding principle of the NHS by creating a two-tier system — one health service for the comfortably off and another for the poor.

Studies of health insurance schemes in Europe have shown them to be very diverse. They differ in cover (all health costs, some costs or just a small contribution), choice (Belgium has six schemes, compared to West Germany's 1400), payments (in some the patient pays and is reimbursed, in others the doctor is paid directly), and coverage (some are voluntary, some compulsory and some leave significant numbers of people uncovered). When the Conservative Party was last in Opposition Patrick Jenkin himself warned of the dangers of some insurance-based schemes, pointing out that many people in the USA go bankrupt because they are unable to pay health bills.

When the DHSS officials began their study of overseas systems, one year ago, we were promised a speech from the Secretary of State on the issue. The speech was never made. The working party will labour on, but do not spend too much time worrying about a major new health finance Bill in this Parliament. It would be too complicated, too full of pitfalls and too unpopular.

much as they buy house or motor insurance. There would be competition between companies, and there might be a compulsory minimum level of health insurance in much the same way as owners of motor cars are obliged to take out third party cover. There would be good risks and bad risks among users, and premiums might vary accordingly."

One advantage might be that "patients, becoming more directly aware of what health care costs, would become more responsible in their demands on the service. However, fully insured patients would have little direct incentive to economic use of the service, because the extra costs imposed by their demands on it would be spread over the premiums of all those insured. By the same token, there would be little inducement for providers of the service to keep their costs down".

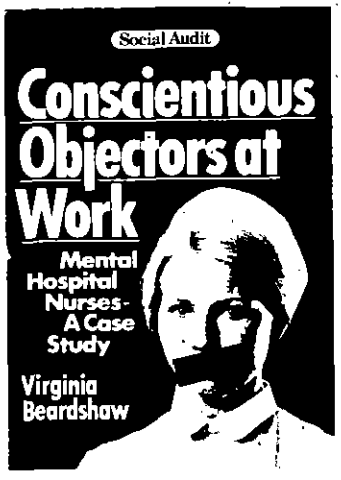
One important disadvantage would be that "there are groups in the community who are both bad health risks and too poor to pay high premiums. They include elderly people, children and the mentally and physically handicapped. Over 60% of NHS expenditure is currently accounted for by these groups ... poorer people tend to have worse health, but they are of course also least able to pay insurance and are most likely to be deterred by charges at time of use ... an insurance scheme which offered a range of benefits according to ability to pay would inevitably favour the wealthier members of society ... The introduction of an insurance system would incorporate into the NHS a new principle, namely that a different standard of health care under the NHS was available to those who chose to pay for it".

Another major disadvantage would be increased administration costs.

"We do not think that the NHS should be funded by health insurance. The advantages of the market place could well be real but there would certainly be significant disadvantages."

anonymous threats and more concrete damages. At no place in the hierarchy is the complainant immune from reprisal; unions and management alike may collude with abuse. Small wonder that student nurses learn early to balance their loyalties. Social Audit's questionnaire to 5000 of them yielded only 126 responses and at least one hospital advised its students to steer clear of such a contentious subject as the making of complaints.

External checks and safeguards cannot alone provide the protection of standards and their upholders that is needed. As Social Audit rightly concludes, vulnerable patients can be protected only if individuals feel free to act



according to their consciences when they recognise serious abuse. That means that the nursing unions have to put their own houses in order. It demands a new emphasis in the education of nurses. It means that managements must strengthen their own determination against abuse and make clear that the protection of complainants is part of their accepted duties.

It also means that CHCs must make it as plain as they know how that they will support the upholders of standards and, when necessary, get very tough indeed on patients' behalfs. The Davies committee on hospital complaints procedures recognised the importance of CHCs; it wanted a standard entry in every staff handbook in the land which not only made clear the duty to complain when things go wrong for patients, but told staff that the CHC was one of the places they could safely go if they were unable to talk to their own seniors.

But the new complaints procedure, finally produced by the DHSS, makes no mention at all of complaints by staff, far less how they should go about making them. Will the new DHAs fill this dangerous gap in expectations of staff behaviour? Social Audit found that over half of its sample of two thirds of the AHAs have not done so — and that only one authority in the country had instructions for staff which are wholly comprehensive and available to all who might need them. No one who cares about standards and quality in the NHS can afford to leave it at that.

Ann Shearer

"What would it be like to be a patient here?"

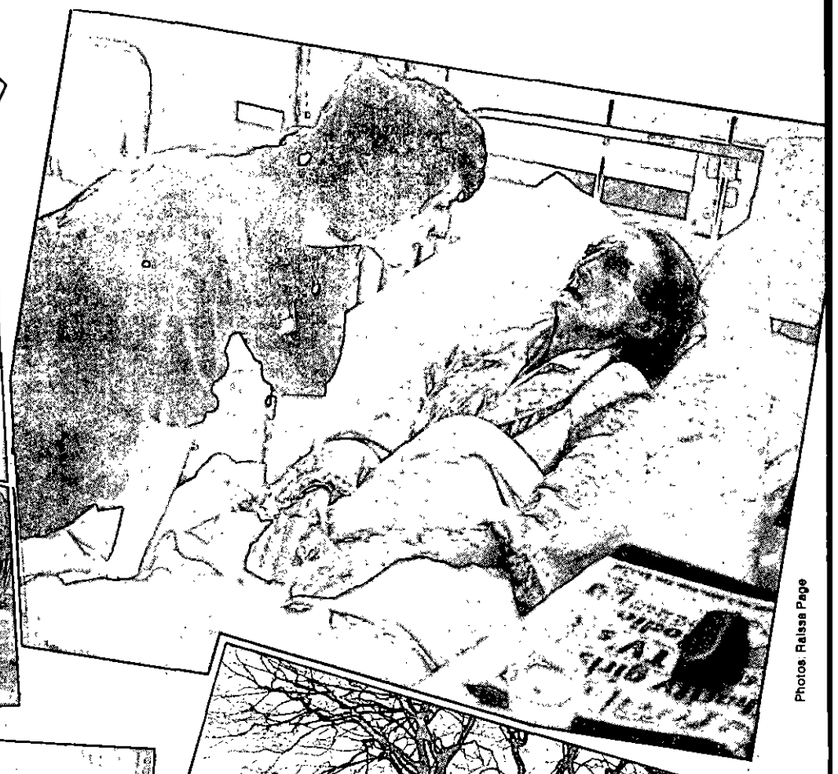
by Dr D H Dick, Consultant Psychiatrist and Director of the Health Advisory Service

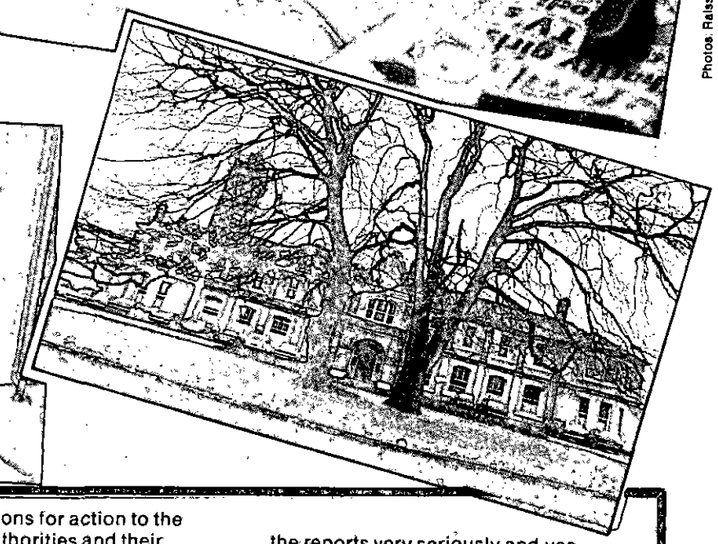
The Health Advisory Service is one of the ways in which the National Health Service checks the quality of services in both the hospital and the community. At present it is restricted to services for certain groups of more vulnerable patients—those that are likely to spend a long time in hospital. In twelve years of visiting, the Health Advisory Service has learned many lessons which might be of value to CHCs when they are planning to visit the component parts of the services in their district.

One of the most important lessons is the need to avoid the trap of concentrating too much on physical surroundings and not looking beyond to the experiences of people entering a complex institutional system. Such people are often vulnerable and are easily overwhelmed by practices that have almost certainly been devised to meet the working priorities of staff rather than patients. Old age is not an illness and mental illness is not a career, but strong forces need to be ranged against these assumptions to stop them being built into the daily lives of patients who are resident in hospital.

It is essential that a group of CHC visitors should decide on the objectives of a visit before starting and establish how they will know if the objectives have been met afterwards. It is a good discipline to produce a written report for the full council for later discussion with the health authority. Visitors should resist the conducted tour set up by senior staff, who will wish to influence the conclusions of the visit by selection. Such a tour may be designed either to show off areas in which there is pride, or to raise indignation about

Continued on page ten





Photos: Raissa Page

The Health Advisory Service

The Health Advisory Service was originally established in 1969 as the Hospital Advisory Service. It is responsible for informing and advising the Secretary of State for Social Services about the conditions and quality of care in long stay hospitals — that is geriatric, psychiatric and mental handicap hospitals. In 1976, the scope was widened to include both hospital and community-based services (including personal social services) for the elderly and the mentally ill. Except in Wales, mental handicap became the responsibility of the National Development Team for Mental Handicap.

In 1976 the HAS also took on responsibility for reviewing the care of children who spend long periods in hospital. Visits are now made jointly with the Social Work Service (SWS) of the DHSS. However the HAS remains independent of the DHSS to preserve the advantage of being able to advise upon the impact of central policy upon local services. It reports directly to the Secretary of State for Social Services in England and to the Secretary of State for Wales on Welsh services.

The director of the HAS is seconded for a three year period from clinical work as a consultant in the NHS and has so far been either a psychiatrist or a geriatrician. Team members are seconded for much briefer periods, usually a few months or so from current practice, though they may be senior staff who have recently retired. Typically a team consists of five people: a consultant in the relevant specialty, a senior nurse manager, a health service administrator, a remedial therapist and a social worker or social services manager. Additional members such as a clinical psychologist, a child psychiatrist, a community psychiatric nurse or a general practitioner may join the team to look at special issues.

A visit to a particular health district is planned about six months beforehand and lasts three to four weeks. Teams seek to inform themselves about all aspects of services for the group they are visiting — the elderly or mentally ill living in the district. Meetings are arranged with the health authority, the social services committee of the local authority, their management and service staff. General practitioners meet the team, and so do many individuals. The local community health council is invited to meet the team early in the visit with a prepared agenda for discussion.

Fifty letters are sent to patients who have recently been discharged from each hospital to be visited, seeking views of the services. Opinions are also sought from the DHSS, the regional health authorities, the regional offices of the SWS, voluntary bodies and, if interested, the trade unions. In effect the visit is an important occasion on which a community is asked to declare what it is doing for the elderly, mentally ill, mentally handicapped or chronically sick children in its midst. Discussion and questioning by a body of well disposed and knowledgeable strangers is stimulating. It can often lead to decisions over development, the re-ordering of priorities or filling in gaps in services on which action has so far been deferred. The team can reflect back the quality of the service by comparison with other parts of the country.

At the end of the visit, the team gives a verbal report with recommendations for action to the responsible authorities and their senior officers. A written report follows which is sent out in draft form to be checked for factual accuracy by the health authority and the social services department. It is then presented in its final form to the Secretary of State. Since August 1980, a summary of the report and a list of recommendations have been prepared by the HAS for the CHC. All reports are confidential and should be discussed in committee.

Advice often takes the form of suggesting where to look in other services for solutions that are known to work for similar problems. As well as reporting on services, the task of the HAS is also to spread good practice and new ideas.

The final stage of a visit is follow up. The HAS asks the health authority, the SWS and the local authority to respond to the report and its recommendations, six months to a year after distribution of the report. Authorities usually take the reports very seriously and use them to shape strategic planning of services and the correction of deficiencies. If the response is more loaded with promises than reports of action, a further follow up visit may be arranged to stimulate further progress. Within its present resources, the HAS is able to mount a full visit to a service about every five or six years but it also develops additional programmes to look at specific issues. For example, in 1981 brief visits have been made to over twenty health districts throughout the country to gather information about the functioning of psychogeriatric services with a view to drawing conclusions for general application about the best models to follow. Occasionally, on request, a special visit is mounted to evaluate a particular problem that is causing concern, but usually the programme of visiting is drawn up on the initiative of the HAS and does not require an invitation.

"What would it be like to be a patient here?"

Continued from previous page

those that are neglected. These objectives are entirely worthy but may not be the same as the objectives of the visitor.

The visitors should ask for a guide to take them through the hospital and have a brief feedback meeting afterwards with senior staff. And although the lay visitor cannot be expected to make evaluations of technical processes there is no reason to hold back the stranger's questions about the purpose of procedures and equipment, or not expect a clear explanation.

Personal choice

The tour that concentrates on physical surroundings reports the sights, smells and sounds that it encounters, the state of decoration, colour schemes, tidiness, cleanliness and orderliness. It observes the lavatories, comments on the food, clothing, furniture and heating. These are all very important but to leave it there is not enough. The real issues should concern personal choices for patients — their privacy, dignity, personal space, personal possessions, self determination and sense of usefulness.

People who enter hospital for a brief period hand over control of their lives, bodies and personal dignity quite willingly in the interest of soon being restored to health. They rapidly regain control as they improve and go home relieved to be able to tell tales of the cameraderie of the surgical ward and how they outwitted the iron rule of the forbidding staff. The elderly and the mentally ill may never regain control of their own lives — the mentally handicapped may never be given it. Personal possessions are a nuisance in an institution, personal clothing cannot be laundered, personal space becomes untidy, providing choice wastes staff time and anyway the staff come to assume that they know what is best for the patient. So the individual becomes submerged in conformity and loses forever the habit of coping for himself.

Examining these aspects of hospital life is not as difficult as it might appear at first sight. The visitor only has to compare the number of choices he or she has made since waking that morning with the choices made by a resident patient to get an excellent idea of the quality of life available. These are choices about time, clothing, washing, breakfast, transport, who you talk to, where you go. In a thoughtless hospital the patient will have had only one choice — whether to conform with the system or not. In a thoughtful one there will be evidence that choice is available through staff attitudes, wardrobes that lock, single rooms or cubicles, domestic laundry, menu choice or a self-service restaurant, a bank with real money, libraries, self-service shopping, a range of activities and useful work. The visitor only has to ask "what would it be like for me to be a patient here?" or "what would happen if I wanted to complain?" to answer many questions about the quality of life for patients.

A comprehensive system?

No hospital should ever be visited in isolation. The inpatient beds are only part of a service. How do people enter or leave the system? Is one patient here because there is no day hospital or another because help came too late to prevent caring relatives abandoning care? What will happen after discharge? Is there a comprehensive system linked to the social and welfare services that is designed to meet all the needs of patients and their relatives going through an episode of illness?

The Health Advisory Service and Social Work Service seek the partnership of the CHC during a visit although at present HAS reports are confidential. Even so, in future, a visit could easily become the occasion for negotiation within a community about the quality of care and the priority that this community gives to its elderly, its mentally ill, its mentally handicapped and its vulnerable sick children.

Parliament

Destruction of patient records

Following the recent discoveries on public land of patient records intended for destruction, the DHSS has written to all health authorities asking them to review their procedures for destroying confidential material. It has also reminded them of the need to use methods which ensure that full confidentiality is maintained (Greville Janner, Leicester West, 19 October).

Home helps

During the year ending 31 March 1980, 660,000 households in England with at least one member aged 65 or over received a home help. The net cost of the home help service to local authorities was £157 million. A further £3.5 million was provided by health authorities in joint finance contributions (George Foulkes, South Ayrshire, 27 July).

Child benefit

From 15 March 1982 mothers becoming eligible for child benefit will normally be paid the benefit every four weeks in arrears, instead of weekly. Those whose entitlement began before this date can choose to continue with weekly payments. New recipients can opt for weekly payment if they are single parents or if their family gets supplementary benefit or family income supplement or if they can show that four weekly payment would cause hardship (Frank Field, Birkenhead, 23 October).

Compensation

There are no resources available to finance the special benefit for severely handicapped children recommended in the Pearson report on compensation. At a weekly rate of £6 a week it would have cost £23m in 1980-81. Nor has the Government any intention of amending, amplifying or extending the present vaccine damage payments scheme or introducing new legislation on vaccine damage (George Foulkes, South Ayrshire, 21 July).

Sickle-cell anaemia

Health Minister Dr Vaughan does not consider that an inquiry into the incidence of sickle-cell anaemia among ethnic minority communities "would serve a useful purpose". He says that there is already considerable information on the groups at risk. High risk patients are generally screened prior to anaesthesia and are always screened during pregnancy. Many hospitals serving at-risk communities offer screening facilities on request either from individuals or their GPs. Couples found to be at risk of having an affected child may be referred to genetic counselling services (Michael Brown, Brigg and Scunthorpe, 6 July).

Transfers from special hospitals

In the first nine months of 1981 169 patients were transferred from special hospitals to NHS hospitals — compared to 106 in the corresponding period in 1980. Junior health minister Geoffrey Finsberg calls this "a very significant improvement" and says the position will continue to be monitored (Robert Kilroy-Silk, Ormskirk, 19 October).

What women want – *A flexible service*

This is the second of three articles in which Jo Garcia discusses CHC surveys about maternity. Here she looks at the findings of 24 surveys about care at and around the time of birth.

*by Jo Garcia**

Nearly 5000 women from all over England took part in these CHC surveys about care at and around the time of birth. Many common themes emerge in spite of the marked variations in the questionnaires used and the wide range of local circumstances.

For those who provide maternity care these surveys provide invaluable information about the strengths and weaknesses of the services, and the unmet needs of childbearing women. At the same time, they reveal the inconvenient fact that not all women want the same things from the services. Women have different experiences, needs and circumstances, so any care that is offered will best fit their needs when it is flexible and allows the widest possible choice. It should be noted that very few home births were represented in these surveys.

Women's views about the length of time they spent in hospital after the birth illustrate the need for a responsive and flexible service. In many surveys a sizeable minority of women would have preferred a shorter or, more rarely, a longer stay in hospital. Some had been offered a choice — for example between 48 hour discharge and five or seven days in hospital — but they had to make the choice early in pregnancy. Few women can foresee at 14 weeks of pregnancy how a birth will affect them. It ought to be possible for a woman to make provisional plans about the length of her stay in hospital which if necessary can be altered later. The survey findings suggest that a more flexible approach to discharge would reduce the average number of days spent in hospital and could allow staff to spend more time with women who really need their care.

Several other aspects of hospital care emerged as rather rigid. It is clearly a difficult task to provide a service of a uniformly high standard to a diverse group of women. Many women were dissatisfied with the visiting arrangements in their hospital. In some places there was a consensus about the changes that were needed. In these cases the results of consumer surveys should enable hospitals to provide the most satisfactory compromise between ready access for a woman's family and friends and the need for rest and privacy. In others, women in the same hospital wanted contradictory changes in the timing and selectiveness of visiting arrangements. A mother summed up very well when she said that visiting times were too short when you had visitors and too long when you had none.

Rooming-in and the arrangements for night-time feeding also present problems, especially in large wards. Not all women want to have their baby with them all night, especially at first and they may find other mothers' babies very disturbing. On the other hand women separated from their babies may be anxious about them during the night and concerned about the interruption of breast feeding. The surveys reveal the wide range of current practice in feeding and sleeping arrangements. Strict regulations about feeding and holding the baby still exist in some hospitals although change is certainly taking place.

One important consequence of changes in practice, especially on infant feeding, is the extent to which mothers complain about conflicting advice. Some differing opinions about care are inevitable and healthy but women in hospital tend to find these differences of opinion confusing and troublesome. They may lack confidence and experience and need clear advice about their new babies. Many women find that they are "told off" for following instructions given by the previous team on duty. This demoralising experience can to some extent be avoided by the adoption of clear policies by all care givers. However it is necessary to make policies flexible and to discourage an authoritarian approach by staff to mothers in their care. It is remarkable how seldom a relaxation of the "rules" of hospital maternity care seems to have resulted in chaos, infection or other disasters.

Women report that they appreciate accessible and caring staff at all stages of maternity care. During labour they welcome explanations about medical procedures and about hospital routines. They are sensitive to evidence of staff shortages and sometimes report being left alone at times when they need support.

While the human aspects of care in labour and after delivery are evidently important, most surveys also review opinions on food, noise, cleaning standards and toilet facilities in hospital. Administrators should find valuable the specific findings about non-smokers forced to share a single lounge with smokers or about Asian mothers unhappy with the food provided.

The surveys highlight the needs of special groups such as the parents of babies admitted to intensive care units or mothers discharged early to the care of community midwives. Many report that facilities for fathers present during the confinement are rather inadequate. Local problems of care after mother and baby return home can be identified — as in one London survey which found that a few mothers had no visit at home from a midwife or a health visitor.

Finally, it is good to note that one report comments on the absence of facilities for changing and feeding babies in the local town centre. No amount of devoted and thoughtful care by professionals can remove the responsibility of all of us to see that children and their parents receive the social and financial support that they need.

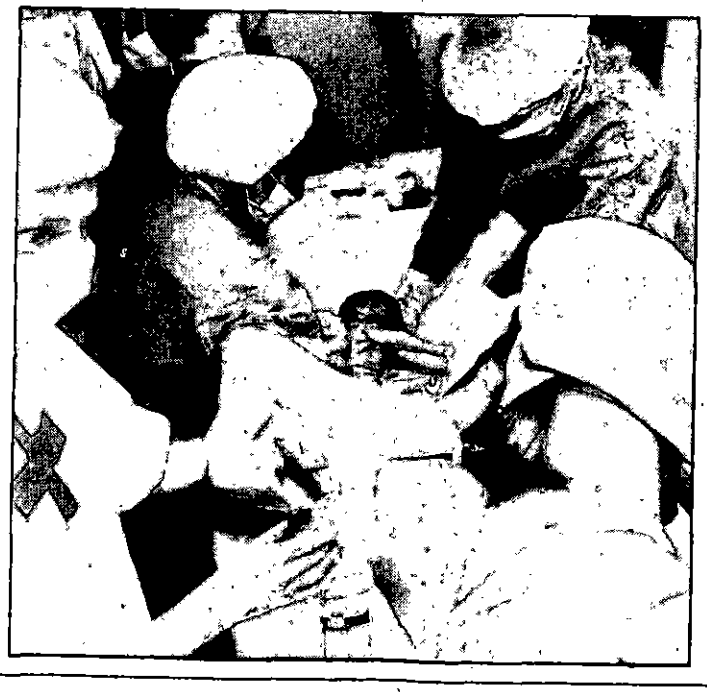


Photo: Sally and Richard Greenfield

* *Jo Garcia works at the National Perinatal Epidemeology Unit, Oxford.*

Jo Garcia's first article — on antenatal care — was published in CHC NEWS 70. Her third article will be published later and will look at the lessons to be learnt about survey methods.

GOING TO THE SHOW?

by J A Dunning, Secretary, Norwich CHC

One aspect of publicity that was not touched on at the CHC publicity seminar at the Association of CHC's AGM was the possibility of having a stand at the local "show" or fair. For the past four years Norwich CHC has had a publicity and display stand at the Royal Norfolk Show. It has been a thoroughly worthwhile exercise — a very good way of letting the public know about CHCs.

With each year we learn more about how to attract the public, and the number of people calling at our stand out of curiousity or the need for information or help has gradually increased.

It seems to us that it is useful to have an eye-catching theme because then those stopping to look at it can be captured and steered towards the main CHC stand. Our special emphasis this year was on the need for well woman clinic facilities — which are not provided in this health district. A small separate stand was prepared with the help of the health education department and special leaflets were printed and added to those already available on cytology, breast examination etc. We were surprised at the interest this generated — in a line of sombre stands perhaps the large colourful garden umbrella above our stand attracted attention.

This year we invited the local health education office to join forces with us. This meant that many more of its attractive coloured leaflets were available and the presence of a health education officer at the stand gave us a very useful extra pair of "specialist" hands.

About 5000 sets of literature were handed out or requested by callers at the stand. Packages of information about the CHCs were made up and given to passers-by or those actually stopping to look at the stand and various other relevant information leaflets and booklets were handed out. We try to match people to the literature we are offering — eg a *Stop smoking* booklet to someone with a cigarette on the go, *Looking after yourself in retirement* for an elderly lady. Children were usually handed a varied bundle and told that there was something in it for all the family. They seem to compete with each other to see who can collect the most information, badges and "bumf" and we hope that when they get home mum and dad have a look at what they have brought.

As far as helpers are concerned — about four at a time seems to be the right number. We have the secretary and assistant, and members on a rota basis.

The stand used by the CHC is a touring caravan — my own — plus an awning which houses the display material. This can be put out on a couple of wallpaper pasting tables covered with cloth and the space under the tables can be used as a store for replacement literature. Those who don't have access to a caravan and awning could consider hiring them — or alternatively could consider hiring a suitably sized tent.

If a tent is hired don't forget to hire a camping stove and equipment as well. These are for making the vital cups of tea which revive wilting helpers. Small folding garden chairs are also necessary for this purpose. It might be just as well to advise all helpers to bring a pair of wellington boots — it has been known to rain at the Royal Norfolk Show and it's amazing how muddy showgrounds can become after only a little rain.

If you want to have a stand at a show in your locality contact the county agricultural association which is in charge of organising the local county show. In towns get in touch with the recreation officer of the local council who should be able to put you in contact with the people organising the major fetes and fairs in the borough. Remember that you need to book well in advance — it's best to make contact soon after the previous show has ended as pitches at these shows are much sought after. In Norfolk, entries for a show in June close in mid January.

As to cost — in 1981 a well-sited pitch with a frontage of nine metres costs about £100. And you may also need to buy extra entry tickets for your volunteers if you do not get enough free ones.

One final remainder — if you use a caravan of your own, or hire a van or tent, don't forget to insure it for the duration of the show.

ROUTINE TESTS REINSTATED

by Peter Arnold, Chairman, Gloucester CHC

After a campaign lasting many months, Gloucester CHC was delighted to learn that a full cervical cytology smear service will be reinstated in the Gloucester health district. In other words, routine cancer smear testing would again be available to women under 30 years of age.

The story goes back to February 1979 when the area health authority announced that it was discontinuing its previous practice of routinely screening the under 30s. (It is worth emphasising that the restriction applied only to *routine* testing — anyone who had unusual symptoms or who had some reasons to be worried could always have a smear taken.)

The action taken by the AHA naturally aroused a great deal of reaction — women's organisations and the press were among the many who took up the issue. The CHC was unanimous in opposing the decision.

From the outset of the campaign to get testing reinstated, the CHC found difficulties in the contradictions which arose when the need for routine testing was investigated. DHSS policy is that all women over 35 or under 35 who have had three pregnancies should be screened once every five years. Local professional opinion varied — one doctor going as far as to say that smears should be taken annually.

The reasons for the AHA's restriction were also contradictory at first. The CHC was given various explanations — that it was impossible to recruit trained technicians, to undertake the tests — then that untrained technicians could be recruited, but it would take six, nine or even twelve months to train them. Finally, on a visit to the pathology department of Gloucestershire Royal Hospital, members were told that competent technicians were available but were engaged on other work.

It seemed that the facts of the matter varied according to who was supplying the information. Eventually the reasons for the cut emerged as follows:

Two technicians who were processing smears had resigned from the pathology department. They were replaced fairly quickly but the lengthy training period meant that the backlog of smears waiting to be processed was steadily increasing. There was no possibility of technicians being asked to work longer hours to clear the backlog. The nature of the test — careful examination of slides under a microscope —

WARNING: Adverts may damage children's health

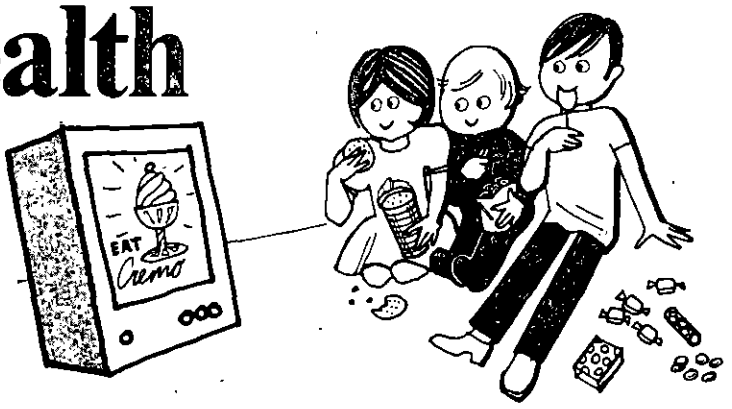
by Penny Cloutte, Research Worker, City and Hackney CHC

Many products which are advertised on television around the time of children's programmes are hazardous to children's health. Products such as chocolate bars, with a high sugar content, are advertised on Saturdays in the breaks during and around the popular children's programme *Tiswas*.

The dangers of sugar are well documented. Refined white sugar has been implicated as a factor in causing heart disease, diabetes, hypoglycaemia and obesity, and its connection with dental caries is well established. Eating refined white sucrose is particularly dangerous for children for two reasons:

- It is addictive and could threaten their safe eating habits for a lifetime.
- Eating sweets between meals, without any other food being eaten at the same time, is the quickest way to promote caries — ie rot your teeth.

More subtle health hazards are also implied in these adverts. An advertisement for one doll shows a baby being bottlefed, then cuts to a little girl feeding the doll with a bottle while a voice over tells us that the doll is "more natural than ever". This suggests that bottle-feeding is "natural" — against both medical opinion and historical fact.



Cartoons from "Feeding growing children" (BMA)

Government reports have repeatedly found that "breast is best" for a variety of nutritional, economic and social reasons. Infant formulae are expensive, difficult to mix in the right proportions, less well-adapted to infant human digestive systems than breast milk and possibly carry a long-term risk of heart disease. They may also be unnecessarily sweet — containing refined sugar — and therefore prepare the infant for a lifetime's addiction to sugary artificial foods.

Another doll advertisement starts with a shot of a child combing colour into the doll's hair while a voice proclaims that "every girl dreams of lovely hair". Yet it has been established for some years that hair dyes are potentially hazardous.

These adverts not only risk long-term harm to the mental, moral and physical health of children, contrary to the first paragraph of the first appendix to the Independent Broadcasting Authority's Code of Advertising Standards and Practice, but in my opinion they also contravene paragraph 9 of the Code. This states that no advertisement may be "directed towards a political end" or "show partiality as respects matters of political .... controversy or relating to current public policy". The role of women in our society is now a matter of heated controversy, with some people — including Government ministers — stating that a woman's place is in the home as an unpaid childminder and servicer of men, while others — most notably women — challenge this view.

The doll advertisements are also a threat to the long-term well-being of children in non-physical ways. They advocate a stereotyped view of women's roles which must be highly damaging to both sexes — and especially to the self-image of girl children. One doll becomes "lovely" by having artificial colour combed into her hair and her owner "dreams of how she'll live" as a cook and consumer of electrical gadgets. Another doll tidies her bed, makes herself "pretty" and puts on nice clothes in order to make friends for her owner.

This view of femininity as obsessed with neatness, tidiness and appearance, and this dreaming of serving others through housework and cooking, is highly dangerous to the self-esteem of little girls. A child who absorbed such a message would be in danger of inflicting all kinds of psychological and physical mutilations on herself when she grew up.

It is a moot point how far these adverts contravene other parts of the IBA Code. For example, although the Code's appendix forbids the encouragement of sweet-eating throughout the day, it does not forbid the advertising of sweets — despite the well-documented threat that these present to children's health. Children should not be shown using "medicines, disinfectants, antiseptics and caustic substances" without parental supervision, but mutagenic and possibly carcinogenic hair dyes are apparently OK.

City and Hackney CHC has now written to the IBA, the Advertising Standards Authority, the Health Education Council and advertising agencies, making all these points and asking them to change their practices. If other CHCs want more details about this issue they can contact me at City and Hackney CHC.

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meant that a three-hour session was as much as a technician could be asked to undertake before fatigue set in and accuracy became questionable.

It must also be admitted that the pathology department had to some extent become a victim of its own efficiency. The system of recalling patients who exhibited suspects smears had recently been very much improved. This contributed to the workload and therefore to the backlog. Furthermore the neighbouring laboratory at Cheltenham was working at full capacity and could not be asked to assist.

Clearly there was a need for more technicians before the full service could be resumed. With valuable help from the press the CHC campaigned for this. The campaign culminated in a personal approach to the AHA chairman and every member of the authority by the CHC chairman in January 1981.

A report to the AHA by the area medical officer followed and the authority responded by recommending that two additional technicians be recruited. They have now been appointed and are being trained. The full service should be in operation again by next May or June.

The total cost to the AHA of supplying two extra technicians plus clerical support is estimated at £17,000 per annum. It seems likely that even if only one or two cases are picked up at the pre-malignant stage rather than later this cost will be more than recouped.

GOOD PRACTICES IN MENTAL HEALTH

by Kevin Richards, Information Officer, GPMH

How did Newcastle CHC help in planning a support group for agoraphobic people in Oxfordshire? How might one organise a holiday service for patients in mental hospitals? Where are there examples of boarding-out schemes for mentally ill people in the community? Many CHCs who are well informed and committed to improving their mental health services already know one answer to questions such as these —ask the Good Practices in Mental Health project.

The GPMH project was set up by the International Hospital Federation in 1977 to discover and publicise details of noteworthy small-scale schemes for aiding mentally ill people and their families — schemes which often go unnoticed outside their own immediate locality. The project relies on the willingness of local people with an interest in mental health — both lay and professional — to collect information about effective services in their area. In return it offers a central information exchange through which the ideas and techniques collected in these local studies can be shared.

The initiative to organise a GPMH study, set up the few necessary meetings and provide clerical back-up, requires a group with reasonable mental health experience and a solid organisational base. This has often been found in the local CHC or association for mental health. CHCs have played a major part in GPMH development — their independence and their wide range of contacts in local health services gives them an ideal base from which to co-ordinate the work. Of the 35 studies currently under way or completed in England, over half have been co-ordinated either wholly or in part by CHCs.

The method used in the local studies is very simple and flexible, and sufficiently inexpensive to be carried out by communities of any size. Each local study begins with the formation of a "core group" of local people from statutory and voluntary services concerned with mental health care. They take on responsibility for the progress of the study and its final published report. They arrange a "springboard" meeting, inviting a wide range of local people interested in services for the mentally ill and their families. These people bring suggestions about which services are working particularly well in their locality.

An "information gatherer" — often a mature student or volunteer — then collects details of those services selected by the core group from the suggestions received at the springboard meeting. The information gatherer writes a brief description of each of these schemes according to a set of standard guidelines provided by GPMH and then submits them to the core group who use their knowledge and local experience to select the ones which go into the final report.

The outcome of each local study is a published report containing descriptions of local services for people at risk due to stress or mental ill health, but there are other equally important though less tangible results. The identification of good local services raises the morale of the staff involved and frequently brings to light little known resources. The studies also have an educational role — they have formed the basis for local conferences and have been used as a resource in training programmes for social workers and hospital staff. CHCs have found that the "non-threatening" approach of the project can help to break down the barriers between the organisations involved and clear the way for closer co-operation on the planning of future services.

Using material extracted from the local study reports the GPMH information service can provide enquirers with information about specific types of schemes. It can also supply names and addresses of local project co-ordinators.

If you think your CHC might like to take part in a GPMH local study, or if you want to use our information service, please contact GPMH, 67 Kentish Town Road, London NW1 8NY. Tel: 01-267 3054. The *GPMH guide to organising local studies* is available from this address, price £2.50, cheques payable to "International Hospital Federation".

CHCs which have published GPMH local studies

Basildon and Thurrock	Haringey	Oxfordshire
Central Birmingham	Newcastle	Sheffield
Coventry	North Camden and South Camden (jointly)	Southend
Exeter and District		Torbay

Other CHCs actively involved in published GPMH local studies

Bromley	Norwich	Salford
Cambridge	Redbridge	

CHCs presently involved in GPMH local studies

Ipswich	Southern	Medway
Islington	Liverpool Eastern	Wirral Southern
Kensington-Chelsea-Westminster (South)	Manchester Central	Worcester
Liverpool Central &	North Manchester	
	South Manchester	

Your letters

Continued from page two

Dental therapists under threat

Mrs Angela Willatt, Member, Greenwich CHC

I am a trained dental therapist, and I was interested to read the article on page four of *CHC NEWS 70* about the recently published DHSS report *Towards better dental health*. The report made many welcome recommendations, but includes two which in my view are totally unacceptable. These are to discontinue the class of dental ancillary known as dental therapist, and to close the training school for dental therapists at New Cross, in south London. These proposals are in direct opposition to those of the Nuffield Report and the Royal Commission on the NHS.

Dental therapists are trained at New Cross to treat children of all ages. At present they are only allowed to work in the community services, not in general practice. They treat dental disease by fillings and extraction, and are trained to carry out preventive techniques. They teach dental health education at the chairside and in larger groups, eg in antenatal clinics, schools, mother-and-toddler groups and similar. They can offer a great deal to patients, and it would seem logical to allow them to work within the general dental service, where they can play a useful role in the dental team.

The New Cross School for Dental Therapists has existed for 21 years. The experience gained over those years will be wiped out if it is closed. There are eight other types of therapist within the NHS, and I wonder how the public would feel if one of those other groups of therapists was similarly threatened?

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.

Crossing the Humber

John Fryer, Secretary, Scunthorpe CHC

CHC members may be interested to know that it is possible for people receiving mobility allowance to apply by post for vouchers which will enable them to have free use of the new Humber Road Bridge. The address to write to is, The Bridgemaster, Humber Bridge Board, Administration Building, Ferriby Road, Hessle, North Humberside, HU13 0JG.

The toll is £1 each way for ordinary motor cars, so this is quite a concession but unfortunately it is only known to local people. We would like to publicise this facility to people living in other parts of the UK who may wish to travel across the Humber bridge on holiday or on business.

Scanner

Getting it right?

Is the title of a guide to the 1982 reorganisation of the NHS, perhaps hinting at some sceptical reservations on the part of the publishers, the Institute of Health Service Administrators. The shape of the future is still not clear — CHCs for example still await government decisions. But IHSA's bold step in publishing a guide to the story so far is to be welcomed — the bones of the new NHS are clearly marked out. There are sections on health authorities, management arrangements and costs, professional advisory machinery, family practitioner services, as well as area services such as supplies and the ambulances. *Getting it right?* by Norman Chapling, from Institute of Health Service Administrators, 75 Portland Place, London W1N 4AN (£2.75 inc post).

The unkindest cut

Episiotomy is the most commonly performed obstetric operation. In some hospitals it has now become routine to cut the skin at the vaginal entrance during childbirth. The National Childbirth Trust's booklets cover this controversial procedure very thoroughly and will aid the growing consumer pressure on doctors to reassess the need for episiotomy. *Some women's experience of episiotomy* by Sheila Kitzinger and Rhiannon Walter (60p) and *Episiotomy: physical and emotional aspects* edited by Sheila Kitzinger (£1.50) both from National Childbirth Trust, 9 Queensborough Terrace, London W2 3TB.

Sick or sad?

Is the title of a booklet, written by Dr Dick Thompson, to his recent series of talks on BBC Radio Four about depression. It is helpful and remarkably free of jargon. From Mental Health Foundation, 8 Hallam Street, London W1N 6DH (free).

Grants for work with the disabled

Grants to support voluntary work with disabled people are available from the Royal Wedding Souvenir Fund. The fund was set up by the Royal Jubilee Trusts to receive the proceeds from sales of the official souvenir and programme of the royal wedding, and from the fireworks displays. It aims to distribute this as grants by the end of next March. Application forms from the Director, The Royal Jubilee Trusts (RW), 8 Buckingham Street, London WC2N 6BU.

Professional conduct

The blue book has been updated — the General Medical Council's advice to doctors about what is and is not considered within the bounds of "professional conduct". Following the recent growth of private hospitals and cosmetic surgery clinics, the GMC has clarified its advice to GPs about patients who ask to be referred to specialists. There are also guidelines about doctors' advertising. GPs are warned, "consider very carefully any request by a patient for a second opinion even if .... not convinced that such consultation is essential". *Profesional conduct and discipline: fitness to practise* from the General Medical Council, 44 Hallam Street, London W1 (25p inc. post).

The case against private medicine

The private medicine care sector is expanding more and more rapidly. The Politics of Health Group — "a discussion forum for doctors, nurses, research workers and users of the health service" — is

strongly opposed to this trend. Its booklet contains a survey of recent private hospital developments and information on insurance and treatment costs. It also examines why more and more people are turning to the private sector and attacks the claim that private medicine helps the overworked NHS. *Going private* (70p plus 30p post) from POHG, 9 Poland Street, London W1V 3DG.

Complaints: pick of the bunch

Poor handling of complaints made to family practitioner committees has caused the Ombudsman concern this year. In his report, *Selected investigations completed April-September 1981* (HMSO £7.70), the Health Service Commissioner takes an FPC administrator severely to task for failing even to acknowledge a complaint and totally failing to look into it. The official told the Ombudsman that the "tried to ignore the complaint in the hope that it would go away". Totally inexcusable, says the report.

FPCs' handling of complaints also cropped up in the deliberations of the Parliamentary Select Committee which examined the health Ombudsman's annual report for 1979-80 and heard witnesses. The MPs learned from the DHSS of the minor reforms of the complaints procedure which have recently been implemented but, apparently not satisfied by this, they asked the Department to issue further complaints procedure guidance to FPCs. *House of Commons Select Committee on the Parliamentary Commissioner for Administration First Report, Session 1980-81* (HMSO £4.20).

City health

Is a new supplement to *Inter-City Network*, the bi-monthly newsletter of the National Inner Cities Unit. The first two issues cover local community health initiatives, funding information and coming events. Subscription details from National Council for Voluntary Organisations, Inner Cities Unit, 26 Bedford Square, London WC1B 3HU.

Inpatients' benefits: HN(81)29

Mobility allowances, therapeutic earnings and pocket money for long-stay patients all increased last month, as well as travel allowances for in- and out-patients. Details in DHSS circular HB(81)29.

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: Hartlepool CHC Chairman: Coun. W Middleton. 32 Victoria Road, Hartlepool, Cleveland TS26 8DD (return to permanent address).
Page 3: Harrogate CHC Chairman: Coun. Miss K M Bradley
Page 5: Great Yarmouth and Waveney CHC Chairman: G V James
Page 5: North Bedfordshire CHC Chairman: Mrs Margery Hamer Harries
Page 6: North Herts CHC Chairman: Allan Brett
Page 6: Ealing CHC Joint Chairmen: Tony Oliver and Mrs Rosemary Robinson
Page 8: Dartford and Gravesham CHC Chairman: Mrs Helen Skellorn
Page 8: Maidstone CHC Chairman: A R Lawrence
Page 10: Salisbury CHC Chairman: Len J Carroll
Page 11: Frenchay CHC Chairman: Coun. George Bee
Page 13: Rugby CHC Chairman: Coun. Mrs E A Byrom
Page 13: Central Birmingham CHC 2nd Floor, Ringway House, 45 Bull Street, Birmingham B4 6AF. Tel: unchanged
Page 13: Wolverhampton CHC Secretary: G M Walsh. Chairman: Mrs P Byrne
Page 14: Southern Sefton CHC Chairman: Mrs B E Roberts
Page 15: Blackburn CHC renamed Blackburn, Hyndburn and Ribble Valley CHC. Chairman: D G Lund
Page 15: West Lancashire CHC Chairman: Mrs A A Wynne
Page 15: Bolton CHC Chairman: K Hahlo
Page 16: Clwyd South CHC 9 Grove Park Road, Wrexham, Clwyd LL12 7AA. Tel: unchanged.
Page 17: Arfon-Dwyfor CHC Chairman: Huw Williams
Page 18: Northern Region Association of CHCs c/o South East Cumbria CHC, 60 Highgate, Kendal, Cumbria LA9 4TG. Chairman: Mrs Susan Buckingham, Secretary: Mrs Fiona Drake. Tel: Kendal 21304.
Page 20: Borders LHC Chairman: J H Millar.

News from CHCs

☐ After approaches from **City and Hackney CHC**, local brewers and distillers have agreed to provide funds for a small alcohol counselling service in Hackney. This followed on from a very well-attended public meeting organised by the CHC on "alcohol and its problems". Many people spoke at this of the need for a local counselling service. A full-scale project was drawn up and put forward for joint finance but pending the outcome of this application there seemed to be a need for a basic counselling service now. This is where the CHC came in. The brewers' grants will fund a weekly counselling session in Hackney for a year or more and the CHC hopes that the existence of this temporary service will help the joint finance application.

☐ As the names of disabled drivers are displayed on their orange parking badges **Darlington CHC** was disturbed to hear that a group of youths had been seen hovering around a disabled person's car and peering at the orange badge. The CHC is worried that vulnerable disabled people could easily be traced through the telephone directory and it is pushing for the name to be replaced by a serial number. The CHC has written to the Department of Transport which says that a serial number would make enforcing the system too difficult. The CHC is now hoping that the all-party Disablement Group will take up the issue and the local MP is asking a parliamentary question on it.

☐ **Lewisham CHC** is advertising for a community worker to assess how far the CHC could stimulate interest in health issues among the local community. The CHC has managed to get a grant from the Health Education Council for three years for this worker. As far as the CHC knows, this is the first time the HEC has funded such a project. The worker will be doing "action research" — first finding out local people's views about health care and then looking at ways of overcoming problems that were shown up in the survey.

☐ Relatives of mentally handicapped patients at a long-stay hospital in Avon were very upset when the bus which used to take them to visit the hospital on Sundays was suddenly withdrawn. Many of the relatives, and staff at the hospital, contacted **Southmead CHC** who got in touch with the bus company involved. Eventually the CHC was able to persuade the company to re-route one of its buses to call at the hospital again. Apparently the company felt that for the sake of goodwill it was worth making the half mile detour to the hospital. The CHC is very pleased with the outcome —the bus was only off for a month.

☐ **In Hamilton and East Kilbride**, the LHC managed to get an equally successful solution to a similar problem. British Rail withdrew the special train it had been running to a longstay geriatric hospital and visitors from Hamilton were unable to reach it by public transport. The LHC contacted the local bus service who willingly agreed to provide a bus to the hospital. This followed action by the LHC the previous year when it persuaded the bus service to put on a direct bus to a psychiatric hospital — previously visitors had had to take three buses and the round trip had often taken four or five hours.

☐ Meanwhile **Airedale CHC** is trying to persuade the local county council to reopen a station or introduce a "halt" near Airedale General Hospital. At the moment the train whistles straight past and it would make life much easier for patients and their relatives if the train would stop.

☐ *This is the first public telephone box specially designed for disabled people — and it's in* ***Oldham*** *because the CHC persuaded British Telecom of the need for a phone box for wheelchair users. The CHC's approach was an added spur to the company which had already been considering the problem. The photo shows the official opening — the lady is CHC member Mrs Hunt and the man in the wheelchair is co-opted member Steve Ogden.*

☐ The Government's plan to cut the lead content of petrol by 62% in 1985 is "not acceptable", a seminar organised jointly by **North Birmingham CHC** and the **Association of CHCs** has concluded. CHC representatives at the meeting called instead for a cut of 88% by next June, followed by "the elimination of the use of lead in petrol, which it is believed is technically and commercially practicable to achieve by January 1984". Amongst the panel of expert speakers was a senior engineer from BL Technology Ltd, who explained that acceptable substitutes for the lead "anti-knock" additives are already available, and that if necessary it is "perfectly straightforward" to design engines that will run on lead-free fuel. The meeting voiced its concern at the threat environmental lead poses to the health of young children, and also called for the elimination of lead from domestic paint. ACHCEW was urged to "instruct the public" about the hazards of lead.

☐ Following allegations of racist screening procedures at Heathrow Airport's health control unit, made in **Brent CHC's** report *Black people and the health service* (see *CHC NEWS 67* page 16), **Hillingdon CHC** revisited the unit. The CHC disputes Brent's finding and its own report says that "immigrant are treated with courtesy and competence". Hillingdon CHC calls for all immigrants to be medically examined in their country of origin — it is concerned that dependents of permit holders are not screened in their original country and cannot be forcibly detained for treatment if found to be ill on arrival at Heathrow. The CHC understands that half the addresses given by new arrivals are incorrect and proposes the introduction of a more efficient system of checking immigrants' destined addresses before they travel. The CHC says that it has had "surprisingly little reaction" to its report.

☐ When members of **South West Durham CHC** heard about volunteer schemes to help terminally ill and chronically sick patients they wondered if there was a need for such a scheme locally. After doing a survey which showed that there was, the CHC set up a scheme involving volunteer retired nurses who relieve the family and friends of patients for periods from two hours to all night. The CHC pays the volunteers' expenses using money it has raised in grants and donations.

☐ *November in* ***Manchester*** *was Thank U month — members and staff of the three CHCs are shown here starting their campaign to get members of the public to nominate NHS staff who had been particularly kind or helpful. The campaign was publicised on the local radio stations and through exhibitions in local hospitals. The response from the public has been "excellent". Thank U nominations have come in for members of every branch of the health service — receptionists, dentists, nurses, doctors, health visitors etc.*