CHC NEWS

For Community Health Councils September 1983 No 89

A dusty answer on asbestos

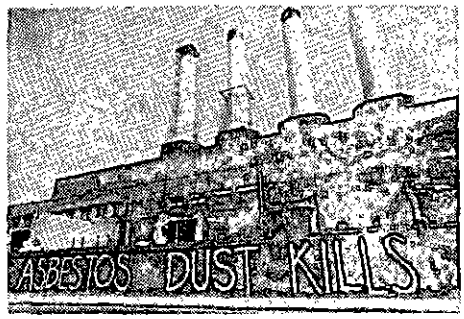

Photo: The Guardian

After some months of growing controversy over controls on asbestos the Health and Safety Commission has produced a package of proposals condemned as inadequate by trades unions.

And parts of the package — on safety measures to protect the public — may be delayed still further because of disagreements within the European community.

During a nine-hour meeting the Commission — under its full-time chair Bill Simpson — discussed reports of two investigations ordered after the TV documentary *Alice — a fight for life* was shown last summer.

The first report — by the DHSS' chief medical officer-designate Professor Donald Acheson and Dr Martin Gardner of the Medical Research Council — assessed the medical effects of asbestos from evidence arising since the Commission's advisory committee on asbestos (ACA) reported in 1979. The Acheson report confirmed that asbestos causes cancer — and Professor Acheson has called for the phasing out of asbestos use.

The second report, by Stephen Grant — the Scotland area director of the Health and Safety Executive — gave the findings of a team drawn from management, unions and the HSE on the potential in industry for tighter controls on asbestos.

That report is very critical of present control standards. The team found a widespread disregard for the most basic safety measures within industry, and called for a ten-fold reduction in present limits on airborne asbestos dust.

After the Commission's meeting Mr Simpson announced:

- a halving of the control limit on airborne white asbestos from 1 August 1984
- a reduction from 1 June 1984 of the brown asbestos limit down to the present level for blue
- a formal ban on blue and brown raw material and finished product imports, and use in UK manufacturing
- a recommendation to ministers to implement draft regulations on licensing asbestos removal contractors
- consultation with the Department of the Environment on two EEC directives dealing with labelling and marketing of asbestos products, medical surveillance of workers and other initiatives proposed — but never implemented — by the ACA in 1979
- a working group to prepare guidance on the criticisms in the Grant report
- further discussions between Government, the Commission and the European Commission to reassure the public about asbestos in homes and public buildings.

But the licensing regulations will exclude employers using their own staff to strip out asbestos on their own premises, and unions point out that:

- airborne dust levels are still too high
- no date has been set to phase out all asbestos use
- there are still no positive proposals to protect the public from asbestos in the environment.

After the meeting a European Commission spokesman said there is disagreement on asbestos within the council of the EC. Proposals published so far are "fairly modest" he said.

Listening to the customer

Mr Roy Griffiths, managing director of Sainsbury's

The NHS management inquiry team under Sainsbury supermarkets' managing director Roy Griffiths has turned late in the day to tap CHCs' knowledge of patient satisfaction.

Set up in February by Secretary of State Norman Fowler as an advisory body, the Griffiths team has a broad brief — to examine how NHS resources are used and controlled, and to identify how management practice can ensure "the best value for money and the best possible services for patients".

Within this wide sweep of the NHS scene Mr Griffiths has homed in on general management function and the line of executive authority from the centre — the DHSS — down to unit level.

The team will also look at doctors' clinical and administrative decision-making, and a small study in Bromley aims to follow clinical decisions from first contact with a GP, through the treatment process, to discharge from hospital — a train of events expected to take ten days.

Other small studies have started around the country and in mid-July Mr Griffiths was quoted as favouring market research to ascertain patients' views.

In interviews with the health press he emphasised the importance of how patients experience the treatment they receive.

Late in July the team wrote to the Association of CHCs asking for its comments by early September. ACHCEW's Secretary Tony Smythe is trying to extend this deadline, and may meet the team with other ACHCEW representatives to discuss the CHC role of patient watchdog.

The team is expected to report to Norman Fowler in October — though the form this report will take has not yet been decided. Comments may be addressed to the NHS Management Inquiry, Room D402, Alexander Fleming House, Elephant and Castle, London SE1 6BY.

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Book reviews

Coming to terms with mental handicap

by Ann Worthington, Helena Press, PO Box 2, Slaithwaite, Huddersfield, £4.95

Time and again the fact that parents are excluded from decisions on the educational, medical and social needs of their children makes newspaper headlines. It is a long time since the notion of making parents party to such decisions was first raised.

Ann Worthington brings together a large number of case studies which illustrate the problems of parents needing help. She quotes a study conducted by Huddersfield CHC in which 95 parents were questioned — all replied with some misgivings about how the professionals approached their needs.

I particularly liked her sentence — "For most parents receiving the news, it is a short, sharp introduction to the world of mental handicap which they enter blindfold and, apparently, alone."

My only criticism of the book is that so much refers to other people's work, booklists, addresses and so on. But it should be read by students in training for the professions involved with mental handicap — it would do them a world of good.

Alfred Boom, Member, West Berkshire CHC.

Children in clinics

by Alan G Davis, Tavistock, £11.50.

The aim of this study is to show the ways in which medical work with children takes on different characteristics depending on tasks and clientele. Based on research in a variety of settings — mainly out-patient clinics — its main argument is that doctors are in various ways subject to the contexts of their work settings and the nature of their clientele.

Considerable evidence is given of this and it is suggested that previous research may have given too much attention to studying the characteristics of doctors and patients and not enough to the context of medical practice.

I found the most interesting section was that concerning a clinic for developmental assessment, where children known or suspected to be handicapped were seen. This explores the ways in which the child's change from a "normal" to a "handicapped" identity is managed, and shows the clinic's setting as the last specialist referral in a system which creates a context of doubt and ambiguity around the child's identity.

While containing interesting detail, the study seems to be written for professionals rather than the general reader.

Juliet Metcalfe, former Member, Walsall CHC.

Books received

Holidays for the physically handicapped 1983 (Royal Association for Disability and Rehabilitation, £1). **Guide for the disabled traveller 1983** (Automobile Association £1.50 — free to members). **Motoring and mobility for disabled people** by Ann Darnborough and Derek Kinrade (RADAR, £1). **The new good birth guide** by Sheila Kitzinger (Penguin, £3.95). **The directory of private hospitals and health services 1983** produced by MMI Medical Market Information Ltd (Longman, £20).

Your letters

Weedkiller concern

Judith Cook, 5 Park View, Sheepy Magna, Near Atherstone, Warwickshire.

As part of research I am doing for the Agricultural Workers Trade Group of the TGWU I am putting out a questionnaire to people who think they may have been affected by the garden and agricultural chemical 245-T. The questionnaire has been drawn up with assistance from a consultant pathologist and is strictly confidential.

At this stage we are trying to assess the size of the problem. The chemical can affect not only workers but also their partners and families — or indeed, householders, gardeners and members of the public who have come into contact with 245-T through sprays. Would anyone willing to assist contact me at the address above.

Community care pilots

Fiona Cartmell, Secretary, Northern Region Association of CHCs, c/o South Cumbria CHC

We are currently planning a regional conference on care in the community for spring of 1984, and would like to ask other CHCs if they know of any research projects on this subject in their districts.

We are aiming for a well-planned assessment of pilot projects anywhere in the country so that delegates can be as well briefed as possible on recent developments — with emphasis on care of the elderly.

Aids on line

Jane Whiteley, BARD Project Assistant, Handicapped Persons Research Unit, Newcastle upon Tyne Polytechnic, No 1 Coach Lane, Coach Lane Campus, Newcastle upon Tyne NE7 7TW. Tel: 0632 664061

We are in the process of establishing the British Database on Research into Aids for the Disabled and are collecting outlines of projects involving research into aids, prototypes and one-off designs.

If *CHC NEWS* readers know of relevant work being done then we would like to hear about it. A leaflet is available from us describing BARD and explaining the sort of detail we need on each project.

Shop feeding

Susan Townend, 143 Bywell Road, Dewsbury, West Yorkshire, WF12 7LN

I am compiling a book listing shops, stores and other public facilities where mothers can breastfeed in private. Both Dewsbury and Huddersfield CHCs offer these facilities — do any other CHCs offer facilities themselves or know of such services in their districts? If so, please write to me at the address above.

The *Handbook for patients having a hysterectomy* mentioned in our last issue — page 9 — has been delayed in printing. Please send a stamped addressed envelope to the address on the article if you wish for a copy when ready.

Wanted

Information from any CHC or DHA on successful or unsuccessful examples of privatisation of hospital "hotel" services in their districts. — Leeds East CHC

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

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Comment

In July the *Guardian* newspaper revived some old scandals — in the form of 19 leaked reports from the development team for the mentally handicapped on appalling conditions in our most decrepit and inadequate mental institutions.

It is shameful to have to say that there is nothing new in these reports. The catalogue of squalor they contain has been exposed time and again by campaigners in the field and through official sources — the team's work was last leaked in February.

But ministers are aggrieved that these reports — some almost seven years old — should return to haunt them now. Are they not pushing ahead with community care? Health Minister Kenneth Clarke says "The *Guardian* articles help to illustrate the difficult balance between upgrading hospitals and moving people into the community".

Luckily enough another report published in July — with a great deal less media interest — allows us to examine the community side of the coin.

The Richmond Fellowship enquiry was set up after a 1981 House of Lords debate in which the Government was "unable to show that the necessary alternative services had been provided" to care for those who once occupied some 67,000 beds lost from mental hospitals since 1959.

Concentrating on mental illness, the enquiry looked at what happens to those who are not taken into hospital care. The answer is a bleak one.

The caring, neighbourly community is a "romantic vision". Mental health services are in "crisis". The voluntary sector is expected to cope but is starved of funding. Meanwhile chronically sick people live "in poverty or even destitution" and hostels for the homeless shelter an increasing proportion of mentally ill people.

Hospital-based care has eroded irreversibly but so far we have failed to construct its replacement. The enquiry calls this situation "intolerable" and has issued a demand for action.

Mental health and the community is £2.50 inc post from the Richmond Fellowship, 8 Addison Road, London W14 8DL.

Health News

Hard times

The tough cash limits for 1983/4 set out in health circular *HC(83)4* — see *CHC NEWS* 84 page 3 — have been revised downwards in *HC(83)16* which spells out the consequences to health authorities of the Chancellor's post election financial statement.

Authorities must pursue reductions in "less essential" spending — while preserving long-term aims and service plans. Ministers "intend that firm manpower targets will be agreed for each region by mid-September" to reduce overall staffing by up to 1% by 31 March 1984, with ancillary staffing taking the brunt of the reductions. "No vacancy should be filled unless there is a clear case for its continuation" says the circular.

Resource planning assumptions announced in June for 1984/5 and 85/6 will remains as in *HC(83)12* — but must be seen as "provisional".

Nawch grouch

Almost a quarter-century after a Government report recommended unlimited access by parents to children admitted to hospital, children are still separated from their parents for up to 36 hours in some cases — particularly in ear, nose and throat wards.

Adult wards are more likely to restrict parental access than are children's wards, yet 28% of wards admitting children are adult wards — according to a survey by the National Association for the Welfare of Children in Hospital (NAWCH).

Following disturbing reports on the lack of adequate staffing for children's units — see *CHC NEWS* 88 page 3 — the NAWCH survey reveals that only half of all English wards admitting children implement the access policy laid down in the 1959 Platt report *The welfare of children in hospital.*

The survey found regional variations in access policy — with the Northern region *least* likely to permit unrestricted parental access — but within regions variations in policy may depend on the attitudes of individual consultants. NAWCH is working closely with CHCs to improve two children's "blackspots", where consultants claim that preventing parents from seeing their children before or after an operation is a "clinical judgement".

The Airedale, Bradford and Dewsbury CHCs have combined to fight a blanket ban on operation-day visits at the Bradford Royal Infirmary's ENT unit, while Bromley CHC has recruited the Children's Legal Centre to oppose a similar ban at the Albert ENT ward at Farnborough hospital — where visiting problems are worsened by poor ward-theatre design.

Initial data from the survey is in *Parental access and family facilities in children's wards in England* by Rosemary Thornes, *British medical journal*, Vol 287, 16 July 1983, pages 190-2. The full survey findings have been sent to the DHSS.

Unemployment kills

A study by the Medical Research Council's Epidemiology Unit in Edinburgh shows strong links between trends in male unemployment and in attempted suicide.

Sociologist S Platt looked at data for 1968 to 1982 covering male admissions to the regional poisoning treatment centre in Edinburgh — where admissions policy makes it possible to identify all treatable para-suicide cases. He found that in 1982 an unemployed man in Edinburgh was over eleven times more likely to attempt suicide than an employed man, and those jobless for over a year ran a risk of para-suicide 19 times greater than those in jobs.

Mr Platt is still preparing his findings for full publication, but he says results so far show that through the period studied para-suicide doubled, while the jobless rose five-fold, yet since 1976 the relative risk has stabilised at eleven or twelve attempted suicides among unemployed men for every one in those with jobs.

Statistics on women are difficult to prepare because data on women's unemployment is unreliable, but crude figures from the treatment centre's admissions point to a similar para-suicide risk among unemployed women.

News in brief

- A Health Education Advisory Committee for Wales will begin work in January — initially for three years — to support the Welsh nominee on the Health Education Council and to co-ordinate activities in Wales. Chaired by the Welsh nominee, it will have up to 20 members nominated by professional, local and health authority, industrial and consumer interests — including CHCs — and a £2500 yearly budget. Comments on its structure and terms of reference are required by 30 September.

- "Distress and disappointment" from campaigners greeted the *Code of practice for the marketing of infant formulae in the UK* last month. Sponsored and prepared by the Food Manufacturers' Federation, the code accompanies health circular *HC(83)13* and *WHC(83)16*, and differs little from the draft code — see *CHC NEWS* 83 page 3 — which was harshly criticised by CHCs and others during consultation. War on Want says "Any resemblance between this code and the World Health Organisation's international code on breast milk substitutes is pure coincidence".

- Figures from the National Food Survey for January to March 1983 — issued by the Ministry of Agriculture, Fisheries and Food — show a drop in sugar consumption from 10.46 to 9.81 oz per person per week — giving a fall of nearly one third in a decade. White bread purchases fell by nearly 0.4 oz to 21.3 oz per person per week — brown and wholemeal bread were up by 0.6 oz to 5.57. Fresh fruit and vegetable consumption is also up and the average intake of iron, B vitamins and vitamin C are all higher than the first quarter of 1982.

How to stop the rot in the dental service

by Michael Silver
Dental Surgeon

Dental decay rates are falling throughout the country — especially in those under 25 years old — and this decrease in decay is dramatic. It is now quite usual to find at secondary school inspections that only 20 or so pupils are in need of fillings.

This is partly due to decreased sugar consumption and the preventive fillings placed over the last 40 years, but it is mainly due to fluoride toothpaste and the fluoridation of water.

Approximately 10% of the UK population drink tap water adjusted to one part per million of fluoride. This has played an important part in the 50% reduction in dental decay in these communities compared with similar but non-fluoridated areas — see *CHC NEWS* 71 pages 8-10.

But the recent Strathclyde Court anti-fluoridation decision — see *CHC NEWS* 88 page 8 — may mean more pressure to stop the important development of water fluoridation.

Nevertheless decreasing decay rates have important implications for the structure of dentistry in the UK.

As people with "super teeth" spread upwards through the age range of the population increasing numbers of the elderly will not need dentures — at present around two thirds of pensioners have no natural teeth.

The continued reduction in sugar and glucose consumption — especially if more people become interested in nutrition — will also force decay rates down.

New and more pleasant sweeteners are due within four years to replace saccharine — which means sugar-free foods, drinks and confectionary — and an anti-decay vaccine is in an advanced stage of development. If these two projects are proved safe there is no doubt that dental decay will be a rare occurrence in 20 years' time.

The next major public health measure to be tackled is the removal of dental plaque. This is the thin sticky film of bacteria that covers teeth and causes soft gums — gingivitis. It is usually well-established by the age of ten and by the age of 40 soft gums begin to recede. If unchecked this causes loose teeth by around 55 and if teeth become very loose painful extraction is the only remedy.

This inevitable sequence can be prevented by effective hand toothbrushing and scraping between the teeth with wooden gum sticks. Brushing should be practised from the age of one and becomes effective during the early teens. The use of gum sticks should start at the age of 20.

Along with restricted sugar intake the twice-daily removal of plaque and daily use of gum sticks will be rewarded by fewer fillings and firm natural teeth for a lifetime.

To be effective these preventive measures depend on the dental scene evolving to help the public with home care advice. We need dental teams which are keen to help the least motivated sections of society and a pay system that does not encourage dentists to pick up the drill at the earliest sign of decay.

The NHS supplies about £40,000 in gross fees to the average general dental practitioner (GDP). Most of this is earned by repairing the results of decay and soft gums.

Since these diseases are preventable, declining in incidence and are cheap to treat in their early stages it is clear that GDPs will be unable in future to obtain their £19,000 average taxable profit from NHS work — nor will they be able to top up their income from private practice.

Private profits are under threat — and so is the survival of general practice. If current trends are left unchecked dental care will become more expensive and be more thinly spread through the UK. The improvements seen in the 1969 and 1979 national adult dental surveys and the parallel improvements in the 1973 and 1983 children's surveys will be difficult to maintain.

In the community dental service (CDS) cuts are likely in operating clinics because of hostility from GDPs. This will mean longer and more expensive trips to the dentist for many poorer families.

The CDS "ticks over" at around 50% of its potential and many GDPs would like to see the service closed down and the £60 million per year running costs added to the FPC allocation pool.

Plans were drawn up some five years ago to increase the scope of the CDS to include pensioners and handicapped adults and to treat more housebound people. But without new money from the DHSS these plans are unlikely to come to fruition.

Dentistry at present is self-governed, self-managed and self-disciplined, and gives low priority to dental health education.

It is possible to envisage an entirely different scene — a national dental team of around 15,000 trained combined therapist/hygienists supplying the whole family with dental health instruction and supervised by some 5000 more highly trained general dental surgeons.

The team would be salaried and work from perhaps 5000 district health authority dental centres — with the CDS and the general dental service having combined.

The dental surgeon would be responsible for diagnosing and would take a larger role than at present in treating advanced conditions. With experience the paradentist would take on a diagnostic role and — along with the dental surgery assistants (DSAs), receptionist and health educators — would be part of a truly integrated team.

All members of the team would take on dental health education tasks inside and out of the surgery — including lectures and exhibitions. At present less than 1000 of a national dental workforce of more than 60,000 are involved in this kind of community teaching.

This new dental service structure would require a similar number of teaching hospitals — but they would be training fewer dental surgeons and more paradentists. The staffing of general hospitals and the numbers of DSAs and dental technicians would continue as at present.

Those GDPs who wished to could opt for self-employment in private practice, and a five-yearly review of future staff needs would ensure that adjustments could be made without sackings.

It is unlikely that this sort of development in the dental service will occur without active interest and participation by consumer groups and grass-roots community organisations.

Low income groups and the growing army living below supplementary benefit levels will need to become very annoyed at present levels of service if we are ever to experience the reality of "teeth for life".

Dentists at work

In the **community dental service** a district dental officer advises each district health authority on dental affairs. DDOs also manage the CDS staff, co-ordinate the different branches of dentistry and carry out two days per week of clinical dentistry. The DDO does *not* have a place on the district management team and has to report to the district medical officer — this means the DMO needs a positive attitude towards dentistry and the local population's dental needs.

The CDS caters for babies, pre-school children, state schools' pupils and state nursery schools. Pregnant women and nursing mothers can also attend.

The DDO is assisted by a senior dental officer and 110 consultant orthodentists also work in the CDS along with 1280 full-time and 640 part-time clinical staff operating from 2500 fixed and 300 mobile surgeries.

There is a commitment to out-of-the-surgery dental health education but this part of the work has been much neglected.

In the **general dental service** some 14,500 dentists have NHS practices and most of these also take private patients — around 3000 dentists do private work only. Most general dental

Continued on page eight

Cartoon: David Myers

The dental profession

There are 23,200 dentists on the dental register held by the **General Dental Council**. There are 17 teaching hospitals. Some 900 dental students qualify each year — one third of them women.

The **British Dental Association** has 15,000 members and is the only negotiator with the Government. There is a sub-committee for each branch of the profession but policy decisions are taken by the largest group — the general dental practitioners. The BDA's public relations tend to present an image of the past and tries to keep dental affairs out of the media.

The **General Dental Practitioners' Association** claims 2000 members. Its policy is closer to the interests of dentists in private practice, though it has an NHS policy commitment which is seldom reflected in its activities. The GDPA has recruitment problems which stem from the BDA's dominating influence over dental students.

Both the BDA and the GDPA have branches in family practitioner committee (FPC) localities.

The **local dental committees** consist of NHS dentists from each FPC, along with the FPC administrator and co-opted members from the community dental service and the hospital dental service. There are no lay members and although the LDCs are NHS committees they often concern themselves with private practice.

The **district dental committees** advise the district dental officer. Dominated by general dental practitioners they also have no lay representation.

There are **specialist groups** around work with children, disability, the elderly, surgery and so on. Small numbers of dentists belong to the Confederation of Dental Employees, NALGO, NUPE and the Socialist Health Association.

The ancillary workers

Dental health educators tend at present to be women who already work in dentistry and have one year's training leading to the Health Education Council's diploma or the diploma of the Royal Society of Health. Too few — perhaps 150 a year — are being trained to have much impact on the nation's teeth, but they could become key members of the dental team.

There are 1701 **dental hygienists** — a few of them men — registered with the general dental council and 100 students a year are being trained. Again, they are key prevention workers and undertake teaching home tooth care, scraping and polishing teeth and treating gum disease, working in all branches of dentistry under the supervision of dentists. It has been suggested that they could practice independently.

Dental surgery assistants were formerly called dental nurses and there is now a proposal to rename them dental surgery nurses. There are 25,000 DSAs in the UK — 10,000 are qualified and registered with the GDC. They work with the dentist, hygienist or therapist. Their duties include instrument sterilisation, equipment maintenance, ordering supplies, assisting at the chairside, making appointments and helping with general anaesthetics and patient recovery.

Their pay and conditions are Victorian — the Low Pay Unit has twice reported on them — they have little job security and unpaid overtime is frequent.

Around 1000 women have been trained as **dental therapists** since 1960 — 553 are on the GDC register and around 250 have posts in the community and hospital dental services. A small number work as health educators in general dental practice but more than 400 have left the profession because posts have not been created for them, and their training school at New Cross closed in June.

Supervised by dentists they handle preventive procedures and dental health education, as well as carrying out routine fillings on children and extracting baby teeth.

There was never enough support for their important role from the dental profession, and now that decay rates are falling so dramatically their job will have to be redefined. As each therapist leaves or retires the post will be reallocated and remaining therapists may be able to retrain as hygienists or educators.

Dental technicians work with plastics, steel, gold, porcelain and rubber making replacements for teeth, eyes, ears, jaw bones and so on. Many work alone at home or in a dental surgery or hospital. It is a very skilled job with a three-year full-time training course.

Denturists cannot practice legally in the UK but they provide an effective service in Canada and parts of the US. They are dental technicians who also carry out the surgery procedures in denture making.

Accounting for our role

Pauline Phillips, Secretary, East Herts CHC

Two or three years ago I came across an information sheet for student nurses which contained the statement "CHCs are not accountable to anybody". What nonsense, I thought. Members are accountable to their appointing bodies and the population they serve, while CHCs ultimately — as statutory bodies — are accountable in law.

I was reminded of this a few months ago at the School for Advanced Urban Studies in Bristol, where I was involved in running a seminar for CHC staff and members on CHC finance and budgeting.

Towards the end one participant remarked that CHCs were not accountable enough for how they spend their money. As she was not immediately torn limb from limb either literally or metaphorically one can only assume that others had come to have the same impious thought.

We had begun by looking at a set of sample CHC budgets for 1981, gathered from every region in England and Wales. Using the crude method of dividing the total budget allocation by the population served, I showed that expenditure varied between eight and 23 pence per head.

Wherever in the "league table" they came, CHCs spent most on staff salaries. Some also spent a lot on premises, whilst three were in rent-free NHS-owned property.

At first sight the latter group would seem to be virtuously saving money to spend directly on the job but in fact their per capita expenditure was ten, eleven and 15 pence as compared with the sample average of 13p — which proved nothing.

In any case the purpose of the seminar was not to prove that some CHCs were "better" than others. What we did was examine these budget figures, correlate them to staff numbers and grades and take into account such variables as London weighting, being in an inner city or having high rural travelling expenses.

We also looked at how regional health authorities determine CHC budgets. This was in preparation for the discussion session, when we considered three topics — a formula for ensuring equitable treatment for CHCs throughout the country, constraints on CHCs' freedom to spend, and the effect of RHA restrictions on staffing.

This brought us back to basics. Any formula for equitable allocations must take account of firstly the statutory duty of RHAs to provide staff and premises and secondly the statutory functions of CHCs.

Here we meet the first hurdles. Who determines the grade and number of staff — and on what criterion?

Our sample set of CHCs ranged from three full-time staff to one whole-time-equivalent. Who could decide which was giving a better service to the local community?

As for premises — if a high rent is paid for "shop-front" premises on what criterion is that decision made? It could be argued that — for example — such premises waste CHC resources by attracting a large number of visitors with non-NHS queries.

If it meets an obvious need does this matter? Perhaps it does if it blurs the CHC image. But what *is* the CHC image?

The more we looked at other topics, the more we came to examine our *raison d'etre* — to be an advisory body to the providers of health services.

It is of course a matter of judgement how this purpose is fulfilled — and the original DHSS guidance circular *HRC (74)4* acknowledged that CHCs' financial requirements might vary.

Some CHCs see themselves as campaigning pressure groups, others as a kind of extension of NHS administration. Some seek publicity and see their base as the community at large, while others are content for their members to act as delegates.

Who is to say which is right? Indeed, who *does* say which is right? This brings us back to the question — how accountable are we?

CHC secretaries are accountable in two ways — to their CHCs and to their employers, the RHAs. But CHCs themselves are in a large measure free to determine the way in which they fulfil their statutory duties. There have been one or two notable confrontations over this but — apart from the issue of whether CHCs can use their funds for litigation — little in the way of budgetary control.

Indirectly the level — and possibly the type — of CHC activity is constrained by limits on staffing and many CHCs would argue for more staff.

But our sample of CHC budgets showed that — using per capita spending as a guide — the top two places in the "league table" were taken by CHCs with three and one whole-time-equivalent staff respectively.

There is much talk at the moment of efficiency and cost-effectiveness. To know whether you are efficient you must know what you are trying to do. If CHCs were asked to set the criterion for health authorities it would be easy — patient care. What criteria might a health authority apply to the efficiency of a CHC? What criteria do *we* apply?

It is obvious that some CHCs see their main criterion as a high local profile — so that if you stopped ten people in the street in their district, eight would know about the CHC. Others measure their effectiveness by the amount of change they have managed to bring about in their district's health plans over the years.

Some confine their efforts strictly to NHS services, whilst others see "health" as all-embracing.

When asked at the seminar whether any constraints should be placed on how CHCs spend their money some said no and maintained — when pressed — that if a CHC thought it should contribute for example to CND funds, it should be able to do so without question.

Of course these questions of role and effectiveness are not confined to CHCs. To some extent the same questions apply in any public organisation which purports to have a public constituency.

We now know that CHCs will come under scrutiny again at some time in the future. Before then we would perhaps do well to ponder the questions raised at the seminar, and try to see just how we operate and why. It could be crucial to our future.

Parliament

Promoting drugs

Pharmaceutical industry returns show that £130 million was spent in 1981 on promoting medicine sales to the NHS. £106 million was allowed as an expense in assessing NHS drug prices (Ralph Howell, North Norfolk, 20 July). The industry spent £242 million — excluding capital expenditure — on research and development in 1981. (Nicholas Winterton, Macclesfield, 26 July). The larger companies' financial returns for that year show an actual return on capital of 19.6% — adjustment for sales promotion spending above the admissible limit will give a "somewhat higher" figure for profits. The DHSS considers a company's profits excessive when more than ten percentage points higher than that company's target profit rate and will take steps in every such case to recover excess profits. The band of profits between target level and excess level is known as the "grey area" and is under consideration within the Government's review of the Pharmaceutical Price Regulation Scheme — see *CHC NEWS* 84 page 1 (Laurie Pavitt, Brent South, 26 July).

Scanner

Their own views

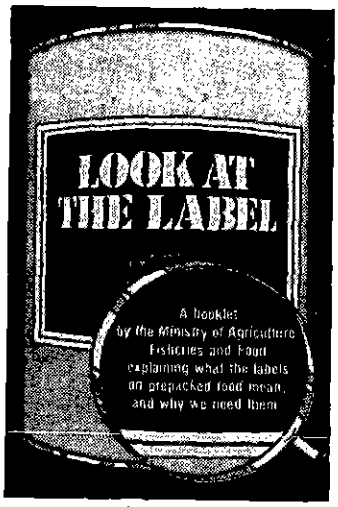
Residents of a local authority hostel for mentally handicapped people give their forthright opinions on life, love, work — and the changes they so often feel powerless to make — in *Beginning to listen* by David Brandon and Julie Ridley. Price 85p inc post from the MIND bookshop, 155-7 Woodhouse Lane, Leeds.

Abreast of delays

A major three-year study into patients' and professionals' attitudes to breast symptoms found that roughly half of women who delayed consulting their GPs for four weeks or longer after finding symptoms were reluctant to do so — mainly through fear of cancer or of being a "nuisance" to the doctor, and because of embarrassment. Women over 65 — the higher-risk age group for breast cancer — are more likely to delay longer and so are women with symptoms other than lumps — suggesting a lack of knowledge about the variety of symptoms linked with breast cancer. GPs' delays in referring women to specialists were reduced by a health education project aimed at GPs and conducted as part of the study. A corresponding project urging women to act quickly on breast symptoms appears to have had a "limited, but not striking" effect on women's behaviour. The University of Southamptom's *Southampton breast study* is £3.50 inc post from the Department of Community Medicine, Southampton General Hospital, Tremona Road, Southampton SO9 4XY.

Diverse DHAs

The spotlight is turned on how district health authorities discharge their duties in a report analysing the diversity of style and activity within six DHAs in three regions. Researchers interviewed DHA chairs and members, district administrators, members of district management teams and CHC observers, as well as attending meetings and studying DHA papers in an attempt to highlight differences in approach and in choices available to DHAs. They found that choices were limited, DHA members were often asked to endorse decisions at a late stage in the "policy process", and when they initiated items for consideration these seldom became central issues of concern — those issues dominating DHAs "largely reflected RHA and DHSS requirements and DMT perceptions of important issues". *DHAs in action — a progress report* is intended to open lines of enquiry into the impact and performance of DHAs. By Stuart Haywood, it is the Health Services Management Centre's *Research report 19* and costs £3 inc post from the HSMC, University of Birmingham, Park House, 40 Edgbaston Park Road, Birmingham B15 2RT.



New regulations bringing the UK into line with the EEC consumer protection programme mean that since January prepacked food has carried more information about contents. But many chemical additives which may be suspected of causing allergies — or which may be dangerous to people with particular illnesses — are identified only by codes. This guide lists the codes and describes the information food labels must now carry. Copies are free from the Ministry of Agriculture, Fisheries and Food, Publications Unit, Lion House, Willowburn Trading Estate, Alnwick, Northumberland NE66 2PF.

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 29p in stamps.

Page 3: Northallerton District CHC Chair: Mrs M W Kenyon
Page 6: Bloomsbury CHC Secretary: Geoffrey Ellam
Page 8: Bexley CHC Chair: Sue King
Page 10: Swindon and District CHC Chair: A G Beauchamp
Page 12: Cheltenham and District CHC 5 St George's Terrace, St James Square, Cheltenham, GL50 3PT. Tel: unchanged
Page 13: Wolverhampton CHC Ground Floor, 45 Queen Street, Wolverhampton WV1 3BJ. Tel: unchanged
Page 16: Cardiff CHC Secretary: H Mansel Davey Chair: E G Owen
Page 16: Pembrokeshire CHC Chair: Mrs J M Smith
Page 17: North Gwent CHC Chair: Mrs J Cowburn
Page 17: Arfon-Dwfor CHC Chair: Vera Roberts

Other publications

Community-based social care — the Avon experience edited by Wally Herbert and Pat Rogers. *NCVO Occasional Paper 4* — Bedford Square Press. Price £4.95 from bookshops or £5.57 from Macdonald and Evans Distribution Services, Estover Road, Plymouth.
Guide to good pharmaceutical manufacturing practice 1983 edited by J R Sharp. Price £3.95 from HMSO.
The management of industrial relations in the NHS by Christopher Fewtrell — Management series 7. Price £5.95 inc post from the Institute of Health Service Administrators, 75 Portland Place, London W1N 4AN.
One parent families — parents, children and public policy by Jennie Popay, Lesley Rimmer and Chris Rossiter. Price £4.25 inc post from the Study Commission on the Family, 3 Park Road, London NW1.
Support for elderly people living in the community — research synopsis edited by Graham Fennell. Price £2 inc post from the School of Economic and Social Studies, University of East Anglia, Norwich

Health circulars

HC(83)14: gives guidance on electoral registration of mental illness and handicap hospital patients — they will not be permitted to register under the hospital address.
HN(83)20: announces new statutory bodies for nurses' education, training, registration and discipline.
HN(83)21: updates advice to health authorities on notifying accidents and serious defects in medicinal products.

Tinnitus

Figures from the 1981 *General household survey* suggest that 6.4 million people in the UK may suffer some degree of tinnitus — 15% of a sample aged 16 and over reported noises in the head and ears — and 1.2 million may suffer severe — daily — tinnitus. Three research centres have provided 600 tinnitus sufferers with maskers and will report on their research when trials end in October (Jack Ashley, Stoke-on-Trent South, 25 July).

Census deleted

The Government has decided a 1986 mid-term census cannot be justified in terms of costs or the burden on the public. Alternative sources of information on the mid-1980s population and other matters may be considered. (James Lester, Broxtowe, 14 July).

Treating burns

The DHSS has no precise figures on units dealing with burns — which are treated in plastic surgery units, intensive therapy units or general wards as well as burns units — but 25 English units are primarily concerned with burns treatment and are equipped to deal with the most serious injuries (Renee Short, Wolverhampton North-East, 14 July).

Consultants

At 30 September 996 consultant posts in hospital medical and dental specialties in England were without a permanent holder — 295 of these were fully or partially occupied by locums (Clive Soley, Hammersmith, 26 July).

News from CHCs

□London hospital closures always seem to attract more national media coverage than closure controversies elsewhere — and *CHC NEWS* has been reluctant to add to that imbalance during the storm of closure proposals now raging throughout the country. But **Wandsworth CHC** believes the South London Hospital for Women is a special case — the last remaining general hospital in the UK run by women for women.

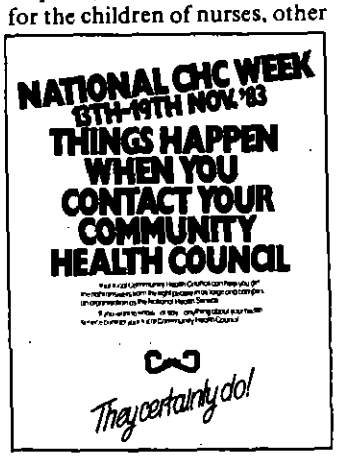
Angry women have demonstrated and disrupted health authority meetings since January — when leaked plans suggested closure of the SLH as a way of saving money to cover the district's deficits and to redistribute resources to the mentally ill and elderly. Now the CHC — working closely with women in the SLH campaign — has referred the closure to the Secretary of State after the DHA agreed to ask for national funding for the SLH yet voted for its closure in April 1984.

The CHC argues that the SLH is a national resource both for training women doctors and for treating women who strongly disapprove of treatment by male doctors and nurses. Women have come from as far as Sheffield, York, Glasgow and Cornwall to the SLH — and media coverage of the anti-closure campaign has increased referrals from all four Thames regions and beyond.

The SLH is important for women with religious or cultural objections to treatment by men — the Commission for Racial Equality opposes closure — and its unique all-women conditions are protected by the *Sex discrimination Act*, which permits discrimination in favour of women when recruiting staff to the SLH and the Elizabeth Garrett Anderson hospital — now providing a restricted service since its own reprieve from closure in 1979. The Act exempts no other NHS premises in this way and the SLH's exemption will be lost if the hospital closes.

The CHC wants it kept open with its own revenue and capital allocations and has submitted alternative management structures for ministers to consider. So far the DHSS has received 300 letters supporting the plans from national women's organisations such as the Housewives' Register and the Women's Institute.

□Another "unique" claim from **Wandsworth CHC** — the only creche in the country for shiftworkers' children. The CHC played a major role — along with the Wandsworth Child Care Campaign — in establishing the day nursery at St George's hospital. After three years' applications Urban Aid money was granted for a 40 place, 10am to 7pm creche for the children of nurses, other NHS workers and doctors. With the waiting list for places now at 118 children, the CHC has gained a small grant from the Equal Opportunities Commission to look at how the creche provision will help the careers of local women.



□*The latest poster in the new series of CHC publicity material has been especially adapted for National CHC Week. The* **Association of CHCs** *has sent each CHC 25 free copies of the poster — which is A4 size, costs between 12p and 8p according to numbers ordered and can be supplied with or without the CHC Week message. Car stickers and A4 handbills are also ready for use — and lapel stickers will follow soon.*

□Meanwhile **North Gwent CHC** is helping a local action committee in its fight to save a hospital workers' creche. Health authorities have operated successful, highly subsidised creches throughout Mid and South Glamorgan for years — but now the AHA has said it can no longer subsidise the ten year-old Nevill Hall hospital creche. Charges to parents have risen 140% in eight months and the action committee claims the plan is to price the creche beyond NHS workers' means before closing it down. The CHC has surveyed 17 of the 18 parents using the creche — ten said they would have to leave work if it closed — and will speak for the creche's retention at AHA meetings this month.

□And **Hampstead CHC** is supporting creches for patients — at family planning clinics. A CHC survey of the district's clinics found patchy creche provision, with receptionists asked to "watch out" for children while their mothers see the doctor. The CHC feels this is unsatisfactory. The survey report also criticises provision of information — particularly for illiterate women and women from ethnic minorities — and recommends a wider service including advice for men and young people, provision of post-coital contraception and vasectomy under local anaesthetic, and pregnancy testing for all women who want it whether registered at a clinic or not. The CHC also urges the DHA to consider a local recall system for cervical cytology. Many women surveyed by the CHC said they preferred to see a woman doctor and some came to the clinics for that reason. Many older women will not attend family planning clinics for well women services, the survey points out — well women clinics should be provided separately.

□**Isles of Scilly CHC** Secretary Lucille Langley-Williams has asked us to express her thanks and appreciation for the "many hundreds of caring letters" addressed to her and to vice-chair Megan Smith after the helicopter crash which occurred on their trip home from ACHCEW's AGM in July. When she spoke to us Lucille did not mention that she herself deserves thanks for the courageous way she supported Megan as they struggled for safety during 25 minutes of treading water before they were rescued. Megan left hospital early in August and is now recovering at home on the tiny island of St Agnes. Lucille was fit enough to attend a regional meeting of CHC secretaries the week after the crash and was brave enough — as millions saw on their TV screens — to travel by helicopter. "We are trying to reply to everyone's letters and messages" says Lucille. "People's kindness has been such a comfort".

□Five CHC members from England and Wales have been appointed to the Royal College of GPs' Patient Liaison Group — see *CHC NEWS* 83 page 1. They will join a patients' representative from Scotland, one from Northern Ireland, and seven doctors when the group has its first meeting on 15 September. The appointees are Anne Crerar — Chair of **Central Birmingham CHC**, Susan Clayton — member of **Lancaster CHC**, Nancy Dennis — member of **Greenwich CHC**, Geoffrey Havelock — member of **East Berkshire CHC**, and Lawrence Murphy — chair of **Llanelli-Dinefwr CHC**.

Dental service

Continued from page five

practitioners (GDPs) are independent contractors and earn fees from the NHS for each item of treatment. A small number work on a salaried basis in health centres while another small group have retained their self-employed status but rent rooms in health centres.

Some 200 salaried GDPs work in the **industrial health service,** financed by large private and nationalised firms.

The **DHSS** has a staff of ten dentists to advice the Secretary of State on dental affairs and 38 regional dental officers work for the DHSS — *not* for regional health authorities — in checking GDPs work for quality control and fraud.

In **teaching hospitals** around 1000 dentists teach and do research while in **general hospitals** 1000 dentists are employed as consultant orthodentists — dealing with tooth straightening — and as consultant oral surgeons — dealing with the results of accidents.

The **armed forces** employ around 500 dentists — mainly GDPs with some consultant oral surgeons — in bases abroad and in the UK. They have good ancillary staffing levels and undertake family dental health education.