CHC NEWS

For Community Health Councils

June 1982 No 77

Why do British Asians get rickets?

A major contribution to the debate on rickets among people of Asian origin living in Britain has just been published by Haringey CHC*. *The rickets report* warns that dietary advice aimed at preventing this disease, which is caused by vitamin D deficiency, could harm British Asians by encouraging them to give up their own high-fibre, low-fat diet in favour of the nutritionally-inferior eating habits of the West.

Concern at the high level of rickets amongst children of Asian origin led the DHSS to set up a working party of the Committee on Medical Aspects of Food Policy (COMA) which reported in January last year, followed in February by the launch of a national *Stop rickets* campaign with £70,000 of DHSS money.

The CHC's report criticises several of COMA's conclusions and suggests that its attitude towards possible toxic effects of vitamin D is contradictory. COMA rejected the proposal that chappati flour should be fortified with the vitamin, as is already done with margarine, because healthy young men are known to eat more than do children, pregnant women and the elderly — the people most at risk of vitamin D deficiency. The fear is that those who need the vitamin will still not get enough, while those with adequate vitamin levels may sufer the toxic effects of an overdose.

Yet the CHC report points out that products such as yoghurt and breakfast cereals are already fortified by the manufacturers — advertised as "enriched with the sunshine vitamin" — and the present, uncontrolled fortification of this sort could lead to a hazardous build-up of vitamin D levels from several sources.

There are other problems with fortification, says the report, but the alternatives proposed by COMA and adopted by the DHSS in its campaign are flawed.

Vitamin supplements are recommended by COMA for vulnerable groups, yet the DHSS has refused to lift prescription charges — though health authorities have the power to do this themselves. For those who *can* afford them vitamin tablets pose the threat of overdose, and the CHC suggests they should be packed in child-proof containers.

But the major plank of the anti-rickets campaign is health education. "Asian families must thoroughly understand (the importance of) correct nourishment" the DHSS said at the launch of the campaign. This attitude implies that rickets amongst the Asian community is due to ignorance, says the report, but the indigenous population's higher vitamin D levels are due mainly to the fact that margarine has been fortified with vitamin D since the 1940s when rickets were common in Britain. The choice of margarine for fortification was geared to British eating habits, and it is used seldom in Asian diets.

The Haringey report grew out of a working party set up by the CHC jointly with the local Community Relations Council to examine the incidence of rickets in Haringey. The working party recommended that the AHA should take action, and in 1981 a local *Stop rickets* campaign began.

Since then the emphasis locally has shifted from changing dietary habits, says the CHC, and now meetings are being held to educate doctors about Asian diets.

**The rickets report: why do British Asians get rickets?* by Helena Sheiham and Allison Quick. Price £1 from Haringey CHC, Tottenham Town Hall, London N15 4RY.

UNIONS: Mood hardens

Industrial action by health service workers in the coming weeks to press their "12% for all" pay claim will be conducted according to the Trades Union Congress code of conduct for strikers in the NHS. And where unions decide to escalate action beyond the two 24-hour stoppages planned for early June, services directly involving patient care will not be involved.

This was the message from leading health service unions during May as they prepared for action.

The code of conduct was introduced to protect patients during strikes (see *CHC NEWS 71* page one for details). It recommends that shop stewards involved in strike planning should make arrangements in advance to ensure that emergency services and services to high-dependency patients — children, the elderly, the severely mentally handicapped — are maintained.

The TUC health services committee said when the code was published that it expects striking NHS staff to observe its principles "to the letter", but there are no means of enforcing the code and Secretary of State Norman Fowler made it clear during the strike build-up at the end of May that he believes the unions "cannot always guarantee" emergency cover. He pointed out that the first 24-hour strike held on 19 May produced two examples of the code being breached. Both incidents involved ambulance services, which the DHSS says closed completely in parts of Kent and Leicester on that day.

Paradoxically, he also cited the fact that certain staff continued to care for patients as evidence of an uneven response to the strike call.

The local health authorities carry the main responsibility for dealing with disputes, and Mr Fowler has recommended that they consult the DHSS circular *If industrial relations break down* (see *CHC NEWS 50* page three), which advises that volunteers, agency staff and contractors may be used as strike breakers.

INSIDE ....

Book reviews

Broadmoor

by David Cohen. Psychology News Press, 71 Boyne Road, London SE13. Tel 318 0967. £3.95 plus 35p

David Cohen depicts a secretive institution within a hierarchical system with the patients in the lowest place. Powerful groups — the DHSS, the consultants, and nurses — occupy defensive positions towards each other and the community outside. Life in Broadmoor for most patients is at best boring — in often overcrowded and squalid conditions — and at worst is cruel, brutal and degrading. This is a timely and thought-provoking book of interest to everyone concerned about human rights.

Gloria Crosby, Secretary, Croydon CHC

Will, my son: The life and death of a mongol child.

by Sarah Boston, Pluto Press £1.95

This book is mainly a very personal account of Mrs Boston's pregnancy, Will's premature birth, the 9 months of his life, and of his death. Through her own story the author speaks out for the right of the handicapped to be loved and valued. One of the biggest problems Will's mother faced was getting hold of practical information on his handicap. This book goes some way towards filling the gap, and includes a section on how to find out more.

Vivian Sanders,

Disability in Britain: A manifesto of rights

Ed. A. Walker and P. Townsend. Martin Robertson, £3.50

This book takes a critical look at the achievements of the International Year of the Disabled and proposes policies that would guarantee a living income and basic rights for the disabled. The 14 authors, people closely involved with disability, cover all the needs of handicapped people, including income, employment and independent living.

Pat Saunders, Member, Portsmouth CHC.

Diseases of civilisation

by Brian Inglis. Hodder and Stoughton, £10.95

This excellent book gives a chilling account of health care as fashioned by the medical profession. Doctors have seen disease as an outside invader to be destroyed by more and better technology and drugs. This books shows the way in which personality influences health, but it is a pity that the impact of environment and occupation are not followed up.

Christine Hogg, ex-secretary Victoria CHC.

Your letters

Getting a postal vote

Arthur Harman, Secretary, Cuckfield and Crawley CHC

In *CHC NEWS 72* Shirley McCarthy suggested that some local Electoral Registration Officers may be taking a narrow view of whose counter-signatures they can accept when disabled people are aplying for a postal vote. The Borough of Brighton's chief executive tells me that the ERO in Brighton will accept the signatures of justices of the peace, ministers of religion, commissioners appointed to administer oaths, police officers, bank managers, matrons of recognised homes for the aged or infirm, health visitors, district nurses, and midwives where the application is on the grounds of pregnancy. He hopes that this is "a wide enough range to cover 99.9% of any cases there may be". Personally, I cannot see too much wrong with this.

Political? Or just self defence?

Jean Franks, Secretary, Mid-Surrey CHC

Whatever one's views on the funding of *CHC NEWS*, I consider the comment in the April issue: "... and this object could become a focus for national CHC activity in the run-up to the next General Election" to be blatantly political. Perhaps the editor is arranging for the promise of funding to be included in the Labour Party's manifesto!

Ed: Or anybody else's manifesto, for that matter! Well, we did our best – see this month's centre page spread and Comment.

At home through choice?

Anne Smith and Joyce Dunne, Members, Waltham Forest CHC

Dympna le Rasle's letter in *CHC NEWS 74*, suggesting that "those of us who give up paid employment to care for our own children often do so because we want to" seems to be based on opinion, not fact.

Surveys quoted by the Equal Opportunities' Commission discovered in 1974 that 64% of mothers desired some form of day care for their under-fives. In inner London figures rose to 90% for mothers of three and four-year-olds. The 1974 General Household Survey showed that 35% of women were prevented from returning to work when they wished by inadequate child care provision.

To suggest that children can be best cared for by "someone who loves them — ie their mother", when it is known that 40% of women at home with under-fives are under treatment for depression, is in itself a contradiction. A bored, lonely, frustrated mother does not make a happy, healthy family atmosphere. We see little to suggest that the main reasons most mothers wish to return to work are financial — indeed, many do so for scant financial gain.

The relevance to health care of the frustrated desires of many mothers has been grossly underestimated. The NHS must wake up to the needs of working parents, both in ensuring childcare is available for its own staff, and in catering for working parents in the Primary Health Care Teams.

We are sure the figures we have quoted on depression are the thin edge of the wedge, and that denying women the right to work costs the NHS enormous sums of money. Any further information would be welcome.

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, on this special "Wanted" section of the Letters page.

Information about personal case histories of Pelvic Inflammatory Disease (PID) wanted by sufferers intending to set up an information/self-help service.

– Kay Carberry, Basement Flat, 9 Highbury Crescent, London N5 1RN.

Details of emergency dental arrangements and whether or not these are available under the NHS — in our district the emergency service is run privately.

— Oxfordshire CHC

Are there any other teaching districts without mammography machines? How many weeks delay between GP referral and mastectomy when it is required?

— Leeds Western CHC

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

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Comment

On our centre pages this month are three articles about the future of CHCs, from the three main opposition parties in Parliament. They make heartening reading. It is good to be told that your work is "vital" and "enormously important", especially during a period when that work has been repeatedly disrupted by the demands of official scrutiny.

All three parties show a clear awareness of the need for CHCs as an antidote to NHS bureaucratisation. The Liberals and Labour both promise a return to larger CHC memberships, and more help with local publicity. The Social Democrats would try to ensure proper funding for *CHC NEWS*, and Labour says bluntly that our DHSS grant "must be immediately restored".

Labour promises to set up a "patient advocate" system along the lines recommended by the Royal Commission on the NHS in 1979, giving CHCs "the duty to take up specific cases and if need be to take action on health service complaints", and the SDP is also prepared to look at this kind of scheme. Both parties sound interested in forging new links between CHCs and their regional health authorities.

Students of the Liberal/SDP Alliance will not need to dig too hard to unearth an interesting contradiction on the subject of prevention. The SDP sees "every reason" for CHCs to get involved in prevention and health education, but the Liberals say this is an area into which CHCs have "mistakenly strayed". Perhaps the Alliance should go "back to the drawing board" on this one!

Later this year we shall be offering the Conservative Government equal space to put its views, and this is an article which will be read closely for any clarification of the Government's attitude. So far its two most consistent strands of policy have been the need for periodic review and the idea that CHCs should restrict themselves to purely local matters.

CHCs received overwhelming backing from the public in the *Patients first* consultation, yet Ministers responded with the announcement that "CHCs would be more effective if they were smaller". Does the Government *really* support CHCs, or is it merely hiding its disapproval and biding its time?

Health News

Data protection

The Government has issued a White Paper on data protection, proposing legislation along the lines of the Council of Europe's Convention on Data protection. Information must be held in name-linked form only as long as is necessary. Data subjects must have access to information held about them. They are entitled to have it corrected or erased where the legal provisions for data collection have not been complied with. Records must be protected against unauthorised access and alteration.

The White Paper proposes registration of users of data systems processing information on identifiable individuals, but does not propose legally enforceable codes of practice for data users, which was a recommendation of the Lindop Committee on data protection.

The principle of data subjects having access to information held about them will not apply to data used solely for statistical or research purposes. Other exceptions include those in the interest of state security, the suppression of crime, and the protection of the data subject or the rights and freedom of others. Medical records are likely to be excluded from scrutiny by the individual under the category "protecting the subject."

The White Paper, which was issued in April, calls for comments to be sent to the Home Office by May 31st. The DHSS has written to the Association of CHCs inviting CHCs to send a copy of their comments to the DHSS. (Mr K. Jacobsen, Room B1201, DHSS, Alexander Fleming House, Elephant and Castle, London SE1). There will be "full consultations" later about what the regulations on health data should contain. A register of computers in the NHS will come into operation in June.

New sick note scheme

From June 14th doctors will no longer sign national insurance certificates for the first 7 days of illness. New self-certification forms (SC1) will be available from DHSS offices, hospitals, and GPs' surgeries. If more than 4 self-certified claims for benefit are made in a year the Regional Medical Officer may investigate the circumstances. Doctors will still be able to issue private sickness certificates, but a charge can be made for these. The regulations covering the sick note scheme were issued last month.

In April 1983 the employers' statutory sick pay scheme will come into effect. Employers will have to calculate and pay the first 8 weeks of sickness benefit and claim it back from the state. A citizens advice bureau report expresses concern that this will lead to more employees being sacked when they fall ill, and to firms being reluctant to take on people with a history of illness. (*Who pays sick pay?* Greater London Citizens Advice Bureaux Service, 31 Wellington St, London WC2. Tel: 01-379 6841.) Employers will get no compensation for the administration of sickness benefit.

An explanatory booklet has been produced by the Society of Occupational Medicine — *Self certification and employers' statutory sick pay.* £3 from 11 St. Andrew's Place, London NW1.

Heart disease in Wales

A report commissioned by the Welsh Office shows that heart disease is far more prevalent in Wales than in England, yet Wales has fewer cardiologists per head of the population. Many patients are sent to London for surgery. The results of the survey were leaked by a Glamorgan GP.

Mr Wyn Roberts, Parliamentary Under-Secretary of State for Wales, said "... it would be irresponsible of me to make the report ... available until the full implications of its recommendations have been assessed."

Closed circuit equipment

Closed circuit anaesthetic equipment has been implicated in 2 serious accidents in the NHS recently. David Woodhouse was left in a coma following an appendix operation in a Hereford hospital in May 1981. In January 1982 Mrs Nayeema Baig died after a sterilisation operation at Whiston Hospital, St Helens's, during which a tube became disconnected in the anaesthetic equipment. The cause of death was given as hypoxia (lack of sufficient oxygen.)

The DHSS is writing to hospitals using closed circuit equipment pointing out how the equipment went wrong in the Hereford case. New instructions for use of the equipment are being prepared by the manufacturers.

Cancer drug trials ...

The inquest into the death of Mrs Margaret Wrigley, aged 84, has brought to light the fact that many people are having drugs tested on them without their consent being sought. When the trials of the drug 5-flourouracil were begun in 1980 ethical committees decided that patients and families should not be told. Some 250 people have been involved in the trials. In Mrs Wrigley's case the trial protocol was not followed. The houseman was not told to take a blood count every other day to check the degree of bone marrow depression. The coroner brought a verdict of misadventure, but said it did not amount to recklessness by the hospital staff. He also suggested that there should be a full public discussion of concealed drug trials.

.....and risks to nurses

The Royal College of Nursing has issued strict guidelines for nurses administering cytotoxic drugs, which destroy malignant cells but also affect healthy tissue. The College is concerned that there may be unrecognised risks to nurses mixing the drugs. The guidelines recommend protective clothing, and ways of mixing the drugs. Staff should have blood counts taken regularly, and allergic responses should be investigated.

WHAT WE WOULD DO FOR CHCs

How the main opposition parties see our future

THE SOCIAL DEMOCRATIC PARTY

by Mike Thomas, spokesman for the SDP on health and social services

Community health councils represent an eight-year experiment on which Social Democrats wish to build. Our starting point in approaching health policy is that enhancing consumer awareness could be a major step in developing a better and more responsive health service.

I think it is fair to say that the quality of CHCs' work, while inevitably uneven, has been high. They are becoing more skilled and effective, and even the least enthusiastic health authorities would now admit that their impact has been positive and constructive.

A Social Democratic/Liberal government would, I am sure, want to strengthen their role as part of a major effort to improve the health and social services.

We should want to develop a flexible approach to the size and geographical coverage of individual CHCs related to their functions at the local level. There is no need for excessively rigid rules — what may be satisfactory in inner-city Lambeth can be entirely inappropriate in rural Cumberland. I should also want to consider whether CHCs should be consulted as of right on RHA plans and decisions.

The recent Government decision on *CHC NEWS* illustrates a central problem of financial relationships between public authorities and government on the one hand and consumer bodies on the other. I personally would like to see a buffer organisation — similar to the University Grants Committee — which would disburse funds to a range of statutory consumer bodies. That may well take some time to work out, but in the meantime, we should be anxious to ensure proper funding for the exchange of information and spread of good practice represented by *CHC NEWS*.

In our forthcoming consultative paper on the health and social services we hope to start a constructive debate on a wide variety of topics. There is a lot that is right in our health care system. It commands the support and loyalty of patients, professionals and voluntary workers alike in a fashion almost unique in the western world. But there is still room for radical improvement.

For example, our service has, under pressure of time and resources, become far too impersonal. CHCs could play a major part in improving the quality of non-medical aspects of patient care — courteous and speedy treatment, firm appointment and admission timetables, and a real element of choice of consultant.

I hope CHCs will increasingly take an interest in the substantial inequalities in health care provision that remain, not just between north and south, but within individual health districts — especially in preventative and community care facilities. I see every reason for us to consider broadening the scope of CHCs into such areas as social services, housing, environmental health, nutrition, health and safety at work, and the preventative and educational area in general.

The role of CHCs in championing individual patients could be developed. The Royal Commission on the NHS recommended CHC-based experiments with "patient advocates", modelled on the American experience. With the decision to provide legal aid to those appearing before Mental Health Review Tribunals it is clear that representation of patients is becoming an accepted principle. It would be useful to see how it could be extended to those voluntarily undertaking treatment.

Those who give so much of their time and commitment to the work of CHCs do the nation and the NHS a great service. The NHS cannot be responsible alone for the health of the nation. We support all you do to make the NHS more responsive to community views and the wishes of patients.

THE LABOUR PARTY

by Gwyneth Dunwoody, Labour Party Front Bench spokeswoman on health

Community health councils were created "to represent the views of the consumer", but that bald remark understates the role that CHCs have to play in the NHS. Bureaucracy, no matter how benevolent, tends not to consult the people who are most important — the users of the service. In the NHS, where plans can take years to complete, this tendency is especially dangerous. Minor problems, which sometimes seem to be unimportant to the planners, can be of vital concern to individuals.

Politicians understand the enormous importance of CHCs to the health service, and that awareness also explains the determination of the Conservative Party to be rid of CHCs as rapidly as possible. It is hypocritical for the Conservatives to pretend that CHCs have not proved their usefulness time and time again. Indeed it is the very success of CHCs which has led to this Government's attack on them.

That attack is most obvious in the new guidelines for CHCs. Suddenly CHCs are no longer required to improve the health service. There is no encouragement to publicise their activities, and circular HRC(74)4's list of matters to which they should direct their attention has been cancelled. Meanwhile CHCs are being starved of the tools with which to achieve their ends: finance for *CHC NEWS* has been undermined, there have been damaging membership cuts, and perhaps most insidious of all there is the recent change which seeks to ban health service employees from CHC membership. This can only be interpreted as an attempt to cut off CHCs from those who best understand the NHS from the inside.

The next Labour Government will act to safeguard the future for CHCs, by broadening their role, allocating adequate staff and helping them to expand and publicise their work. The threat of frequent review will be ended, and CHCs will be given the finance, personnel and support to enable them to do their job in greater depth than has been previously possible.

CHCs will be given a clear duty to monitor the actions of health authorities and to improve access to the health service. Labour's overall health policy will shift health care towards prevention, which will bring the NHS into greater contact with other Government departments. With that change CHCs will have to take a broader view of health care than could be achieved simply by looking at the services provided by DHAs and family practitioners.

We will also institute the "patient advocate" system recommended by the Royal Commission on the NHS, which would give CHCs the duty to take up specific cases and if needs be to take action on health service complaints.

We may need to restore the old level of CHC membership to cope with this level of responsibility. An average membership of 24-30 will be needed. We will immediately consider the appointment of additonal part-time staff and the allocation of additional funds to help members take on greater workloads. Some CHCs are already being forced to deal with too large and diverse a district, and these should be urgently restructured. Leicestershire is the most glaring example.

Long-term success for CHCs will depend on the ability to apply pressure to health authorities at the most important points. Labour believes in the right of attendance at meetings of RHAs and FPCs, as well as the right to attend DHA meetings which already exists. CHCs should also have the right to be consulted by *all* the authorities in their district about major changes.

We will have to ensure that CHCs have the resources to publicise and co-ordinate their knowledge. The grant for *CHC NEWS* must be immediately restored, and additional finances given to enable CHCs to publicise their work in the community.

The Labour Party believes in the principle of an organisation committed to helping those using and working in the NHS. There is much work to be done in order to protect the rights of patients, including those minorities which have special needs.

THE LIBERAL PARTY

by Lord Winstanley, Parliamentary spokesman on health for the Liberal Party

Liberals have no doubt that the need for consumer representation in health matters will continue far into the future. Health authority members may well be dedicated and able, but they cannot be regarded as truly representative of the consumer. DHSS Ministers are answerable to Parliament, but that route to a remedy for a complaint is circuitous and time-consuming indeed!

So CHCs are vital. Their essential job is to monitor NHS services in their districts; to notice deficiencies and bring them to the attention of the authorities; to take careful account of local public opinion and to detect new trends in local affairs which may demand new or different services.

For CHCs, keeping in touch with their communities is not easy. The new health districts have populations ranging from 86,000 to 836,000, and a rural district can cover hundreds of square miles. Despite this, there are good reasons for sticking to the "one CHC per district" rule. We would encourage and enable CHCs to publish newsletters advertising the help they can offer and inviting a public response.

The Royal Commission on the NHS discussed at some length the surveying of public opinion. Public opinion is not always right, but representatives of the public need to know what it is and must be ready to argue the case for overriding it when they choose to do so. "Pure" public opinion is perhaps less useful than an assessment of what public opinion *would* be if the public had all the appropriate information. Pressure group opinion, although usually informed, is rarely balanced, whereas "pure" public opinion, although balanced, is rarely informed, and in any case is very expensive to determine. CHCs should cope with these dilemmas in their own ways.

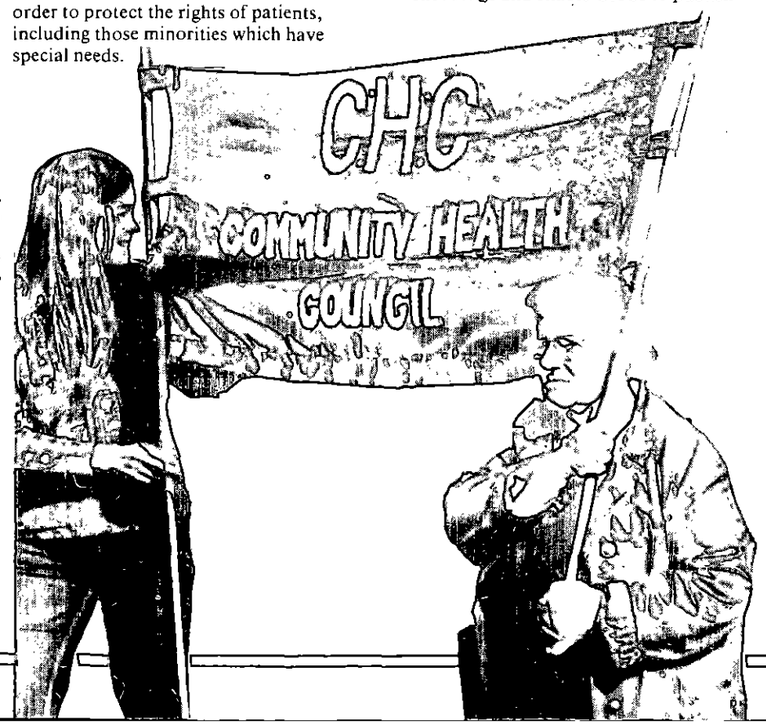
The Royal Commission recommended that CHCs should be given more resources "to enable them to inform the public fully about local services". We would not dispute the need for the public to be better informed about the service, but we do not accept that this is the job of CHCs. They should not be required to provide a public relations service for the NHS — they would lose their credibility if they did so! In campaigning for local improvements it is right that CHCs should highlight flaws in the service.

Another area into which some CHCs have strayed is health education. We believe this is also a mistake. Preventive medicine and healthy living need greater emphasis, but CHCs do not have the staff resources to supplement inadequate health education services without weakening their ability to represent informed public opinion in the field of service provision.

A CHC's membership should broadly reflect the interests in the NHS of its local population. At present the articulate middle-class is over-represented, and we would take positive action to remove this bias. The middle-aged are also over-represented, because of the rule that people over 70 should not be appointed unless they are specifically representing organisations for the elderly. With the increasing number of elderly people in the population and the greater use they make of the service, we believe each CHC should have three or four such members.

At some stage we would like to introduce a small number of directly-elected members, but this will not be easy and will inevitably take time, so for now we must settle for the present arrangements for appointing members. We see no immediate prospect of increasing full-time staff above the present average of two. Thus, much of the workload must be borne by members. We cannot see a CHC functioning effectively with less than thirty. With more than thirty an "elite" is apt to build up, and decision-taking becomes difficult.

In conclusion, a CHC is an advisory body not an executive one. It does not need a policy on every subject, and there is no reason why it should not sometimes advise that opinion is divided.



Teamwork for mentally handicapped people

*by Morag Plank**

The Court report on child health services (1) highlighted the lamentable state of services for handicapped children, which it described as "characterised by overlap and by poor coverage". The report also drew attention to the confusion felt by parents faced with the large number of services and professionals they have to deal with, and recommended that District Handicap Teams (DHTs) should be set up throughout the country to improve this situation.

These teams should include representatives from the fields of health, social services and education, providing a single door through which handicapped children and their families would gain access to assessment, treatment and advice.

Around the same time the National Development Group for the Mentally Handicapped had come to believe that multi-disciplinary team-work would improve the service for mentally handicapped people, and the Group's advice led to the setting up of Community Mental Handicap Teams (CMHTs). Since the Government accepted the need for both these teams in January 1978 (2) many have been established but there has been little information about their numbers and about the way they are structured and operated.

The Campaign for Mentally Handicapped People decided it was important that this information should be known and sent a questionnaire to all health districts asking for details of any DHTs or CMHTs in their districts. The survey sought information on the functions of the teams, which groups are served, where the team is based, membership of the team, referral policy, parent participation and monitoring (3).

We received replies from 73% of all health districts and of those, 25% had no multi-disciplinary teams, 25% had both DHTs and CMHTs and the remaining half had only one type of team — 20% had a DHT and 30% a CMHT. We also looked at teams which are at an advanced planning stage to get an idea of trends in this development, and found that in the future more districts will have both types of teams, making it all the more important that the relationship between the two be clarified.

The survey revealed that, although there were many variations between individual teams DHTs on the whole put a greater emphasis on the co-ordination of existing services while the main role of CMHTs appears to be to provide a practical support service to families, aiming in this way to increase the range of available services. CMHTs tend to be smaller than DHTs with more limited representation and this limits their effectiveness in co-ordinating services.

Problems arise in relation to mentally handicapped children in districts with both types of teams. Which team should be responsible for them? About 40% of the districts in this position have CMHTs which deal only with adults, leaving care of all mentally handicapped children to the DHTs. In most of the remaining cases, all children assessed as mentally handicapped by the DHT are then transferred to the CMHT. These differences cause confusion and uncertainty among parents and a common policy needs to be agreed.

DHTs seem better fitted to take responsibility for mentally handicapped children since they include among their members people who specialise in the care of children — teachers and paediatricians, for instance. As the Court report says, "severely mentally handicapped children have more in common with other children because of their childhood than they have with severely mentally handicapped adults because of their common disability".

Most teams claim to involve parents in assessment and preparation of plans for their children, but this needs to be looked at more closely. Answers to other questions reveal a wide variation in the extent to which they regard parents as equal partners with the professionals on the team. Policy on referrals is one indication of this — only 38% of DHTs (50% of CMHTs) have an open referral policy which enables parents to approach the team directly.

When asked how they involve parents, the teams' answers show widely differing interpretations of the concept of parent participation. On the one hand is the team which "is committed to problem identification and problem solving with the family as co-workers" and on the other hand is the team which answered "parents are informed of proposals relating to treatment".

An enquiry of this nature has to rely on the service-providers for information. It would be very interesting to see if the consumers' views differed in any way. CHCs are in a good position to find out if their local multi-disciplinary teams are meeting the needs of mentally handicapped people and their families or if the service needs to be improved.

It is all the more important that CHCs do take an interest in the operation of these teams because our survey revealed that the performance of many teams — 44% of DHTs and 48% of CMHTs — is not monitored at all by any group or individual outside the team. This can never be a satisfactory situation. Only three replies mention the role of the CHC in monitoring their work but I hope that in the future many more CHCs will recognise the importance of multi-disciplinary teams to mentally handicapped people and their families.

*Morag Plank works for the Campaign for Mentally Handicapped People (CMH)

References

1. *Fit for the future*, the report of the committee on child health services. Cmnd. 6684, HMSO 1976.
2. See DHSS local authority circular LAC(78)2, January 1978.
3. *Teams for mentally handicapped people* by Morag Plank. Price £1.75 inc post from CMH Publications, 8 Church End, Gamlingay, Sandy, Beds.

Parliament

Selling off the surplus?

An enquiry team has been appointed by Social Services Secretary Norman Fowler to consider how to ensure that health authorities identify underused and surplus land and property and, where appropriate, dispose of it (Cyril Townsend, Bexleyheath, 11 March). Between April 1974 and March 1981 NHS land sales raised about £49 million (Dennis Skinner, Bolsover, 4 March) but the DHSS estimates that £20 million will be realised in the year 1982/3 (Gwyneth Dunwoody, Crewe, 5 April).

Prescription inflation

The prescription charge increase on 1 April to £1.30 per item means that charges are now 550% higher than in May 1979 when the charge was 20 pence. (Dennis Skinner, Bolsover, 1 March).

Joint funding

£85 million will be allocated for joint funding in 1982/3, an increase of 6% in real terms on the 1981/2 allocation. Between 1976 and 1982 £12 million was allocated but not spent, and this sum will be carried forward into 1982/3 and subsequent years. (Alfred Dubs, Battersea S, 6 April).

Toothless wonder

In England 28% of the adult population have no teeth of their own. In Wales this figure rises to 37% and 39% in Scotland. Within the English regions fewer people in the South have lost all their teeth

Scanner

Drug effects

Information about drug usage and adverse effects is now available from a computer-based index at Guy's Hospital. Enquiries from doctors, nurses and other health workers are answered. Members of the public are usually referred to their doctor, but the unit may be able to deal with questions from lay advisers, or to recommend other sources of information. Details of the project from Mrs B. Davies, South East Thames Regional Drug Information Centre, Pharmacy Department, Guy's Hospital, London SE1 9RT. Tel: 01-407 7600.

Babies in special care....

A leaflet *Your baby in special care* answers questions parents have when their baby has to go into a special care baby unit. It goes into details about equipment used in the units, the kind of progress that can be expected, and ways of relating to babies in incubators. 35p (inc post), cheaper in bulk. From the National Association for the Welfare of Children in Hospital, 7 Exton St, London SE1 8UE. Tel: 01-261 1738.

Maternity benefits

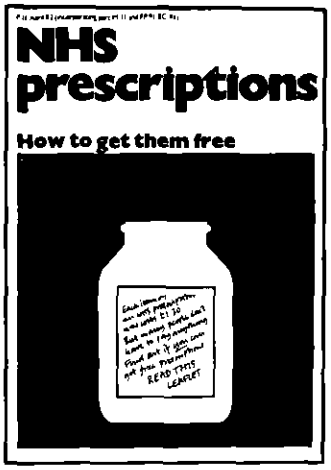
Money for mothers and babies provides a simple introduction to cash benefits for pregnant women and new mothers. It is the first in a series of leaflets on rights produced by the Maternity Alliance. It sets out what the different benefits are, who is eligible, and how and when they can be claimed. The leaflet is free to individual women with s.a.e. Otherwise, 3p per leaflet plus a flat rate of 20p for postage and packing. From the Maternity Alliance, 309 Kentish Town Road, London NW5. Tel: 01-267 3255.

Help with mastectomy

A new cassette, *Coping with a mastectomy* gives information on what life will be like after the operation. It includes advice from people who have already had a breast removed, and an introduction by Claire Rayner. £1.30 from the Mastectomy Association, 1 Colworth Road, Croydon CR0 7AD. Tel: 01-654 8643.

NHS efficiency guide

This index of practice includes details of 165 schemes adopted by health authorities and FPCs to save money. A contact is given for each scheme. £2 (inc post) from the National Association of Health Authorities, 40 Edgbaston Park Road, Birmingham B15 2RT. Tel: 021-454 2669.



DHSS leaflets

New leaflets on: prescriptions and how to get them free (P11), disablement benefit for occupational asthma (NI 239), dental treatment – what it costs and how to get free treatment (D11), glasses - how much they cost and how to get them free (G11).

CHC Directory: Changes

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

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

Page 7: Barking CHC has merged with Havering CHC to form **Barking Havering and Brentwood CHC.** The address, phone no. and secretary as as for Barking CHC. The Chairman is R V Rudge.
Page 7: Islington CHC Chairman: Caroline Osborn
Page 7: Kensington Chelsea and Westminster South CHC has changed its name to **Victoria CHC.**
Page 8: Maidstone CHC Chairman: Mrs Marian Cole
Page 10: Salisbury CHC Chairman: W H Lambert. Secretary: J P Tighe.
Page 13: East Birmingham CHC Chairman: Derek Whipp
Page 15: Manchester South CHC Secretary: Isabel Chewter
Page 15: Tameside CHC has changed its name to **Tameside and Glossop CHC.**

Bereavement and mentally handicapped people

This discussion document underlines the importance of mentally handicapped people being allowed to grieve fully following the death of someone close. It includes a list of useful publications, and addresses of voluntary organisations concerned with bereavement. 50p (inc post) from Ms M Elsdon, King's Fund Centre, 126 Albert St, London NW1.

Handicapped living

is the new title of the magazine planned as *Disabled living* (see *CHC NEWS* 73). It contains news, views and features and is on sale at bookstalls for 60p.

Health circulars

HN(82)7: gives the timetable and arrangements for the submission of annual accounts, statements and financial and costing returns for 1981-82. The deadline for health authorities is June 30th, and AHAs that have been reconstituted as DHAs without a boundary change are responsible for their own accounts. For the remaining DHAs, the RHAs will decide which DHAs are responsible.
WHC(82)12: describes arrangements for reviewing management costs in Wales, with the aim of reducing them by 13%.
HC(82)5: notifies new requirements for carrying out land transactions for the NHS.
HC(82)9: introduces arrangements for the provision of computing services, and draws attention to the new NHS Computer Policy Committee.
HN(82)15: increased charges for optical appliances.

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than in the Midlands or the North. (Ivan Lawrence, Burton, 8 April).

Industrial disability appeals

A new right to appeal against diagnosis decisions has been granted to people claiming industrial disability benefit for pneumoconiosis or byssinosis.. From 19 May appeals have been acceptable against medical board decisions made on or after that date, unless an earlier appeal has been rejected within two years. (Brian Mawhinney, Peterborough, 28 April).

The costs of appealing

The Secretary of State at the DHSS has a statutory power to award costs against a person appealing against an FPC decision, but this power has never been exercised since it was established in 1974. The power will be retained in case of the need to award costs in a frivolous or vexatious case (Jack Ashley, Stoke-on-Trent, 12 March and 28 April).

Drug spending

Expenditure on drugs in the NHS — excluding the Family Practitioner Services — rose from £128.1 million in 1978/79 to £185.3 million in 1980/81, but remained at between 2.1% and 2.3% of total NHS revenue expenditure (Robert Rhodes James, Cambridge, 28 April). The administrative cost of processing a prescription is estimated to have been 3.5 pence in total in 1980/81 (Robert Parry, Liverpool, Scotland Exchange, 19 April).

CHC budgets

The DHSS does not collect information on the allocation of CHC budget by RHAs, but does keep figures on past spending. Expenditure by CHCs in England was £3,458,296 in 1978/79 and £4,934,088 in 1980/81 (Nigel Spearing, Newham S, Barry Sheerman, Huddersfield E, Dale Campbell-Savours, Workington, 9 February).

News from CHCs

☐ The **Association of District Committees** (the equivalent of CHCs) **in Northern Ireland** is still waiting to hear its fate under reorganisation, but fears that present uncertainty over health and personal social services in the Province may continue well into 1983. Consultation with the Northern Ireland Office's own Department of Health and Social Services was due to end in December, but was extended to the end of March by the minister with responsibility for health, John Patten. A provisional reorganisation date of 1 June has been abandoned and members of Area Boards (roughly matching RHAs) have been reappointed for a further year. But the feeling amongst district committees is that whatever decisions are made, lack of money precludes major changes in the system.

☐ Nurses and doctors have "tended to lose interest in the deceased" says **Newcastle CHC's** report *Bereavement in hospital* — the death of a patient is seen as a failure and so too little attention is paid to mortuaries and the needs of bereaved relatives. The CHC has always included mortuaries on its hospital visits. Its report praises upgraded mortuary premises and broadening staff attitudes, but still sees room for improvement. A lack of refrigeration chambers in smaller hospitals is a problem — especially in warm weather. Training in bereavement counselling for nurses is patchy, and though chaplains earn praise from all sides, the religious needs and grieving rituals of ethnic minorities are not well understood.

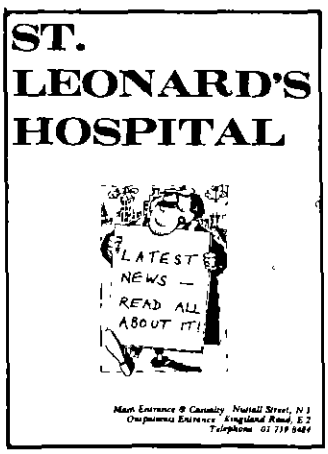
☐ Pressure on the service has forced the well-woman clinic in Wythenshawe, Manchester, to close its doors to women from outside the district, but **South Manchester CHC** is encouraged by plans for a second clinic soon to be opened in Withington. Women came fron as far as Birmingham and Wales to the Wythenshawe clinic, and an evaluation report from Manchester University provides new evidence of the need for well-women services (available c/o Dr Judith Gray, Specialist in Community Medicine, N Manchester DHA, Central Drive, Crumpsall, Manchester 8). Of the women attending, one third presented with gynaecological problems and a further third wanted to discuss problems about husbands and families. The CHC believes the predominantly working class population has voted with its feet to make the clinic a success, and points out that few GPs would wish to spend as much time as the clinic can offer to counsel individual women.

The Withington clinic will be run by health visitors, and a clinic opening in early June in nearby Rochdale will rely exclusively on twelve health visitors working voluntarily. **Rochdale CHC** hopes local GPs will refer women for counselling, and sees the clinic as being complementary to family practitioner services.

☐ In contrast, neighbouring **Oldham CHC** is discouraged by lack of success in a local three-year campaign to persuade the health authorities of the need for a clinic. The CHC participates in monthly meetings on women's health topics with attendance varying between 70 and 150, and finds that menopause as a topic always draws crowds, yet the DHA continues to assert that women are served adequately by the existing primary care network. In a contradictory move the district offered women's self-help groups the use of clinic premises without providing staff, but after three sessions the experiment ceased when the need for medical personnel became apparent.

Spanish, Portuguese and Moroccan Arabic translations appear alongside the English text in the annual report of **Paddington and North Kensington CHC.** These languages were chosen because they are spoken by large, well-organised communities in the district and the CHC hopes these flourishing social networks will ensure a wide distribution for their report.

☐ **Basingstoke CHC** fears it has reached stalemate in its efforts to reestablish a service for adults at the clinical ecology unit at Basingstoke general hospital, founded by allergy pioneer Dr Richard Mackarness. When he retired in September **Basingstoke** and **Winchester CHCs** acted promptly to ensure that the DMT kept funding open for the clinic, and a successor was appointed. He is treating children under paediatric consultant supervision but the DMT cannot find a consultant willing to supervise the adult clinic. The CHC feels that every effort has been made by the DMT to resolve the problem of hostility towards the unit from traditional medicine, but concern is growing for Dr Mackarness' patients. They are beginning to run out of the diluted allergen preparations prescribed for them by Dr Mackarness, yet his successor is not permitted to treat them unless they can afford the fee to consult him privately. Meanwhile **Winchester CHC** is trying to discover if such clinics exist elsewhere.



☐ *A cheerful leaflet from* **City and Hackney CHC** *to publicise the facilities still available at this hospital – which was threatened with closure. The CHC campaigned to keep the hospital and managed to save the casualty department and a range of outpatient clinics. A unit for the elderly will be developed in the empty wards.*

☐ The National Association for Mental Health (MIND) has appointed a former CHC Chairman to replace director Tony Smythe, who resigned last year. Mr Christopher Heginbotham was chairman of **North Camden CHC** during 1978 and continued to serve on the CHC, later as a co-opted member, until his appointment this year as a member of the new Hampstead DHA.

☐ Research assistance from Birmingham Polytechnic has enabled **Central Birmingham CHC** to produce a set of information sheets which build into a complete profile of the health district. Current figures on housing, population, social class, births and deaths are presented according to the eight electoral wards, and three information sheets summarise the births and deaths, housing and population figures for the whole district. Copies of the profile have been sent to DHA members and the district team of officers as well as city councillors and local MPs. They have been especially well received by the authority members, who found the DHA's own long, statistical profile somewhat indigestible.

☐ Closely following the attack on its existence by a Tory MP (see *CHC NEWS 76* page 8), **East Berkshire CHC** has come under fire from the other end of the political spectrum after a local group called Save Our hospital Services (SOS) complained to Slough Labour Party over the CHC's approval of a hospital closure. Built in a remote spot for the use of soldiers, the Canadian Red Cross (CRX) hospital is being run down as part of a plan to rationalise scattered acute services in the district. The CHC agrees that patients do not enjoy the long trek out to the present site, and consultants spend many hours travelling instead of treating patients. But some staff members at the hospital believe that the closure is intended to help the development of private medicine, and through the SOS Group have accused the CHC of "allowing itself to be hoodwin':ed". SOS wrote to the Labour Party branch asking local MP Joan Lestor to become involved but so far she has not replied to requests from the CHC for a meeting.

Other CHC publications

Good practices in mental health project — Coventry schemes **(Coventry CHC)** A record of Service 1974-1982 **(Havering CHC).** Proposals for the establishment of a well-woman clinic **(Norwich CHC).** Where to have your baby: the doctor gives the advice — you have the choice **(Oxfordshire CHC).** Survey of access for the disabled to hospitals in Salford **(Salford CHC).**