CHC NEWS

For Community Health Councils July/August 1983 No 88

"Put your minds at rest" says Health Minister

CHCs ARE NOT AT RISK

"The future of CHCs is not at any risk whatsoever" Health Minister Kenneth Clarke told the annual general meeting of the Association of CHCs in July at Sheffield University. "We wish for close and continuing contacts with CHCs" he said "and we value your role as consumer watchdog".

But the Government will be reviewing the role of CHCs — especially their relationship with district health authorities — once they have settled into the reorganised NHS structure.

In a warmly received speech Mr Clarke responded to several points raised in debate before his arrival. He told CHC representatives that "the Government's intention is to make CHCs' relationship to family practitioner committees equivalent to their relationship to DHAs". But FPC independence is "irrelevant" to the planning of primary care services, he said.

And he gave short shrift to a request — made in an emergency motion carried overwhelmingly by the meeting — for a role in the recently-established structure of regional views. The review process is purely managerial, he said, and he could not see how CHCs could be involved. Their turn to discuss reviews comes when the procedure's documents are made public.

The minister's speech came towards the end of two days of debate conducted in sweltering heat by 450 people representing 184 CHCs. Early attenders participated in a debate between former Secretary of State David Ennals and Harley Street Clinic founder Stanley Balfour-Lynn on the NHS and private care.

Delegates were welcomed to the AGM by David Blunkett — leader of Sheffield city council — who in an impressive speech stressed the need for local, collective action to improve environmental conditions. He explained how local authorities taking joint funding money can lose more than they gain because of rate support grant penalties, and issued a challenge to CHCs to oppose these restrictions on local spending.

The meeting voted down a motion from Oxfordshire CHC proposing to reconstitute ACHCEW's standing committee as a nationally-elected body — opposers argued that regional links would be broken by this. A proposal from North Birmingham CHC to organise one day AGMs was also defeated.

Subsequent motions were mostly carried unanimously or with substantial majorities.

The Government and other relevant agencies were urged to take action on generic prescribing, temporary seat belt exemptions for mastectomy patients, care of the elderly, national transfer of joint financing monies, community care for mentally ill and handicapped people, collaboration between health and local authorities, complaints procedures, inspection of GPs' premises, lists of GPs for home births, training in communication skills for NHS staff, a code of conduct in human fertilisation and embryology, DHA staff and members' financial interests in private developments, funding of supra-regional specialties, NHS building projects and fire precautions, community nursing, preventive health and well-women clinics, orthodontic waiting lists, and social security benefits for psychiatric patients.

ACHCEW's standing committee was directed to investigate how CHCs can best

Continued on page eight

New minder for CHCs

As Mike Gerrard takes his leave of the Association of CHCs his successor in the post of Secretary has started making the acquaintance of CHC members and staff.

Tony Smythe is already well known to many as former Director of MIND — the National Association for Mental Health. From 1974 to 1981 Tony played a major part in bringing MIND to national prominence as a highly respected organisation dedicated to representing the interests of mentally ill and handicapped people.

A former member of Barnet and Haringey CHCs, Tony believes the CHC network gave the mental health world its first opportunity to "break out of the ghetto and reach out to the public — MIND could not have been so successful without the help and enthusiasm of CHCs" he says.

Now he hopes to put CHCs themselves more firmly on the map. "I shared with CHCs a sense of relief at the Minister's contribution to our AGM" he says " — but we should be looking for more than the benign tolerance which characterises our relationships

with the Government and with other agencies".

Tony is disturbed that so few people know what CHCs can do for them — "We need more public visibility" — and is concerned that neither ACHCEW nor CHCs themselves have the tools or resources to achieve their full potential.

He intends to build on the firm foundations established by Mike and to continue improving the service ACHCEW offers CHCs — partly through identifying common ground shared by CHCs despite their "enormous diversity of interests and opinions".

And he has all our best wishes as he takes on his new tasks.

INSIDE.....

Your letters

Local closure — national impact

Juliet Mattinson, Secretary, East Berkshire CHC

My CHC has been consulted on a proposal to close Farnham Park rehabilitation centre — which provides intensive, full-time physical rehabilitation.

The DHA's case is based on finance. Over 75% — around 300 a year — of the inpatients come from outside the Oxford region and from all parts of the country, but financial allocations under the RAWP formula do not take this into account. The DHA wishes to use the money from the centre to improve local rehabilitation services.

This CHC's initial response is that the existing position should not continue indefinitely unless the centre's service to the rest of the country is given tangible recognition. This could mean top-slicing perhaps £200,000 a year from the national budget.

We would be grateful to hear from any CHCs with strong feelings about this closure — whether for or against. Further details — including patients' origins and our DHA's response to the first round of submissions — are being supplied to regional groups of CHCs.

Working for mental health

Katia Herbst, Projects Officer, Mental Health Foundation, 8 Hallam Street, London W1N 6DH. Tel: 01-580 0145

The MHF is conscious that current policies which use employment as a prime tool and goal in the rehabilitation of the psychiatrically ill patient may be misguided and even misleading in the present climate of high unemployment.

In its recent examination of services the National Advisory Council on Employment of Disabled People concluded that existing arrangements are not satisfactory and that improvement and development is required at every stage of rehabilitation.

There is ample evidence to suggest that matters have not substantially improved since this review in 1980.

The MHF is holding a conference at the Royal College of Physicians in London on 29 September — in conjunction with the British Institute of Industrial Therapy — with the title *Rehabilitation — the way ahead or the end of the road? Work and occupation for the mentally ill* to debate these policies and services.

Further details are available from the conference organiser at the address above.

We lack time, not interest

Dag Saunders, Secretary, Shropshire CHC

Like other CHC Secretaries, I have recently received a number of letters and questionnaires from individuals requiring information as part either of academic courses or national surveys.

One gets the impression that the letter-writers often imagine CHCs are staffed with several people. If their response rate is low they probably feel that this reflects a low level of interest among CHCs.

Perhaps I could explain through your columns that any lack of response is probably due more to CHC staff being deluged with work — rather than not being interested in the subject under investigation.

What about the patients? II

L B Akid, Secretary and Director of Education, Institute of Health Service Administrators, 75 Portland Place, London W1N 4AN

Marion Wilton of Barnet CHC refers to the IHSA conference "How efficient is the NHS" in her letter in *CHC NEWS* 87. There were in fact 15 CHC representatives at this conference. Their attendance and contributions were very welcome at this as at other IHSA conferences; and the Chair of ACHEW has been a speaker at more than one of our conferences in the last couple of years.

None of the speakers at this conference was an administrator — so their views can hardly be taken as those of administrators. I am sure that members of the IHSA are as devoted to the patient as any other professional in the health service — as a little reflection on the past troubled year in the NHS would demonstrate.

Expanding fast

Jane Carter, Secretary to the Director, Motor Neurone Disease Association, 38 Hazelwood Road, Northampton NN1 1LN. Tel: 0604 22269

CHC NEWS readers may be interested to know that we opened our first full-time headquarters here in Northampton in March. We are here to help MND sufferers and their families in any way that we can, and are now organising ourselves to cope with what we hope will be a fairly rapid expansion of MNDA's work and influence.

We have two patient care officers — one in London and one in Blackburn — who endeavour to keep in contact with professional staff as well as sufferers and their families.

The setting up of our Northampton HQ is a milestone in the MNDA'S history. We shall more than play our part in the international struggle to overcome our many problems.

Drinkers wanted

Josef Ruzek, Drinkwatchers Project Supervisor, Accept Behavioural Science Unit, Western Hospital, Seagrave Road, London SW6 1RZ. Tel: 01-381 3155

"Going out for a drink" is the main British social activity outside the home. It is estimated that as much as 38p in every leisure pound is spent on alcohol. While this is good news for the drinks industry it presents a cause for concern amongst those attempting to deal with the growing epidemic of alcohol problems in the UK.

Drinkwatchers — the sensible drinking organisation — has started a pioneering research programme in London to teach drinkers to enjoy pubs, clubs, wine bars and discos without risking their health, happiness and future careers. By learning the skills of sensible drinking individuals can prevent their drinking habits from causing personal problems.

The project has been created by the national charity Accept, aided by a grant from the Health Education Council. Volunteers are now being enrolled.

We hope later to develop similar projects and set up branches of Drinkwatchers in other parts of the country. People who are interested in forming workshops in their areas will be very welcome to contact us — and *The drinkwatchers' handbook* is available from us at £1 inc post.

Wanted

Information from CHCs which have done any work on health services specifically aimed at unemployed people.
— Central Birmingham CHC

Information on establishing adolescent wards in general hospitals.
— Northampton and District CHC

Information on mobile screening services — well-women clinics or over-60s' screening clinics for instance — and on how schemes are funded, up-take of services and so on.
— North West Surrey CHC.

Copies of CHC surveys or reports on out-patient clinics — we are hoping to do a survey ourselves.
— Winchester and Central Hampshire CHC

Information from any CHC which has looked at the question of putting "use by" dates on drug labels or prescriptions.
— Salford CHC

Information sheets or booklets on the admission of children to hospital.
— North East Essex CHC

CHC NEWS
JULY/AUGUST 1983 No 88

362 Euston Road, London NW1 3BL
Tel: 01-388 4943/4

CHC NEWS and Information Service Staff: GILL KENT (EDITOR), SALLY WILTSHIRE (ADMIN/INFORMATION ASSISTANT)

CHC NEWS is the national magazine for community health councils. It is distributed in bulk to CHC offices for the use of their members. Individual subscriptions are available at £10 a year. Discounts of 25% over 20 copies and 50% over 30. Back copies 50p each.

CHC NEWS is published ten times per year by the Association of Community Health Councils for England and Wales. It is designed by Ray Eden and printed by Feb Edge Litho (1979) Ltd, 3-4 The Oval, London E2.

Comment

A new Government, a new Secretary for ACHCEW and a new ministerial pledge on the future of CHCs — all these factors must surely indicate that it is time for CHCs to take stock of their progress over nearly a decade, and time to decide on priorities and directions for the future.

As outgoing ACHCEW Secretary Mike Gerrard put it in his farewell speech at Sheffield — CHCs must grasp their own future with both hands. "You now have the opportunity to construct the future according to the way you want it — if you are prepared to go out and win it for yourselves" he told CHC delegates.

So what sort of future do CHCs want? One of the remarkable aspects of the recent AGM was the sheer breadth of issues covered — and the range of levels at which they were dealt with. But perhaps even more remarkable — at that very smoothly-run conference — was that CHCs displayed an unusual degree of unanimity on the issues they discussed.

The branching network of the movement has grown and matured, and is beginning to bear fruit.

It is clear that there is broad agreement amongst CHCs about many of the nitty-gritty issues of practical relevance to patients' welfare and well-being — as well as a wide concern for the health of the nation, a clear consensus on the value of the NHS and a desire to participate in shaping and developing the service.

Unfortunately *CHC NEWS* does not have the space to describe in detail all the issues discussed at the AGM — that in itself is a tribute to the variety and number of subjects covered — but the resolutions in their entirety are available from the ACHCEW office.

Many of the resolutions reflected themes and concerns which have been reported more fully in *CHC NEWS* over the past year and longer. Even the Minister's words are not entirely new — in November we reported a meeting with ACHCEW officers at which Mr Clarke said much the same thing.

Perhaps the unexpected aspect of his speech was his firm denial of any "secret manifesto" intention to abolish CHC. He has said in effect — CHCs are safe with us. But ministerial pledges display all the qualities of messages written in sand — we have no room for complacency.

CHCs need to earn their future security by becoming indispensable.

ACHCEW's new Secretary Tony Smythe will find — as he reviews the business of the AGM — that a considerable part of his agenda for action has already been written. But he will also want to look for new ways of helping CHCs to reach out to the public and involve more people in their work.

And he will need to convince public and professional bodies, Government departments and the rest of the NHS that CHCs are here to stay and must be taken seriously.

We hope CHCs will want to help Tony to help them, and we offer our best wishes for what will be a very demanding post. We must also add our words to the chorus of best wishes to Mike Gerrard and his family for their future health and happiness.

Health News

Nutrition message scrambled

Controversial dietary guidelines are now being redrafted for the fourth time to meet objections from the DHSS and the British Nutrition Foundation — a body funded mainly by the food industry. Yet the BNF last year itself called for national guidelines on healthy eating — see *CHC NEWS* 83 page 7.

The guidelines — which say the average UK diet is unhealthy — were drawn up by a sub-committee of the national advisory committee on nutrition education (NACNE) and were leaked to the *Sunday times* after the DHSS repeatedly refused to publish them.

The DHSS maintains that NACNE is an independently-constituted body established by the BNF and the Health Education Council in response to the 1978 report *Nutrition education*. "Its relationship to us is purely advisory — it is not our place to publish its reports" said a DHSS press officer. Yet the HEC says NACNE reports to the DHSS — which decides whether or not to publish its work.

Reports that the guidelines will be published in the summer could not be confirmed by the BNF, the HEC or the DHSS. Representatives of the HEC and the BNF will meet the chairs of NACNE and its sub-committee in August to discuss the "final version" said the BNF.

Meanwhile another advisory committee — whose report *Nutritional aspects of bread and flour* was published by the DHSS in 1981 — says the UK diet is now so healthy that vitamins lost in processing white and brown flour need no longer be replaced.

The committee on medical aspects of food policy (COMA) has proposed that legal requirements to replace vitamins should be abolished. Its suggestions form the basis of draft regulations issued by the Ministry of Agriculture, Fisheries and Food — but millers have opposed the change because they could affect the health of children, old people and minority groups.

A further proposal — that "flour improvers" now permitted in white and brown bread should also be permitted in wholemeal bread — is likely to be supported by millers because it may increase consumption of wholemeal bread.

Diabetes doubles

A study of children included in the British Births Survey 1970 suggests that the prevalence of diabetes mellitus among children may be doubling every decade.

Some 13,823 children born in one week of 1970 were traced at the age of ten and 18 were found to be diabetic — four girls and 14 boys. This compares with earlier studies of eleven-year-old children, when only one of 5362 born in 1946 had diabetes and ten out of 15,500 born in 1958. The study also noted that — contrary to most disease trends — diabetic children are more likely to come from socially advantaged families.

The small numbers of children involved — 1.3 per 1000 in the 1970 group — makes it difficult to draw conclusions about the findings but the study's authors suggest that environmental factors are likely to be involved. Dietary changes due to increasing affluence may explain both the rise in prevalence and the class bias.

Evidence for increasing prevalence of diabetes mellitus in childhood by Sarah Stewart-Brown and others is in the *British medical journal* Vol 286, 11 June 1983, pages 1855-7.

Staffing disorders

The Arthritis and Rheumatism Council has identified serious shortages of rheumatological specialists in eleven of the 14 English regions and seven of the nine Welsh areas. In England 32 districts — nine of them in the West Midlands — have no rheumatologists and while the availability of orthopedic surgeons is lowest in the North West, this region has the highest orthopedic outpatient attendances. In Scotland 71% of health authorities have "gross shortcomings" in staffing levels.

Yet there appears to be a surplus of trained rheumatologists and many now fear the dole. *If you've got arthritis expert advice is badly needed* calls for a national programme to tackle the problem through adjustments in regional allocations. The study costs £1 inc post from the ARC, 41 Eagle Street, London WC1R 4AR. Its findings will be raised with the DHSS later this year in staffing discussions with the British League against Rheumatism.

Meanwhile three reports from the British Paediatric Association show a "desperate shortage" of trained children's nurses — especially in special care and intensive care units for babies.

Children's wards and their nurse staffing in the UK 1980 — a survey by the BPA with the British Association of Paediatric

Continued on page nine

The wider shores of health promotion

*by Peter Draper, Director, Unit for the Study of Health Policy, Guy's Hospital Medical School**

"Health promotion is a popular phrase used to mean many different things. For some it is simply a trendy way of describing health education. For others it implies a high-powered public relations approach to the "selling" of health. Or the positive can be emphasised — a pursuit of the state of *thriving* rather than merely coping.

The term can also cover the whole range of preventive activities from health education to personal services like immunisation, and to policy development which may eventually lead to legislation — seat belts — or a district policy — on smoking or food for example. I shall use it in this sense here.

For CHCs involved in health promotion there are two well-known traps which have recently been described in relation to district planning teams (1).

Firstly, prevention or health education can be used as a safe and time-consuming activity foisted on CHCs to distract them from challenging the power of the various sectors of the health establishment.

Similarly the second trap is to engross CHCs in administrative details and keep them away from key issues of policy.

The answer seems to be for each CHC to press for health promotion to be taken seriously in its district so there are adequate resources and dynamic policies — the CHC itself should rarely try to fill the gaps.

These two traps are part of the bureaucratic and political context of health promotion for CHCs. Elsewhere in the political context there is an outstanding issue — the future of CHCs themselves. There is no point in CHCs trying to get their DHAs to do something about health promotion if meanwhile the present Government's "CHC extermination squad" is not dealt with first.

CHCs need to be armed against attack and must lose no time in speaking up against those who question their value. For example, point out that DHA members' roles are different from those of CHC members — especially at present when they are often called upon to cut costs and withdraw services and — as John Ashton describes it — to act as latter-day Boards of Guardians.

In contrast CHCs — in touch with the voluntary sector and armed with as much information as possible — are not identified with management's plans. When management concentrates on "throughput" CHCs can and do focus on unmet needs and outcome.

A booklet on *Good practices in CHCs* would raise awareness of CHCs' value — perhaps someone could compile one?

And we all have to do something to kill the myth that the administrative overheads of the NHS are too high — as long as CHCs are seen as adding a few million pounds to these costs, or "taking funds from patients' services" they are vulnerable.

In fact the NHS's administrative overheads are *outstandingly low* — 5% or 6% compared with European figures twice as large, a figure of 18% for Australia and 21% in the US.

Discussing health promotion in the context of treatment and care services does not mean setting health promotion in the "enemy camp". In the short term — this year's budget — extra resources for health promotion would have to come from treatment and care allocations but this should not be necessary in the long run.

The UK still spends only about 6% of gross national product on health compared with the 9% spent by countries such as West Germany and the US. Meanwhile we use the oil revenues to finance unemployment, invest much of our capital abroad and have an extravagant military budget.

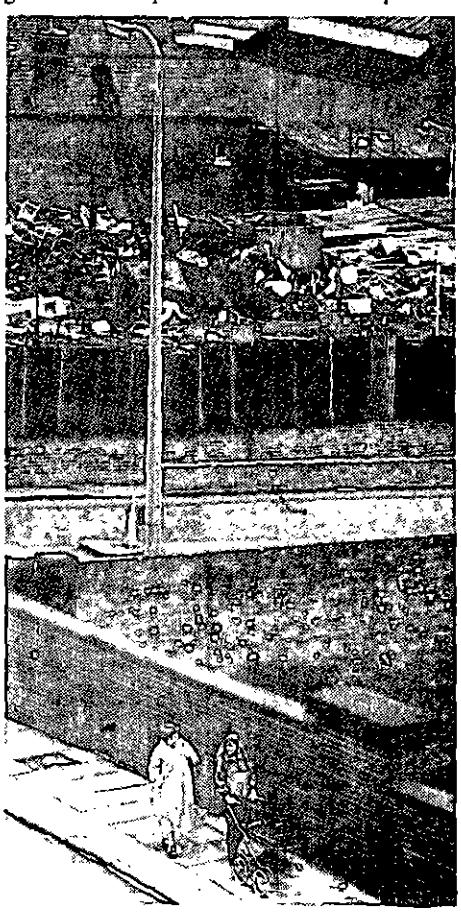


Photo: Raissa Page

We need to achieve a better balance not only between health promotion, treatment and care but also between two contrasting approaches to health promotion.

The first is common and safe — and currently fashionable. The second is rare and risky — but essential if we are to make headway in improving the nation's health.

The first approach is well typified by the Health Education Council's *Look after yourself* campaign. The focus is on individuals and on urging them to be responsible for their own health.

The second approach focuses on the environment in which people make choices — an environment of tobacco and booze adverts, of unemployment and poverty, as well as the physical, chemical and biological environments. The emphasis here is on society's responsibility for the health of its members.

My colleagues and I have suggested (2) that health education can be usefully divided into two kinds to fit the division above, with a third kind being education about what health services are available and how best to use them.

DHAs and bodies like the HEC need a proper balance fo all three kinds. The people who decide the content of campaigns must also be reminded that they need to listen to the public and avoid one-sided edicts — particularly in education about health services.

If we are to take those aspects of the environment which are hostile to health as seriously as the Victorians did when they committed vast quantities of money and labour to build the sewers and supply clean water, then we have to intervene in the economy.

Social policy and social administration normally take the economy as given, and deal with issues such as pensions, benefits and social services. But to be serious about public health we must be serious about anti-health promotion — such as cigarette advertising or the high-pressured marketing of health-damaging foodstuffs.

Economic policy which accepts high levels of unemployment is also a hazard. I will discuss other examples and suggest remedies below.

Public health has a history of having to fight battles over matters of public policy — in building the sewers, for instance, or cleansing the air. This is essentially political in character but that does not mean it is necessarily *party* political, nor that such activity should be taboo.

However, if we recognise that comprehensive health promotion needs to do more than exhort people to "be good", we must be either very strong or very subtle in the present hostile political context which exalts the economic concept of the "market" and which regards modifications or interventions — even on health grounds — as undesirable.

For CHCs the best strategy is subtlety. This means keeping a low profile and helping others to take the lead.

It is a pleasure to acknowledge the financial support to the Unit from the Health Education Council, Joseph Rowntree Memorial Trust and the Leverhulme Trust. I must also thank present and former colleagues whose work and ideas I have drawn on in writing this paper — Gordon Best, James Partridge, Jenny Griffiths, Jennie Popay and John Dennis.

Thus local paediatricians or GPs might be encouraged to point out the health implications of eroding the standards of school meals or cutting them out altogether.

Similarly, prestigious documents such as World Health Organisation reports (3), the *Black report* (4) and the British Medical Association's *Medical effects of nuclear war* (5) can be judiciously used to show that topics like poverty and nuclear arms are on the health agenda.

A "safe" aspect of the political context for CHCs to approach is the EEC and the extent to which the EEC's regional or employment funds could be used to make your districts healthier places. Perhaps you could ask a speaker who knows about EEC organisation to open a discussion on how the EEC might help to improve your environment.

There are five aspects of the socio-economic context which I would like to mention.

Continuing high unemployment — high involuntary unemployment adversely affects wider employment issues such as low pay, health and safety at work, women's employment and the disabled.

In addition involuntary unemployment seems to have various effects on the health of not only the unemployed but also their families (6). These effects seem to be linked to either "social dislocation" — causing anxiety, depression, stress and physical effects such as raised blood pressure — or to poverty with its effects on nutrition, heating and so on.

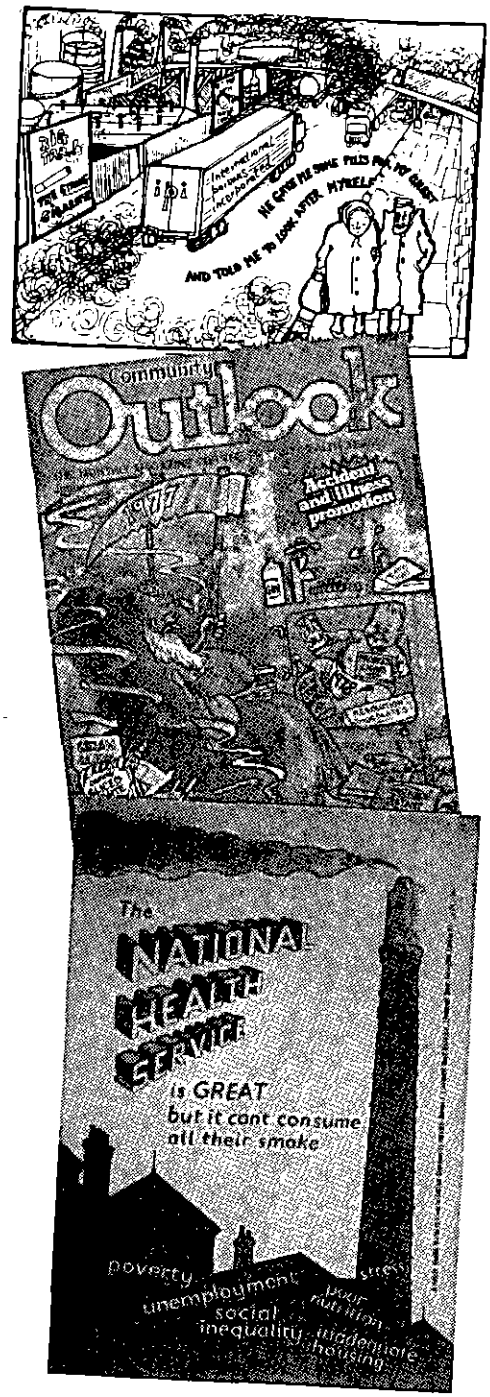
As well as the damage of involuntary unemployment there is the waste of human skills. Is it not time that we connected unemployment with complaints about staff shortages — especially in the caring sectors of the NHS? Economists have shown that it costs much the same to keep someone unemployed — when lost taxes are counted and administrative processes costed — as it does to pay an average wage.

The poor getting poorer — as well as unemployment creating poverty: "all available evidence shows that the higher-paid have gained still more since 1979, while the wages of the poorest workers — both men and women — have fallen both relatively and absolutely... recently tax policies have widened the gap still further. Low-paid households of all kinds now pay *more* tax, not less"(7). This makes the relevance of the *Black report* still greater.

The effects of cutting public spending — public services and nationalised industries often contribute significantly to a safer and healthier environment. Think of conventional environmental health, or water and sewage, or of the low accident rates on railways, or the low accident rates on cycle routes — currently we kill around one cyclist a day and seriously injure thousands of them each year.

Pressure on public expenditure is leading to visible neglect of the environment and to an erosion in standards of public health.

Worsening pressure on public spending — "...the main problem is that public expenditure will have to be cut a lot during the next five years. The oil money that has been giving this country an extra £530 a year for every worker will begin to run out in three years..."(8) Economists argue about precisely *when* North Sea oil will run out but not about *whether* it will. When it does start to decline and tax revenues fail the funding of the NHS will come under increasing pressure and any kind of intervention in the economy on the grounds of health will be that much more difficult.



Cartoons: BSSRS — PoHG. Honeysett for Nursing Times Community Outlook

Poster: Islington CHC

Pressure from other sources — the oil running out represents one of our most obvious ecological crises but there will be other resource problems — such as declining copper reserves — which will all feed inflation. As well as pollution problems there is decreasing soil fertility caused by our current farming methods.

In some ways public health can be regarded as human ecology. A fundamental part of our economic context is that we need to help the shift towards a more sustainable and less damaging pattern of economic activity.

Those with a special interest in *health* cannot ignore the public economic debates which have produced the policies of an accident- and illness-promoting society.

Ecological crises focus attention on the misleading character of many of our economic concepts and indicators. For example, the economists Bacon and Eltis suggest that the UK's economic problems should be blamed on having too many "unproductive" workers and too few "productive" ones.

The basis of their classification is that the products or services of a "productive" worker are sold. This damaging concept leads to this kind of classification:

Productive	**Unproductive**
tobacco promoters	health education officers
sweet manufacturers	NHS dentists
pornographers	educational psychologists

Another example of a bogus economic concept which has damaging implications for health is "real jobs". My colleagues Howard Cox, Linda Marks and David St George are particularly interested in the concept of "added value" as applied to the food industry. It really means "the more processing the better".

Challenging these socially destructive words and concepts is an important part of tackling today's unhealthy environment (9).

More can also be done in developing knowledge about health. Information about positive health indicators is almost totally lacking (10). CHCs could stimulate their DHAs to develop relevant information systems — perhaps by using Manpower Services Commission schemes to finance, train and supervise otherwise unemployed people to carry out interviews and surveys.

Social science and medical students could also do this kind of work with encouragement from CHCs.

The constructive approach to conflicts between health and conventional economic, social and political goals and concepts lies in describing and helping to develop a health-promoting economy (11).

References

1. *CHC involvement in district management teams — policy, politics and practice* by Penelope Mullen, Kate Murray-Sykes and William Kearns. Research report No 15, price £2 inc post from the Health Services Management Centre, University of Birmingham, Park House, 40 Edgbaston Park Road, Birmingham B15 2RT.
2. *Three types of health education* in the *British medical journal* Vol 281, 16 August 1980 pages 493-5.
3. available from HMSO — see also *CHC NEWS* 85 page 1.
4. *Inequalities in health — the Black report* edited by Peter Townsend and Nick Davidson, Pelican.
5. The report of the BMA's Board of Science and Education, John Wiley and Sons, £4.50.
6. see *CHC NEWS* 73 pages 8-10.
7. *Setting the agenda — social justice* in *New society* 19 May 1983.
8. in *The health services* 17 June 1983.
9. *Health and wealth* by Peter Draper, Gordon Best and John Dennis in the *Royal society of health journal* June 1977 pages 121-6.
10. John Catford in *Community Medicine* May 1983.
11. *The health service in the next 30 years*, price £1.20 inc post, Unit for the Study of Health Policy, Guy's Hospital Medical School, 8 Newcomen Street, London SE1 1YR.

Photo: Tony Othen

Photos: Raissa Page

The good, the bad and the unlikely

by Chris Ham, Lecturer at the School for Advanced Urban Studies, University of Bristol.

In March this year the DHSS announced — in *HC(83)6* — its decisions on the suggestions made in the 1981 consultative document *Care in the community*. The health circular is important because it sets out the latest position on community care and joint finance, and introduces some changes in the use to which joint finance may be put (1).

Although in many ways less ambitious than the consultative document, the circular deserves a *cautious* welcome for a number of reasons.

First the amount of money made available for joint finance in England has been increased from £90 million to £96 million for 1983/84.

Second the period of support available through joint finance and the tapering arrangements associated with grants have been made more flexible. Revenue support can now normally be provided for up to seven years — including three years of 100% funding. In exceptional circumstances the Secretary of State may agree to funding for a maximum period of nine years.

However, for schemes which enable people in hospital to move to care provided by local authorities or voluntary organisations grants may be given for a period not exceeding 13 years — including 10 years of 100% funding.

Third in future it will be possible to use joint financing on housing and education provision — whereas in the past joint finance has been used only on local authority personal social services schemes, projects run by voluntary organisations and primary or community health care which contributes directly to collaboration with local authority services.

A statutory basis has been provided for this in the *Health and social services and social security adjudications Act 1983* which received the Royal Assent shortly before the dissolution of Parliament in May. The provisions of the Act will come into force as soon as a commencement order is laid before Parliament.

Fourth money has been set aside for a programme of pilot projects which aims to explore and evaluate different approaches to moving people and resources into community care.

The allocations for pilot projects are £1.6 million in 1983/4 and £3.3 million in 1984/5. Bids have been invited from health authorities and local authorities. The projects will be evaluated by Kent University's personal social services research unit.

Fifth in connection with the pilot projects the DHSS hopes to set up an information resource to assist local development of imaginative schemes.

Sixth the circular emphasises the importance of involving the voluntary sector in the provision of community care and in future joint consultative committees will include members drawn from voluntary organisations.

These are the welcome features of the policy. On the other side of the balance sheet there must be doubts about the feasibility of the main proposal in the circular — that health authorities should make lump sum payments or continuing grants to local authorities to care for people moved from hospital to the community.

The idea is that — *independently of joint finance* — health authorities should find money from their main programmes to assist in the development of community care.

How willing will health authorities be to use their resources in this way? An indication of the likely response is shown by a survey of the old area health authorities carried out by Loughborough University in 1981 on behalf of the National Association of Health Authorities (2).

Some 30% of those authorities which responded to the survey favoured the idea of resource transfer — but 50% were against. Amongst the authorities which indicated support many felt there would be a need to introduce safeguards to ensure that the transferred resources were used for the agreed purpose.

This response reveals a genuine fear among health authorities that resource transfer may simply enable local authorities to spend more on other services rather than to increase the personal social services budget.

The same fear exists on the circular's proposal that eventually these arrangements will be put on a permanent footing through the central transfer of resources. In practice this is likely to mean a reduction in the RAWP allocations to health authorities and a matching increase in the rate support grant allocations to local authorities.

Unless the money transferred is earmarked for the provision of community care — and local authorities have traditionally opposed earmarked grants — then there is no guarantee that the money will be used as intended.

For these reasons it must be doubted whether many health authorities will take up the opportunity offered by the circular to make lump sum or continuing grants.

These doubts are reinforced when the financial constraints facing the NHS are considered. With most health authorities receiving little or no growth in their budgets it is difficult to see where money can be found to transfer to local authorities. Real savings in NHS spending on the mentally ill, mentally handicapped and elderly people are only likely to occur if whole wards or hospitals are closed — and that is a long-term process.

The circular recognises this and suggests that joint finance will provide bridging money to fund the development of community care until the full savings accrue from the movement of people out of hospital.

Whether £96 million a year nationally is sufficient bridging finance remains to be seen.

In any case health authorities which *do* make savings through ward closures may well decide to improve their own services rather than transfer the money to local authorities. Successive Committee of Inquiry — into individual hospitals such as Normansfield — reports together with advice from the Development Team for the Mentally Handicapped and the Health Advisory Service have highlighted the need for greater investment in long-stay hospitals to improve the standard of care for patients.

Equally there is a continuing need to spend money on community health services to help prevent hospital admissions.

One of the flaws in DHSS thinking is that care in the community has to be developed *within available resources*. The argument here seems to be that current health and personal social services spending in the Cinderella sectors is about right and all that is needed is to shift the balance away from health to social services.

The reality is that available resources are inadequate and unles extra funds are found community care will remain uneven and inadequately developed.

In this respect it is worth noting that the title of the circular — *Care in the community and joint finance* — is misleading because the document is not concerned so much with community care as with getting people out of hospital. One of the unfortunate consequences is that the needs of people in the community who may in the future need help from the health and social services are not given adequate consideration.

Admittedly the circular *does* state that vacancies in community care facilities supported from DHSS funds may be filled by people who would otherwise need to be admitted to hospital — but overall the emphasis is on getting people out of inappropriate institutional care and not helping people stay in their own homes or meeting unmet needs in the community.

Unless the care of those already in the community is given attention the result may be simply that the hospital places vacated through resource transfers will be immediately filled by new admissions.

This point was made very forcibly by the Independent Development Council for People with Mental Handicap in its response to the 1981 consultative document (3). It applies not only to mentally handicapped people but also to the elderly and mentally ill.

A final criticism is that — although the circular recognises the importance of joint planning — there is a danger that projects will be funded in an *ad hoc*, opportunistic way without any jointly developed strategy. Unless there is an overall vision of where services are going in the next 10 to 15 years inappropriate schemes may be supported and money will be tied up in buildings which are not wanted.

So it is important that the joint financing cart does not lead the joint planning horse.

In this respect it is relevant to compare the English situation with what has been happening in Wales. The Welsh Office has developed a coherent strategy on mental handicap services and is providing specific funds amounting to £23 million over 10 years to implement the strategy (4). This money has been taken out of the main NHS budget and earmarked for spending on local authority services for the mentally handicapped.

It remains to be seen whether this approach will be more effective than the policy set out in *HC(83)6*. Howard Glennerster and his colleagues suggest — in a recently published analysis of joint planning in two London boroughs over a seven-year period (5) — that central government's role should be limited to facilitating and guiding the development of *local* client group plans.

Glennerster argues that a lowkey approach to planning is likely to be more successful than the centrally-guided comprehensive and rational philosophy pursued from 1976 onwards. Local plans combined with client group budgets provide a sounder basis for developing services, he believes, than national blueprints do.

While this approach has the virtue of acknowledging the realities of bargaining and negotiation at the local level, it is difficult to see how it will assist the development of community care in those districts where health authorities and local authorities are not willing to collaborate in even a limited way.

It will therefore be interesting to follow the progress of the Welsh mental handicap initiative and to see whether the strong leadership provided by the Welsh Office produces effective results.

References

1 For two articles explaining the basis of joint financing see *CHC NEWS* 69 page 11 and 70 page 11.

2 *Survey of joint financing*, NAHA, July 1981.

3 *Response to "Care in the community"*, 1981, Independent Development Council for People with Mental Handicap, 126 Albert Street, London, NW1.

4 *Report of the all-Wales working party on services for mentally handicapped people*, Welsh Office, July 1982. See also *CHC NEWS* 86 pages 4 and 5.

5 *Planning for priority groups* by Howard Glennerster with N Korman and F Marslen-Wilson, Martin Robertson, 1983.

Health News

Continued from page three

Surgeons — calculates that 40% to 50% of children's wards fall below *minimum* staffing levels and 93% are below the *optimum* level recommended by the 1976 Court report — *Fit for the future* — on child health services.

Special and intensive care baby units and nurse staffing in the UK — by CHM Walker for the BDA and BAPS — found 21% of units have no formal staffing establishment and of those that do less than 50% fill the posts. Special care cots are up to recommended levels but there is a 40% shortfall in intensive care cots, it says, and staff turnover is endangering standards.

Midwife and nurse staffing and training for special care and intensive care of the newborn is by the BDA with the Royal College of Obstetricians and Gynaecologists. It examines the pressures and poor working conditions which make nurses reluctant to work in units for the newborn, and says there is an "urgent need" for central co-ordination of training and staffing.

All three reports call for a DHSS-led, regional approach to resources. They are free with a large sae from the BDA, 23 Queen Street, London WC1N 3AZ.

Water fuss

A long-awaited Court judgement on the legality of fluoridising water supplies has been delivered — and offers little comfort to either side of the debate.

In a case brought against Strathclyde regional council — the longest hearing in Scottish history — Lord Jauncey *rejected* the argument that fluoridation can damage health but *agreed* that the *Scottish water Acts* of 1946 and 1980 do not permit water authorities to add chemicals for purposes other than purification. The Scottish judgement does not affect English law but legislation for England and Wales uses *similar language to regulate treatment of* water.

The Fluoridation Society says the ruling is "just a legal hiccup". It welcomes the "complete vindication" of fluoridation's safety and value, and is now pressing the Government for a change in the law.

News in brief

■A redrafted version of the *Data protection Bill* has been reintroduced into the House of Lords and is likely to be amended further by the Lords — who are studying it in committee as we go to press — before it returns to the Commons in the autumn.

■From 1 July all junior doctors' rotas must guarantee freedom from duties every second night and second weekend. Further reductions recommended for August "will be subject to the needs of patient services in terms of time and money" says the Health Minister.

■A new german measles epidemic has prompted the DHSS chief medical officer to write to GPs, nursing and medical officers urging them to screen women of child-bearing age for rubella immunity. A major immunisation take-up campaign will start in the autumn.

■Over one million people have stopped smoking since 1980 — according to figures from the Office of Population Censuses and Surveys. When the figures were announced the Health Education Council took full page adverts in newspapers to encourage more to give up. There are now eight million ex-smokers in the UK, say the adverts, and twice as many people do not smoke as do. But smoking still kills 250 people a day. A new education programme for children aims to halve the number of school-leaver smokers in ten years' time.

Volunteers at large

Like it or not, volunteer groups of all kinds are taking an increasing share of the burdens of caring for the sick, the elderly and the disabled — and their share is no longer confined to the fringes of the health care network.

As essential services come under increasing presure — and in some districts close down altogether — the quality of services offered by volunteeer bodies will come in for close scrutiny.

CHCs will want to be involved in that process, and need to keep informed on developments in the volunteer field.

So here are some examples from a flourishing supply of publications for and about volunteers.

Professionals and volunteers — partners or rivals? takes a hard look at areas of conflict within the field of mental health. Based on a World Federation for Mental Health seminar held in London last July, the report draws on international and UK experiences to examine volunteers' activities in service provision, self help groups and advocacy — a concept which is relatively new to the UK but well-established in countries such as the US. Edited by Pat Gordon and published by the King Edward's Hospital Fund for London, the report is £2.50 inc post from the King's Fund Centre, 126 Albert Street, London NW1 7NF.

A more detailed examination of advocacy comes in *Volunteers as advocates* by Roger Lawrence. The term can cover assistance to individuals in presenting legal or other formal cases as well as the championing of causes at national level. This study includes both in its mapping of the rapidly developing UK advocacy network — and includes the "potentially significant development" of CHCs and their involvement in complaints procedures. Published by the Volunteer Centre, it is £3.50 plus 45p post from the Centre, 29 Lower King's Road, Berkhamsted, Herts, HP4 2AB.

Another Volunteer Centre publication discusses why people volunteer — and how best to tap their potential. *Volunteers — patterns, meanings and motives* incorporates interviews with people involved in a range of volunteer activities along with several research projects examining the sociology and psychology of volunteering. Described as a "symposium" it offers no glib conclusions, but does suggest that an insight into motives can help in assessing the potential for volunteers to plug the gaps in statutory services. Edited by Stephen Hatch, it costs £4.95 plus 45p post from the Centre — address above.

Voluntary effort cannot be seen simply as "an inexhaustible fount of goodwill" which can be drawn on to plug these gaps, says *Mobilising voluntary resources — the work of the voluntary service co-ordinator* (VSC). Effective mobilisation needs skilful organisation by VSCs — whether paid or unpaid. This study by Pat Gay and Jill Pitkeathley analyses the tasks of VSCs working in Berkshire and draws broad conclusions on their common needs — particularly the need for recognition and for the resources to do the job properly. Published jointly by the King's Fund and the Volunteer Centre — King's Fund *Project paper 29* — it costs £2.30 inc post from the Centre — address above.

Guidance for VSCs in assessing their own training needs is offered in *Training for volunteer organisers — a realistic approach* by Chris Wood. Designed originally for VSCs in London, the action plan, lists of information and education sources and the analysis of attitudes and necessary skills will be useful to organisers wherever they work. The booklet is £1.75 inc post from the London Voluntary Service Council, 68 Chalton Street, London NW1 1JR.

Components of welfare — voluntary organisations, social services and politics in two local authorities examines "welfare pluralism" — the mixed provision of social and health services by statutory, voluntary, commercial and informal sectors — by contrasting practice in the two very different areas of Islington and Suffolk. It deals in depth with issues of accountability, collaboration and political control, and discusses the role of participation by interest groups in the political process. The study — by Stephen Hatch and Ian Mocroft — was commissioned by the Personal Social Services Council in response to the Wolfenden Committee's 1978 report *The future of voluntary organisations.* It raises important questions about the voluntary sector's contribution to welfare provision. Published by the Bedford Square Press, it costs £9.95 from bookshops or — plus 50p post — from Macdonald and Evans Distribution Services, Estover Road, Plymouth PL6 7PZ.

Womb for improvement

*by Sally Haslett**

Over 1000 women every week have a hysterectomy in England and Wales. For many the suggestion of a hysterectomy provokes reactions of fear and horror — due mainly to the misconceptions and folk tales surrounding this particular operation — and until recently there were few sources of accurate knowledge readily available.

Now, however, because of pressure from women themselves and increasingly from the media this need is being recognised.

There are now booklets and other publications available, but more important is the opportunity to talk the whole thing through with an informed but approachable person or "counsellor" — preferably someone with nurse training and additional qualifications and experience.

Some gynaecological ward sisters and hospital medical personnel are excellent at foreseeing and fulfilling this need while the woman is actually in hospital. Unfortunately, they are rarely available before admission or after discharge — times when there can be considerable anxiety.

Hysterectomy counselling is a somewhat new concept in patient care. I am grateful to the medical and nursing staff at St Thomas's Hospital in London for allowing me to pioneer this new service.

Patients, their husbands or partners and their families can come to me for discussions at any time after the first suggestion that a hysterectomy may be necessary. I see patients before and after surgery on the gynaecological wards and I am available for further discussions after discharge.

I cover all aspects of advice — including specific information on general health and sexual activity after surgery. I find this service is greatly appreciated by patients and they often express concern that the need for counselling is not more widely recognised.

Initially women require practical advice about their hospital admission. They want to know:

- what the operation involves
- what the options are on vaginal or abdominal surgery
- how long they will be in hospital.

They require practical advice about the convalescent period:

- how soon can they resume housework ... climb stairs ... carry the shopping?
- will they need help at home?
- when may they return to work ... drive a car ... resume a sexual relationship?

Premenopausal women are naturally concerned about whether the ovaries will remain or be removed:

- how will it affect the menstrual cycle and menopause?
- what are the implications of hormone replacement therapy?
- will contraception still be necessary?

Most women want to discuss any relation between the operation and consequent weight gain or depression. And — often the hardest to discuss — whether it will affect feminity and sexuality.

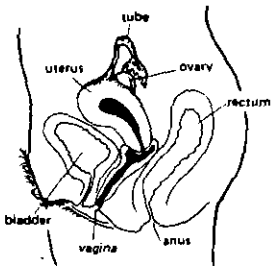
Ideally the surgeon or family doctor should give the necessary information but women are often reluctant to approach them or feel guilty about taking up their time. They are also embarrassed about discussing the more personal and sexual implications of the operation. This is often the very area which causes most anxiety.

One of the most valuable facets of this work has emerged from discussion of sexual activity. For many women simply discussing sexuality on a professional level is a revelation. Many have harboured doubts or misgivings for many years without knowing where to turn for advice. It can be comforting to discover that a "problem" is widely shared or that a supposed "deviation" is in fact normal practice.

Often reassurance or a practical suggestion is all that is needed. If more complex psychosexual problems emerge they can be referred for skilled therapy — but this is rarely required.

Some women have tremendous fears about loss of feminity or altered sexual feeling and many women experience real difficulty in coming to terms with the loss of their womb. Members of certain ethnic groups find this operation particularly hard to accept and may have religious or cultural problems to overcome. Many require skilled and lengthy counselling.

By alleviating a lot of anxiety associated with the operation women can look forward instead to a new lease of physical, mental and sexual life. Hysterectomy counselling should be available wherever the operation is performed.



Before a hysterectomy

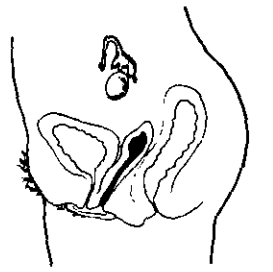

After a hysterectomy. In this case the tubes and ovaries have been left behind.

Diagram: Nancy MacKeith

Handbook for patients having a hysterectomy or vaginal repair by Sally Haslett and Molly Jennings gives essential pre- and post-operative informaion and includes a section on breathing, exercise and physical activity. It is published by Johnson and Johnson and available from Sally c/o Gynaecological Outpatients, St Thomas' Hospital, Lambeth Palace Road, London SE1

** Sally Haslett is a Specialist Health Visitor for West Lambeth DHA and Vice-Chair of the National Association of Family Planning Nurses.*

Continued from front page

take action on glue sniffing — see page 12 — to establish a working party to review complaints procedures and to initiate discussions with relevant bodies on the problems of patients wishing to change doctors.

Controversy arose over a composite motion asking the Government to demonstrate its commitment to the NHS firstly by giving additional funding to under-provided districts and secondly by rejecting plans to direct resources into the private sector — including the contracting out of ancillary services.

The conference decided to vote on the two parts separately — but after debate both parts were carried with substantial majorities.

There was a lively discussion on the health circular section which prevents NHS staff from serving on CHCs in the districts in which they work, but the motion condemning this was lost.

CHCs in the North East Thames region described the drastic cuts made in their budgets on the grounds that CHCs are part of management costs. A motion was carried directing ACHCEW to protest strongly to the DHSS about this way of classifying CHCs.

Fringe meetings were held on centralising waiting lists, "test tube baby" ethics, community mental handicap services and the MSC community programme. Sheffield's Lord Mayor hosted an enjoyable civic reception at the Mappin Art Gallery.

John Austin-Walker was reconfirmed as chair of ACHCEW and Alan Ham retained his post of treasurer. Clifford Davies of Stockport CHC was elected vice-chair in a contest against Eva Mullineaux of North East Yorkshire CHC and thanks went to outgoing vice-chair Judy Thomas. The contribution to CHCs' development made by outgoing ACHCEW Secretary Mike Gerrard was acknowledged with thanks and a standing ovation. He was presented with a home computer and a brief case.

In his concluding remarks John Austin-Walker pointed out that — although around 50% of representatives at the AGM were female — there were no longer any women on the platform. And there was not a single black person at the conference. "We must find ways of ensuring that this situation changes in future years" he said.

Book reviews

Arthritis — is your suffering really necessary?

by William Fox, Sheldon Press, £1.50.

This book is written for the public by a doctor who has served for 50 years as a GP and rheumatologist. He has been a sufferer of arthritis and it was this that sparked his interest in rheumatic diseases and led to his research into early signs and symptoms and methods of treatment.

The book outlines his findings and the reason why so many cases are not diagnosed until the late stages of the disease. The idea that conditions such as migraine and allergies are factors in considering rheumatic disease is illustrated by case histories which make fascinating reading.

The book offers a radical new approach to the understanding and treatment of arthritis. Though many of Dr Fox's views are not accepted at present by a number of rheumatologists, they are certainly worth considering and CHC members should find the book interesting and thought-provoking.

E M Bussby, Chair, Chichester CHC

Living with death and dying

by Elizabeth Kübler-Ross, Souvenir Press, £5.95.

This is one of the most moving books I have ever read. It has a wonderful insight into the psychology of children and their entirely different attitude to terminal illness from that of adults. I was fascinated by the thoughts of Dr Ross and the histories of her patients.

The book is not light reading but for any CHC member interested in hospice work it is "a must". Dr Ross and her co-authors bring into true perspective the phobias about terminal illness which have concerned so many people for so many years.

The first section of the book discusses techniques for dealing with sick children at home and in hospital. Having started to read it I just had to finish with utmost speed. The second section explains the way that children can communicate their innermost thoughts through drawings — thoughts they cannot explain in words. I found this quite fascinating. The final section deals with parents' care of the dying child and highlights the very different approaches that parents adopt, with splendid advice to those faced with such traumatic events.

The book has added a lot to my personal knowledge and I commend it to all in the hospice movement.

E A Hebron, Chair, Wirral CHC

The public/private mix for health — the relevance and effects of change

edited by Gordon McLachlan and Alan Maynard, The Nuffield Provincial Hospitals Trust, 3 Prince Albert Road, London, NW1 7SP, £17.50 (£15 to CHCs) inc post.

This hefty volume predictably plumps for partnership between the NHS and the commercial sector — "the right mix with the right degree of flexibility" — coupled with a strong emphasis on policy-oriented empirical research in place of "naive ideological perspectives".

In doing so it offers some useful insights into the common problems faced by widely differing health care systems in Western Europe and the US.

Foremost amongst these are the spiralling costs arising from medical advances and demographic change — especially where concern for equality of provision remains politically significant.

The major response to problems of cost and equity has been the resort to increasingly detailed regulation. In the UK this has meant cash limits and RAWP — elsewhere complex negotiations between government, funding agencies and service providers have sought similar goals.

These developments challenge two current myths — that only state-run systems are highly regulated and bureaucratic, and that private funding resolves problems of inadequate resources.

Other familiar issues include the pervasive power of the medical profession, the lack of adequate research into the value to patients of many medical procedures, and the problems of containing drug costs in the face of powerful manufacturing interests.

The book's main weakness lies in the issues excluded by its depoliticised, technocratic agenda for health. Questions of democratic accountability below central government level are ignored — although an expanded private sector will make key decisions arguably even less accessible to public influence.

Similarly there is no acknowledgement of the extent to which the definition of problems is itself a political process — if the wider political environment increasingly endorses a principle of inequality health policy will inevitably come to reflect this shift. Private funding would be the most obvious mechanism to legitimise such a change.

This book is a salutory reminder that our current ills cannot be cured by instant political prescriptions, and that rhetoric alone is no substitute for well-based research. Ultimately, though, the choice it offers us between politics *or* research is a false one.

The book threatens to disallow the political vision and determination which created the NHS and which will be needed more than ever if the NHS is to be sustained.

Ged Moran, Health Liaison Officer, London Borough of Greenwich.

The challenge of pain

by Ronald Melzack and Patrick Wall, Penguin, £4.95.

This is a revised edition of a highly technical account of research into pain mechanisms. The authors describe the accelerating discoveries about the nervous system, demonstrating complexities undreamt of a few years ago.

This material is obviously meant for qualified workers in the fight against pain and less than half the book is likely to be fully comprehensible to CHC members. The chapter on pain clinics and the hospice system is simpler — and excellent — and the final chapter indicates the future of pain control.

Edith Wood, former Member, North Nottingham CHC

Smoking — psychology and pharmacology

by Heather Ashton and Rob Stepney, Tavistock Publications, £3.95.

This book deals with the psychology of the smoker and the effects on the body of some of the principal chemicals produced by smoking cigarettes. It gives a history of the growth of the tobacco habit and an appendix lists the landmarks in international tobacco use, trade development and legislative action.

For instance, the introduction of cigarette-making machines in the 1880s made possible the mass production of cigarettes which led to an explosive spread of the smoking habit in the first world war and after, and the subsequent dramatic increase in lung cancer.

The effects of nicotine and the regulation of nicotine intake are reviewed in detail. Other chapters discuss the psychology of smokers, individual and social attitudes towards smoking, habit formation and techniques of stopping.

The authors regard the public as generally aware of smoking as a form of "slow-motion suicide" — despite which, they say, the proportion of the population smoking is not radically different from twenty years ago. But recent evidence supports major changes. According to official statistics the proportion of male smokers fell from 52% to 42% in 1980, and of female smokers from 41% to 37%.

So the majority of the nation is now non-smoking, but the significance of this important change is not discussed. Of course there is still a large minority of smokers but it seems that the public outlook is changing more rapidly towards positive action on smoking — despite the vast publicity expenditure of the tobacco companies.

There are good grounds for the authors to be more optimistic — but the book is a valuable source of references and information.

Dr Victor Freeman, Honorary Medical Advisor, National Society of Non-Smokers.

Scanner

Safety in hospitals

Care for health service employees has sometimes taken second place to patient care, says a report from the health services advisory committee of the Health and Safety Commission, while management structures and NHS reorganisation have made it difficult to identify who should take responsibility for health and safety policies. *Safety policies in the health service* — HMSO, £2.40 — advises on legal requirements and on preparing, publicising and monitoring policies under the *Health and safety at work Act 1974.*

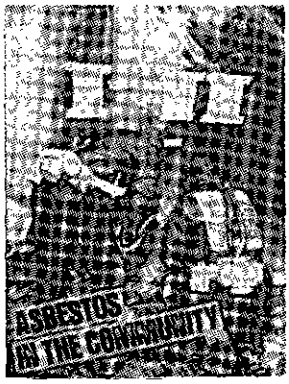
A recent questionnaire from the Association of Scientific, Technical and Managerial Staff with the Guild of Hospital Pharmacists found a poor understanding in hospitals of the hazards of cytotoxic drugs — used to *treat* cancer, they can also *cause* cancer — and identified a considerable confusion between "safety equipment" which protects the drugs from contamination and that which protects staff using the drugs. *The safe handling of cytotoxic drugs* gives safety guidelines for pharmacists — £1 inc post to ASTMS members, £2 inc post to others, from ASTMS health and safety office, 79 Camden Road, London NW1 9ES.

The child on the ward

"Children can be seriously disturbed by a period of hospitalisation" says a study from the Royal College of Nurses, but telling a child the truth about what will happen in hospital reduces anxiety and helps the child to cope. *Will this hurt — preparing children for hospital and medical procedures* by Jocelyn Rodin reproduces the violent fantasy of a badly frightened child, and reviews methods of reducing fear through games, books and teaching. Price £4 inc post from the Rcn publications department, 20 Cavendish Square, London W1M 0AB.

Ombudsman in brief

A new presentation of the health ombudsman's report gives "epitomes" — short summaries of selected cases — before giving the investigation reports at length. The ombudsman says the degree of detail in his reports formerly made them "relatively inaccessible". The epitomes have been circulated separately to DHAs, FPCs and CHCs. *Report of the health service commissioner — selected investigations completed October 1982 to March 1983* is £9.90 from HMSO. The epitomes accompany "Dear administrator" letter DA(83)30.



Asbestos action

Spelling out the hazards to workers, tenants, children and the public, *Asbestos in the community* from the General, Municipal and Boilermakers union explains safe disposal procedures, refutes common myths about asbestos and includes a checklist to weed out the cowboy removal contractors — free to GMB members or 20p inc post from GMB regional offices or Head Office, Thorne House, Claygate, Esher, Surrey.

A report on current practice in local authorities from the independent Labour Research Department describes action by 54 councils which replied to a survey, with details on the 39 which allowed their names to be published — it also describes the planned removal programme adopted by Lambeth Council. *Coping with asbestos — local council solutions* is in *Bargaining report 26*, £2 inc post from LRD, 78 Blackfriars Road, London SE1.

Preventing GPs

After five reports on the prevention of particular forms of ill health a new discussion document from the Royal College of GPs develops the concept of "anticipatory care" — "the union of prevention with care and cure". The document discusses how GPs can make room in their practice for screening and other preventive measures, and criticises the DHSS for "a tendency to let curative medicine wither from underfunding without any commensurate additional provision for the promotion of health and prevention of illness". It calls for changes in medical education and urges doctors to accept the contribution of CHCs — especially in educating the public on the best use of health services. Each local medical committee should nominate GPs to meet their CHC quarterly it suggests, and CHCs should be able to appoint a member to the DHA's primary care committee. *Promoting prevention — occasional paper 22* is £3 inc post free from the Publications Sales Department, RCGP, 14 Princes Gate, Hyde Park, London SW7 1PU.

This free leaflet from the Sickle Cell Society explains in simple terms the difference between sickle cell anaemia and the healthy carrier state of sickle cell trait. Fuller details are in A handbook on sickle cell disease — a guide for families — *including a clear description of the different combinations of gene inheritance, guidance on symptoms of the several blood disorders known as sickle cell disease, advice on problems of children and adults, and a useful glossary of terms. Price £1 inc post from the Society, c/o Brent CHC. Two new leaflets from the Health Education Council are* Sickle cell disease — a guide for teachers and others caring for children *and* a guide for GPs, nurses and other health professionals — *free from health education units or the HEC, 78 New Oxford Street, London WC1 1AH.*

Health circulars

HN(83)16: invites RHAs to apply for funds — up to £10,000 each — for district-level dental health surveys and education programmes.

HN(83)17: revises guidance on recovering capital costs of schemes shared with universities.

HN(83)19: introduces a new NHS spectacle frame for women.

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 4: North Derbyshire CHC Secretary: Beverley Langton
Page 5: Huntingdon CHC 119a High Street, Huntingdon, , Cambs PE18 6LG. Tel: (0480) 51657
Page 6: Hammersmith and Fulham CHC Address and Tel as for South Hammersmith CHC. Secretary: Susan Beatty Chair: Joy Mostyn
Page 6: East Hertfordshire CHC Chair: GD Game
Page 10: West Dorset CHC Tel: (0305) 63123
Page 10: Portsmouth and South East Hampshire CHC Tel: (0705) 383832
Page 10: Croydon CHC Tel: 01-680 1503
Page 11: Bristol CHC Tel: (0272) 277840
Page 12: Somerset CHC Secretary Jennifer Martin
Page 14: Blackpool, Wyre and Fylde CHC 10 Queen Street, Blackpool FY1 1JU. Tel: remains unchanged
Page 16: Pembrokeshire CHC 1st Floor, Picton House, 2 Picton Place, Haverfordwest, Dyfed SA61 2LU. Tel: unchanged
Page 16: Rhymney Valley CHC Chair: Colin Wakely
Page 22: Edinburgh LHC 21 Torpichen Street, Edinburgh EH3 8HX. Tel: remains unchanged
Page 24: Society of LHC Secretaries 11 Orchard Street, Falkirk FK1 1RF. Tel: (0324) 34658. Secretary: Anne Robson. Chair: JWH Murray

News from CHCs

The lack of facilities to help glue sniffers is worrying many CHCs and Government support for a low-key approach to solvent abuse has been criticised for encouraging inactivity.

□ **Arfon Dwyfor CHC** believes the problem of children interpreting warnings as how-to-sniff guides could be overcome by labelling solvents with simple "danger to health" warnings — without specifying the dangers. The CHC also wants laws against drunkenness in public extended to cover other forms of intoxication including that produced by glues and solvents.

□ But **Rhymney Valley CHC** thinks the problem can be tackled by self-help methods. At a public forum called by the CHC, sniffers and ex-sniffers described the difficulties of kicking the habit without help and parents complained that they were unable to identify the right agencies to approach for advice. Young people at the forum were adamant that punitive methods would not help them or their peers. Instead the CHC is encouraging sniffers to set up their own group — perhaps based at the CHC office with a 24-hour phone line — and to invite support from whatever agencies they themselves feel would be most helpful.

□ **Dudley CHC** is using its answer-phone as a 24-hour link into a network of agencies offering confidential advice by phone during office hours. Posters advertise the phone number and tell parents how to obtain one of the 20,000 leaflets produced for their guidance. So far the leaflets are in great demand but not a single sniffer has come to light. This suggests says the CHC that the true problem — at least in this district — could be one of parental anxiety.

□ And good news comes from **Bromley CHC** — in its district glue sniffing is no longer fashionable. After discussing the DHSS consultative letter — see *CHC NEWS* 84 page 3 — the CHC contacted its local youth services and learned that a Bromley-wide counselling project had found only one customer in six months.

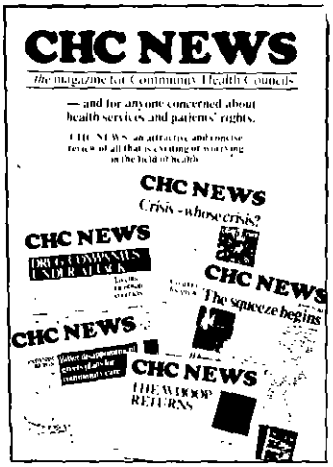
□ **Somerset CHC** is hoping to publish a leaflet telling sniffers how to minimise the dangers — do not sniff glue on derelict sites, for instance — describing the long-term damage to health and advising parents on tell-tale signs.

□ Regional groups of CHCs are being offered a stake in a booklet produced by the **Oxford Regional Association of CHC Secretaries**. *CHCS — origin, role and objectives* was designed to plug the publicity gap in the Oxford region. Some 7000 were published at 15p each but this price could be reduced with a larger print run and the booklet is designed to take alterations in the regional information. Health Ministers were asked to fund the booklet — the secretaries pointed out that national publicity for Citizens' Advice Bureaux is funded by the Government — but the DHSS replied that publications must be paid for from CHCs' resources.

□ Cultural and language barriers can make it difficult for elderly people from ethnic minorities to use services for the over-65s. **Wandsworth CHC's** working group for the elderly is concerned about the lack of resources for this group. At a meeting to discuss the issue members heard about a further problem — traditional family support for old people is breaking down under pressures from British society.

□ Proposed changes in the system of funding capital developments in Wales have prompted the forming of a **Joint Committee of Gwent and Mid Glamorgan CHCs** to ward off a threatened crisis in hospital services. A change from central to area funding means schemes at the end of a 17-year queue for money are unlikely to be built. Since 1966 the Welsh Office has been working through a list of 39 hospital building schemes by top-slicing money from total allocations for Wales. From April 1984 the funds will go directly to AHAs — leaving eight schemes unfinished. Five of these are in the joint committee's area — the two most populous counties in Wales. The CHCs argue that the NHS is already under severe strain in these counties and sharing out the money means no one AHA will have enough to complete its share of the building programme. The plan is a good one in principal but premature say the CHCs. The new system was announced two years ago but AHAs themselves were unaware of the implications until CHCs called a meeting to discuss their fears.

Since then the CHCs have taken their fight to a wider audience — a conference involving representatives of local authorities, trades unions, professional bodies and voluntary organisations. A delegation elected by the conference has asked to meet the Welsh Secretary of State in the hope of persuading him to delay the funding change until all remaining schemes are finished.



CHC NEWS sales figures are looking very healthy but the magazine's survival still depends on subscriptions from outside the CHC movement. We hope CHCs themselves will want to be involved in spreading the word — and to help you to help us we have produced this leaflet. Perhaps it could be slipped into mailings of your annual report or why not take a few along to DHA meetings? Free from the CHC NEWS office — and we can supply sample copies of the magazine too.

□ **Ealing CHC** identifies similar problems in its report *Provision of health services to the immigrant elderly in Ealing.* Some elderly immigrants live alone because they were unable when younger to bring their families to the UK. Larger numbers live — sometimes in overcrowded conditions — with families whose westernised children may not respect them and may not speak the same language. Tensions within the family and racial hostility outside it cause alienation leading to mental illness and alcoholism — which the report says appear to be on the increase. The report discusses the obstacles to seeking and getting help and suggests some solutions to problems with staffing, provision of NHS facilities, prevention, local authority facilities and voluntary provision.

□ CHCs are getting into health promotion in a big way — judging by a recent King's Fund conference. Around 100 CHC staff and members gathered in London to discuss *Health promotion; the challenge for CHCs* but another 200 were turned away for lack of space. The conference was sponsored by the King's Fund with the **Association of CHCS**, the Guy's Hospital Unit for the Study of Health Policy and the HEC. Director of the Guy's Unit Peter Draper spoke on the social, economic and political context of health promotion — an article based on his speech is published in this issue of *CHC NEWS* — and Bloomsbury district medical officer June Crown described the opportunities to take health messages to NHS staff and even — in her central London district — to tourists and Oxford Street shoppers. Outgoing ACHCEW Secretary Mike Gerrard outlined future directions for CHC initiatives — in preparing for pregnancy and parenthood, preventing accidents to children, improving drug safety and development and in promoting health for the elderly. The HEC's Director David Player described his strategy of health education as a preventive package allied with legal, fiscal and political measures. The conference decided to send him a letter to applaud his marketing approach to health and to ask him to give positive support in combating the anti-health environment of the twentieth century. So successful was the conference that the organisers are planning to hold another.

□ Our sympathies to **Meirionnydd CHC** and to the family of Emyr Davies who died suddenly in May. Emyr was 53 and had been Secretary of the CHC since October 1980.