CHC NEWS

For Community Health Councils January/February 1984 No 93

Consultation poser to go to court?

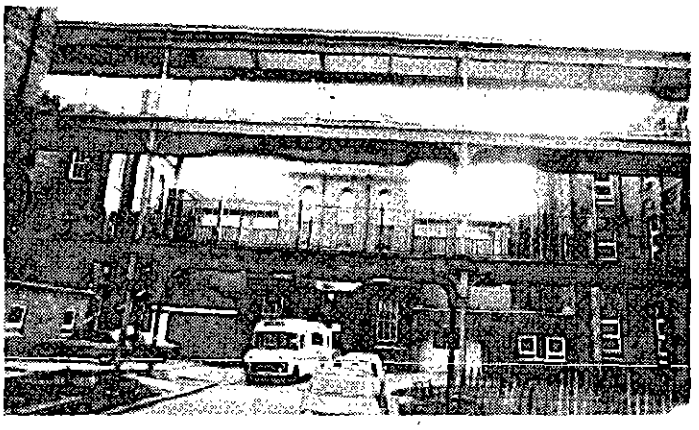


Photo: John Cogill

Statutory rights of consultation for CHCs could be strengthened — pre-empting decisions on the Griffiths report — by a court ruling being sought by Islington CHC in north London.

The court judgement would decide whether Islington district health authority fulfilled its statutory duty to consult and provide information to the CHC and two local authorities on a "substantial variation of use" of the Highgate Wing of the Whittington hospital.

If Haringey Council, which has taken up the court action on behalf of Islington Council and the CHC, fails to obtain leave for a full High Court hearing on the case, then the CHC's rights could still be established by representations to North East Thames regional health authority being led by local MP Jeremy Corbyn.

Haringey's affidavit to the court is based on two issues — consultation with public bodies, and necessary information for the CHC on a substantial variation of service — and would pre-empt the Griffiths report which stated that the new NHS management board "should review all consultations arrangements required by legislation or administrative order, e.g. closure or changes of use of health buildings".

The CHC first demanded information on the proposed change last summer but the DHA maintained that the proposals were not a substantial variation of service. They were included in the district's operational plan despite criticisms from the consultant geriatrician. Both the DHA and the RHA rejected appeals from the CHC that consultation rights had not been observed on the change of the wing from an in-patients' service for geriatrics, paediatrics, neurology and chest cases to accommodation for patients from the Friern Barnet mental hospital.

But the CHC is supporting the court action to overturn the district plan, agreed in December, and the outcome of the case could set a precedent on consultation rights for CHCs throughout the country.

OXFORD TAKES THE RADICAL PATH

Oxford regional health authority has embarked — with the blessings of health ministers — on a radical restructuring of its health services, based on a strategy which makes district "rawping" secondary to the finance of development "packages".

The new strategy grew out of a controversial "question-posing" document issued in autumn 1982 — see *CHC NEWS* 81 page 1 — which was heavily criticised by ministers. The far-reaching questions raised by the 1982 paper have now been resolved into a coherent ten-year strategy based on community care, better use of resources, more co-operation with local government — and development money expected to reach £45 million across the decade.

The sharing of resources between districts is seen as a key issue. RAWP targets — the levels of resources aimed at for each district — will continue to be calculated, but districts will be allocated money on a "package" basis to fund specific development plans.

And the RHA has recognised the importance of proper staffing for community care services. Administrative staffing will be held at present levels by introducing new technology, but the RHA expects an overall increase in staff of around 1.23% per year — a 36% increase over ten years in district nurses, health visitors, chiropodists, physiotherapists and other community-based staff.

The Government's resource assumptions for the decade indicate sufficient funding for much of the strategy, but acute services will have to become more efficient to keep up with a growing population and to allow funds to be transferred to priority care groups — the elderly, mentally ill and handicapped. As long-stay hospitals are run down, money will be switched to pay community care staff, acute hospitals will be asked to increase their level of day case surgery to 25% of all operations by 1994 — with appropriate community back-up — and the trend towards shorter maternity hospital stays will be encouraged.

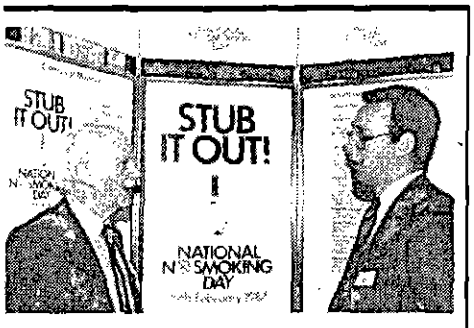


Photo: The Guardian

February 29 is D-Day — Don't Day — for smokers. "Stub it out", launched by 11 organisations, aims to get one smoker in 20 to give up for good. Tom Hurst of the National Society of Non-Smokers is pictured with Professor John Camm of St Bartholomew's hospital at the campaign launch.

• Smokers' lobby — see page 8.

INSIDE...

Your letters

CHC NEWS — ONE YEAR ON...

Cliff Davies, Chair, CHC NEWS Editorial Board

CHC NEWS has now been operating for a full year without any DHSS funding. In view of this the Editorial Board of the magazine has decided to instigate a far-reaching review of the present funding structure to ascertain whether the present system of subscriptions from both CHCs and outside is adequate to sustain *CHC NEWS* in its present form. In view of this we are asking all CHCs — whatever their subscription level — to give detailed consideration to the question of at what level they will be prepared to subscribe to the magazine between April 1984 and March 1985.

This should not be taken as a rejection of the present subscription system — indeed the response of CHCs to *CHC NEWS* in the last 12 months has exceeded all our expectations. On the other hand the number of outside subscriptions gained during that period, while substantial, falls well short of the target number set last April, and it will clearly take some time before sufficient outside subscriptions have been obtained to make the finances of the magazine secure.

So in the short term we need to know that we can rely on the continued support of CHCs. *CHC NEWS* is your magazine — and the feedback we receive suggests that you like and value it. We hope that you will help us to ensure that it survives.

CHCs will shortly receive a detailed questionnaire from ACHCEW about subscriptions. I implore you to take this matter very seriously, and to answer the questionnaire as quickly as is possible.

An open letter to the Secretary of the Association of CHCs

Tom Richardson, Secretary, Oxfordshire CHC

Dear Tony,

In view of the somewhat derogatory remarks you made about CHCs at the Guy's Hospital conference in January, I thought you might be interested in some of the things my CHC is currently working on.

1. Implementing our plan for services for mentally handicapped people — accepted in its entirety by all parties concerned,
2. Negotiating with the DHA, RHA and local authorities over improvements to services for elderly people — as we seem to be the only organisation able to bring all the interest groups together,
3. Establishing a working party to do for psychiatric services what we have done for mental handicap,
4. Starting a full study of women's health facilities in partnership with the community physicians of both DHA and RHA,
5. Supervising a grant-aided study of transport in rural communities jointly with Oxford Polytechnic and Oxfordshire Rural Community Council,
6. Starting to take a place in the training programme for medical students for one afternoon six times a year,
7. Completing a survey of catering in hospitals,
8. Briskly selling our consumer guide to all the old people's homes and nursing homes in the county,
9. Designing and supervising a research programme for our current post-graduate student,
10. Processing the 50 complaints we usually have at any one time — several through the medical and dental service committees,
11. Dealing with a stream of callers to the office.

Most CHCs will be doing at least as well as us because CHCs have a vast number of people, members and staff, who whatever their party political persuasions, care very much about our national health service.

Much of our work is in the mainstream of health service provision, so why not join us Tony? We could do with your abilities, experience and commitment. It gets a bit cold and wet here in the deep end but it is often work of fundamental use which can also at times be fun.

ACHCEW's Secretary Tony Smythe replies:

The "somewhat derogatory remarks" were directed at the half-hearted way in which CHCs were established and structured, and the continuing failure of Government to resource and empower them adequately. I argued that everyone committed to the NHS should recognise the potential of CHCs and work with us to move from defending our existence to the extension of our role. In spite of all the obstacles most CHCs have worked wonders. This record of achievement can be built on. We must all follow your example to blow our trumpets in the ears of ministers, MPs, our NHS associates and the public. Sorry if I did not make myself clear.

Successful visiting

Doreen Sinstadt, Secretary, Plymouth CHC

The theory is sometimes put forward that CHC visits are unnecessary and a great waste of staff time — particularly now that health authority members visit as well. Yet recently my CHC undertook a visit which was well received by the sector administrator and proved very useful to patients and their visiting friends and relatives.

The Moorhaven psychiatric hospital — which serves the Plymouth health district — is some 15 miles from Plymouth in an isolated position on the edge of Dartmoor. CHC members caught the bus from Plymouth to the nearest village one Sunday afternoon, having first asked the hospital to inform visitors that members would be available to meet them if they wished.

Members found that visitors had travelled to the hospital especially to meet them, but neither staff nor visitors knew that a taxi provided by the League of Friends was waiting at the village bus stop to take them up the steep hill to the hospital. Because of the distances involved in travelling from some parts of this large district, visitors would have welcomed the opportunity for refreshments and the use of a visitors' toilet.

Members also discovered that a rumour was circulating, suggesting that the hospital would close in two years because of a planned redeployment of resources. And they found that weekend staff appreciated "out of hours" visits.

The results of the CHC visit were that:

- the sector administrator has widely circulated travel information to staff and visitors,
- the canteen is to be made available to visitors on Sunday,
- the hospital closure rumour has been rectified, and
- a happier relationship has developed all round.

CHC NEWS

JANUARY/FEBRUARY 1984 **No 93**

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

CHC NEWS Staff:
Gill Kent (Editor), Adrian Roxan (Assistant Editor), Sally Wiltshire (Information and subscriptions)

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% over30. 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 group of responsible adults crowded into a packed lecture hall in the first week of the new year for a spot of energetic economist-bashing. No blood was spilled, but the hall resounded with the noise of hollow theories knocked against solid common sense, and a good time was had by all.

The occasion was an imaginative conference arranged by the Unit for the Study of Health Policy at Guy's Hospital Medical School in London.

Entitled *Health and economics — the NHS crisis in perspective*, the conference was a major triumph for the Unit's director Peter Draper, who will be known to many CHC members and staff for his championship of public health issues — those social and environmental factors which create the climate of health or sickness.

After a gloomy year of economics lectures and wrist-slapping dealt out to NHS workers by those who think they know better — the business elite, the Confederation of British Industry, the Institute of Directors — it was a refreshing change to hear workers, researchers, medical journalists, MPs and CHC representatives reassert those values and ideals which form the bedrock of our nation's health.

An economic orthodoxy which has come to dominate our thinking in the last year was roundly challenged by speaker after speaker. The slogan of the new orthodoxy — "never mind the quality, look at the cost" — was exposed by 16 commentators drawing on their experience of health issues in the fields of medicine, administration, academic research, specialised journalism and economics itself.

June Clark — a Royal College of Nursing council member — gave a particularly telling example of just how dangerous is the path this slogan points us towards. She could very easily improve "efficiency" on her already short-staffed ward, she said. It is done by saying to each old lady entrusted to her care: "Think of yourself as a lump of meat." How much quicker and more efficient it is to bathe, dress and toilet 20 or 30 inert bodies, and how unnecessary to train nurses to concern themselves with their patients' dignity, when untrained staff can swing those lumps of meat from bed to loo to chair in half the time!

Now that economics has come to dominate our public and political life we are in danger of losing the human values that economists call "externalities". Yet evidence presented to the conference makes it clear that the "science" of economics has failed to produce a coherent view of the world, and while the Chancellor calls for further cuts in future public spending, no two schools of economic thought can agree on their forecasts to the end of the decade.

Perhaps the last word should come from Leo Kaprio, European Director of the World Health Organisation, who told the conference that the UK should be proud of so high a standard of health services at such a low cost — and can afford to pay for innovation.

Health News

Renaming efficiency

Across-the-board national efficiency savings have been dropped by Secretary of State Norman Fowler in favour of supervision of districts by regional health authorities.

Following on from his November announcement of £400 million for hospital and community health services — *see CHC NEWS* 92 page 4 — Mr Fowler has put RHAs in charge of assessing district programmes, with any savings through efficiency being ploughed back into services on regionally determined priorities. The efficiency savings are now called cost improvements and health academics have suggested that this decentralising move is to prepare the ground for the implementation of the Griffiths report which emphasised that the centre should be less concerned with detail.

But Mr Fowler is not relinquishing complete control and the circular — *HC(84)2* — asks RHAs to submit summary reports of their programmes and their districts' programmes as routine procedure. It insists that the DHA plans must:

- be consistent with national and regional priorities
- be affordable within the cash limit
- contain a satisfactory cost improvement programme
- contain viable staff targets consistent with service objectives and cash available
- generally represent a good return on the investment of resources.

If DHAs do not fulfil these criteria, then the RHA can reject the programme. Regions will then report to ministers annually for approval.

The details of revenue distribution show the four Thames regions getting no "new" money, while East Anglia tops the table with a 1.9% increase. The overall allocation is based on the assumption of a 3% pay rise for staff — a figure which has already been condemned by union leaders.

Generic substitution rejected

Health minister Kenneth Clarke has announced the Government's rejection of a national policy of generic substitution in the prescription of drugs by GPs.

In a statement to the House of Commons before Christmas, he also announced that £65 million is to be saved on the NHS drug bill in 1984-85 and a further £100 million in subsequent years. The saving will mean that drug companies' profits from the NHS will be reduced from 25% to 21% and their sales promotion budgets will be curtailed.

The Government will introduce tighter licensing on imported drugs as well, to cover safety aspects such as storage, labelling and tracing.

The rejection of national generic substitution was followed by a pledge from Mr Clarke to initiate a new campaign to encourage generic prescribing by GPs themselves.

Labour shadow health minister Michael Meacher condemned the announcement as "outrageous" and claimed that £25 million could be saved by generic substitution.

see page 10 for GPs' action on generics

Griffiths and gripes

Detailed responses to the Griffiths report are beginning to emerge — and many of the professionals do not like all they see.

Nurses, doctors, medical officers and administrators have all voiced concern at aspects of the NHS management inquiry, with the role of general managers top of their list. The Association of District Medical Officers summed up the conclusions on this by saying — "Only where there is a clear lack of effective management should a general manager be appointed."

The National Association of Health Authorities commented — "while many of the recommendations are welcome, there are serious doubts about the wisdom and practicality of the proposal to identify general managers at all levels".

Nurses have responded by demanding that "nurses must lead and manage nurses at all levels in the NHS". The Royal College of Nurses also condemned the absence of any nursing representative on the new NHS Supervisory Board.

Doctors have split in their response — the British Medical Association warn that they will refuse to co-operate with general managers but junior doctors have welcomed the idea.

Curing racism

A conclusive report on racial discrimination in the NHS is to be compiled by the Commission for Racial Equality as a follow-up to its discussion document *Ethnic minority hospital staff*.

Special teams from the CRE are due to visit district health authorities in the next few months, according to the Commission, with a brief to provide concrete facts and

Continued on page four

DEPUTISING SERVICES

by Cyril H Beales, Member, Newham CHC

Deputising services are taking up an ever larger part of GPs' duties without proper supervision.

They are run for profit and the increased usage is because an ever-increasing number of family doctors are loath to leave their homes at weekends and night time.

Public concern about deputising services does surely indicate that there is something wrong. By far the majority of GPs in Britain fulfill the contracts for providing emergency services — a minority do not and let the side down, and some would argue have caused unnecessary harm to GPs as a whole.

The GP is responsible for his patients seven days a week —for 24 hours a day he has nominal responsibility. The idea of a deputising service was originally a good one. It gave the GP the odd weekend or night off, but in some areas GPs are increasingly running a lock-up shop, working bankers' hours of 9-to-5 throughout the working week and switching over to deputising services for the rest

of the time — thus opting out of their real responsibility.

Round-the-clock care is a big responsibility for GPs and so are the rewards — they earn an average of around £35,000 a year including nearly £4,000 for unsocial hours. Traditionally some GPs have done their own night duties and shared the rest with colleagues, and many still do.

Most GPs who are unable or unwilling to be on a rota hand over to a deputising service. There are now more than 50 such services operating throughout Britain. Family doctors hand over thousands of patients and rarely is there consultation about treatment or any formal procedure with the deputies. The Royal College of General Practitioners believes that the hand-over system, as it is at present, is the correct one.

Deputising doctors out on their rounds decide which call receives priority from information passed by their telephonist. Deputising services have differing systems for assessing urgent cases. In some cases telephone operators, without formal medical training, decide on priorities from symptoms they are given — this is one of the points taken up by MPs such as Nigel Spearing, Gwyneth Dunwoody and Christopher Hawkins, who are campaigning for major reform of deputising arrangements.

If you have a group practice where doctors cover for each other at night, then when you phone in at least you talk to a GP who frequently asks questions about symptoms and from that they can tell whether it is a serious case.

Patients should not be involved in self-diagnosis and clearly telephone operators at deputy services should not be expected to diagnose priorities. A GP should be available at every deputising service to ask the right questions and decide the right priorities. Even when the deputy doctor arrives he will seldom have met the patient before or know anything about them — in cases where the medical records are important this can be a problem.

Many GPs see the special relationships they and their partners build with their patients as all part of a caring service. No emergency doctor can have the knowledge of the

Health News

Continued from page three

figures on the disadvantages of ethnic communities.

The preponderance of ethnic staff in low-paid and low grade jobs is to receive particular scrutiny. The preliminary report revealed that the NHS has "minority group employees in large numbers at the lower levels and in unpopular jobs and has under-representation at the prestigious and higher paid levels".

The report concludes that the health service must ensure that training methods are tightened up to prevent racial discrimination when candidates apply for jobs and recommends the introduction of ethnic records to help form an effective equal opportunities policy. Free copies of the preliminary report from the CRE, Elliot House, 10-12 Allington Street, London SW1 5EH.

Open secrets I

After a star-studded, new year launch, the 1984 Campaign for Freedom of Information will press home its demands for more open government with a regular *Secrets file* exposing restrictions on the public's right to know and publicising existing rights of access to information. The first *file* covers legislation on local government meetings and documents — and future issues for the spotlight will include aspects of NHS secrecy such as medical records.

The campaign is at 2 Northdown Street, London N1 9BG. Tel: 01-278 9686. It wants to hear from people who know of excessive secrecy or unnecessary with-holding of information.

Open secrets II

Ministers have decided that the Health Advisory Service will in future make public its reports on health authorities' hospital and community services for mentally ill people and the elderly.

The reports of HAS visits to district facilities have until now been available only to the Secretary of State and the authorities to whose services they refer — although CHCs receive summaries of conclusions and recommendations in confidence. Reports already in existence will remain confidential, as will reports on visits already arranged on a confidential basis.

Because of the difficulties in handling sensitive aspects of the reports a consultative document spells out the implications of the new policy. The HAS will continue to be an independent advisory body — ministers emphasise that it will not take on an inspectorate role. Reports will be distributed to local voluntary bodies and CHCs within one month of submission to the Secretary of State and will be available on request to members of the public. The HAS director will produce an annual report drawing general conclusions from the year's reports and visits.

Copies to: Mr AM Clayton, Community Services Division, DHSS, Alexander Fleming House, Elephant and Castle, London SE1 6BY. Tel: 01-407 5522 x 6123. In Wales, contact: Mr D Willicombe, Health Policy Division, Welsh Office, Cathays Park, Cardiff. Tel: Cardiff 823502.

Courting contraception

Opposition is growing to the bid by mother-of-ten Victoria Gillick for a Court ruling to test the legality of prescribing contraception to girls under 16.

Mrs Gillick has challenged DHSS guidelines — which permit contraceptive advice in "exceptional cases" to under-16s without their parents' consent — because she wants to ensure that Wisbech health authority will not prescribe contraceptives to her five daughters without her knowledge. The hearing is in the Spring.

Opponents of the Gillick move say the

family GP about the area in which he serves and it is an essential part of the service.

The GP receives an average of £2,500 a year for working unsocial hours plus payments for late-night calls which add a further £1,500. Yet an average doctor using deputies for most out-of-hours calls will pay £2,650 — so a GP who farms out most night calls remains

£1,350 in pocket.

The deputising service has to pay for telephones, often drivers and cars for deputies, and premises — but it is still big business. The latest figures published by one emergency group showing a turnover of £1 million with the highest paid director earning a salary of £52,000.

Deputies in some parts of the country earn as little as £25 for a night shift with an extra payment for a few individual calls. This is, of course, an incentive for a doctor to carry on when he should have gone off, or in other words, a financial interest in doing as many calls as possible.

It cannot be right to pay deputies on piecework rates. If they are dashing from one patient to another as quickly as they can in order to earn a reasonable living, the quality of care must suffer.

The Department of Health has delegated the job of supervising local deputising services to family practitioner committees (FPCs) which give the job of scrutinising the day-to-day services to a professional advisory committee. At each level of supervision the medical profession has a substantial presence. The FPC usually has 30 members of which 15 are GPs, pharmacists and other professionals, 11 are appointed by local district health authorities and 4 by local authorities.

For a doctor, deputising services offer nights and weekends off and they also offer income because some GPs either own, part-own or work for deputy firms.

It is clear there is a need for an independent service and the public want to be sure of getting good doctors.

Therefore they should have some say in monitoring the use of deputising services. The CHCs are the most obvious bodies to do this — after all they are the consumer's voice in the health service.

Draft circular attacked

Proposed changes in GPs' use of deputising services were announced by health minister Kenneth Clarke in December.

But already the draft circular, now out for consultation, has been attacked by the British Medical Association. The proposals have been dubbed a "draconian measure" by Dr John Ball, Chair of the BMA's General Medical Services Committee. He commented: "Such a reduction is as unacceptable as it is impracticable. In putting forward the proposals there must have been an awareness that they will result in the closure of the majority of deputising services and substantially disrupt the remainder."

He warned that the changes could mean doctors will resort to "bootleg services" beyond monitoring or control. The BMA has also re-affirmed its strong support for proper supervision but believes the Government has mishandled the proposals.

The circular includes:

- **Controls on frequency of use**
- **creation of a new deputising services sub-committee of family practitioner committees to monitor deputising**
- **annual reviews of GPs' use of deputies including random checks**
- **a new code of practice for deputies.**

.....profits of boom

guidelines on under-16s are already strict and further restrictions on advice and treatment would affect the most vulnerable, exposing them to the risk of unwanted pregnancies. The British Medical association has urged Secretary of State Norman Fowler to ensure continued DHSS support for the BMA's own, more comprehensive guidelines — contained in the *Handbook of medical ethics* — which the emphasis on doctors's judgement.

Meanwhile support for confidentiality in cases of moral concern was taken a step further with a letter to the *Lancet* of 17 December 1983 alleging that "extremist pressure groups" are recruiting "informers" in hospitals and clinics. Signed by 52 nurses, midwives, health visitors and doctors — including Sir Douglas Black and former BMA president Dame Josephine Barnes — the letter warned that the privacy of medical information is threatened in cases of contraception for under-16s, late abortions and severely malformed newborn infants.

Save a Welsh baby

Consultation on a Welsh Office scheme to tackle baby deaths in the principality — see *CHC NEWS* 87 page 3 — has caused a slight change of plan. The concept of a two-member "catalyst team" with a supporting survey group was welcomed by health authorities, CHCs and professional bodies, but less enthusiastic support for a Wales maternity services forum led to this proposal being dropped.

The full-time catalyst team of Mary Cotter, a Welsh Office medical officer, and Mary Hope, currently a director of nursing services (midwifery) in Stockport, will for two years tour Wales to stimulate confidential clinical reviews of all perinatal deaths, to encourage districts to set up maternity liaison committees and to survey and report on services.

Their reports will pass to the survey group — which with 11 members will be larger than originally proposed. As well as advising the team, the group will suggest service improvements to districts and to the Welsh Office, and will prepare a Wales perinatal mortality survey based on data gathered by the team.

Consultation on the appointments to the group is under way and the team is expected to start work this month.

News in brief

•Health ministers have suspended the licence to promote and supply the anti-inflammatory drug indoprofen — brand name Flosint. Used for arthritic diseases and pain relief, the drug has led to 217 adverse reaction reports — including seven deaths — since its launch in September 1982, when doctors were invited on a much-criticised Orient Express promotional trip to Venice by the drug manufacturers, Farmitalia Carlo Erba.

•Legislation permitting Scottish, English and Welsh water authorities to add fluoride to water supplies will be introduced "when the Parliamentary timetable permits", say health ministers, following the "Strathclyde judgement" — see *CHC NEWS* 88 page 8 — which cast doubt on the technical legality of adding chemicals to water for any purpose other than purification. Meanwhile ministers will protect existing fluoridation schemes with indemnities.

•A "package of new measures" announced by junior health minister John Patten to combat solvent abuse consists of voluntary guidelines to retail managers and sales staff, information and guidance — including regional seminars — for parents and professionals, a reminder to police of their existing powers to act, and "urgent consideration" of the case for banning glue sniffing kit sales. Consultation last year revealed little support for making glue sniffing a criminal act.

A watchdog with teeth and a future

*by Alexandra Lewis, Vice-Chair, Croydon CHC and Member, MHAC**

On 30 September 1983 the Mental Health Act Commission came into operation as a special health authority in the NHS. It was conceived out of debates between those with opposing views — civil libertarians such as MIND, and those who consider treatment provision should be paramount — and these debates focused around the particular circumstances of detained patients.

Parented by the *Mental health Act 1983*, the new watchdog's birth was not an easy one. It faces a difficult future where early maturity will be essential. Both the Act and the Commission are regarded by many as marking a new era in mental health in England and Wales — especially for detained patients.

The Commission will have to comply with directions from the Secretary of State for Health and Social Services, but as a special health authority it will perform its functions and give advice independently.

It is subject to the jurisdiction of the Health Service Commissioner and is required to prepare, publish and periodically revise a code of practice giving guidance to all people involved in the care of mentally disordered patients. This will include compulsory admissions to hospitals and mental nursing homes under the Act, and medical treatment of patients with mental disorder.

The first part of the code will affect the care of a minority of mental patients — those who have been detained — while the second part will affect the treatment of all mental patients and includes everything to do with patient care whilst under medical supervision in a hospital or mental nursing home.

This code of practice will be submitted to the Secretary of State and, after consultation with appropriate bodies and revision if necessary, will be tabled for Parliamentary approval and published. It will not have the backing of law, but will be taken as a measure of good and bad practice in mental health, in institutions and in the community.

The Commission has certain functions to perform on behalf of the Secretary of State.

Firstly, it has to appoint medical practitioners to work on its behalf in the review of the "consent to treatment" provisions in Part IV of the Act. These practitioners may be Commission members — as at present — or they can be from outside. A panel of around 90 outside medical practitioners has been drawn up and, once approved by the Commission, will help to provide second opinions on treatment or medicines which have been prescribed for more than three months.

Three commissioners — one a medical practitioner — must certify that a patient about to have psychosurgery is capable of giving informed consent, and the medical member must provide a second opinion as to the appropriateness of this treatment in the particular case, before the operation can proceed. Other second opinions are required in certain cases of drug treatment and electro-convulsive therapy.

Commission-authorised medical practitioners may approve treatment proceeding without consent where medically beneficial, or may withhold approval. These powers are substantial in the review of clinical judgements of practising psychistrists, and in protecting patients from possible uninformed consent or inadvisable treatment. This area of the Commission's work is likely to be professionally contentious.

A second main function of the Commission is to provide a general protection to detained patients by reviewing the exercise of powers conferred in the Act over these patients.

Commissioners are required to visit detained patients in hospitals — including special hospitals and mental nursing homes — to interview them in private and provide medical examination by an approved practitioner where appropriate.

Commissioners may investigate any complaints made by patients, relatives, friends or others acting on behalf of the detained patient, as well as complaints made by formerly-detained patients relating to their period of detention and considered by them to have been dealt with unsatisfactorily by managers.

All complaints must have been referred to managers and the commissioners may refer to them. If the patient remains unsatisfied the Commission is able to take up these matters or refer them to the appropriate bodies. Where MPs have referred complaints the Commission must inform them of the action it has taken, and the outcome.

A third function is to review decisions to withhold postal packages from patients and to direct that this restriction be terminated in individual cases where commissioners consider this to be appropriate.

The Commission must prepare a report every two years on its activities, and this will be given to the Secretary of State to lay before Parliament. It will also provide a focus for discussion on mental health matters — especially related to detained patients and, in the future, to all mental patients.

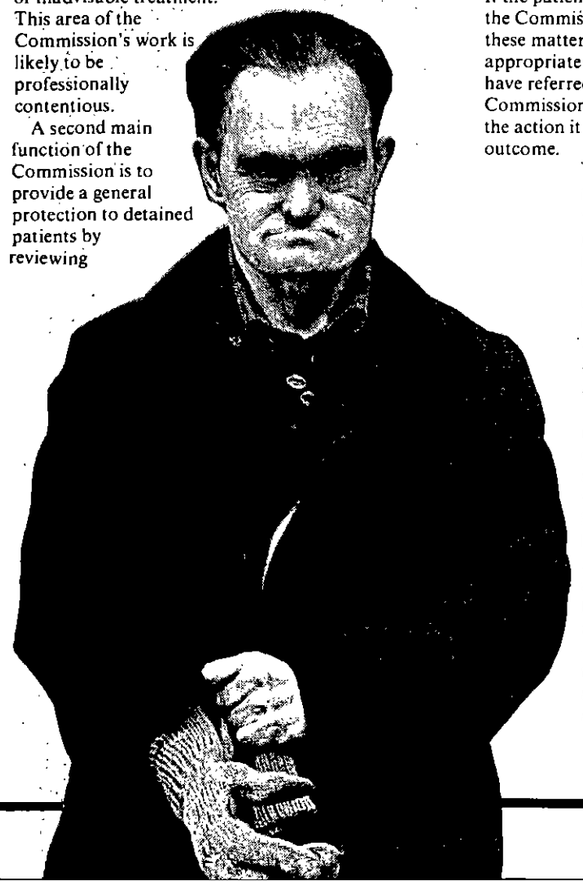


Photo: Raissa Page

* *Any views expressed in this article are those of the author and not necessarily those of other Commission members, or of the Commission.*

The Commission has substantial statutory rights of access and action which support its functions. It has access to all detained patients and their records at any reasonable time, and commissioners cannot be obstructed in carrying out their duties. They have powers to visit, interview and examine any detained patient in private. They may require the production and inspection of any records relating to detention or treatment — including admission documents, medical notes, seclusion records and so on. Commissioners must be allowed access to check complaints, to verify that detention accords with the Act, to look at how detention powers are exercised and to monitor the provisions on consent to treatment.

The Commission has recently begun regularly to visit institutions with detained patients and will visit special hospitals frequently. Visits will normally be made with prior notice to managers, but the Commission has the right to visit unannounced.

The publication of a report of the Commission's activities should enable it to draw attention to these aspects of its work where necessary. These rights and powers are substantial mainly in respect of detained patients' treatment. It remains to be seen whether in operation these are sufficient for action to be instigated on the advice of the Commission — or whether the "teeth" will need to bite.

The Commission is not intended to affect or interfere with the operation of other national or local reviews, complaints bodies or legal bodies in England and Wales. The Health Advisory Service and the National Development Team as review bodies, and the Health Services Commissioner as a complaints body have very different compositions and remits.

At a local level the Mental Health Review Tribunals remain the only bodies to review the need for individual patients to be detained, and this function has been increased in the new Act. The CHC's role to review services and help complainants to formulate and direct their complaints will not be affected by the existence of the Commission.

CHCs are likely to be asked to help the Commission by providing relevant information about services for detained patients in their area, and to help individual detained patients to formulate and direct complaints. The existence of the Commission provides another avenue — which CHCs should welcome — for the investigation of complaints. Similarly, co-operation from voluntary bodies with relevant experience and contact with detained patients should be welcomed by the Commission.

There may be some areas of duplication of function between these national and local bodies and the new Commission. This should not be seen as a disadvantage as it will serve to highlight the service to detained patients from different perspectives, which should help these and all mental patients in the future.

The Commission membership is important to its credibility — especially since it is a body born of compromise between opposing perspectives in mental health care. There are 90 members appointed by the Secretary of State with advice from the Welsh Secretary of State, and selected from over 700 nominees from relevant bodies. Appointments are for one to two days per week and for terms of two or four years.

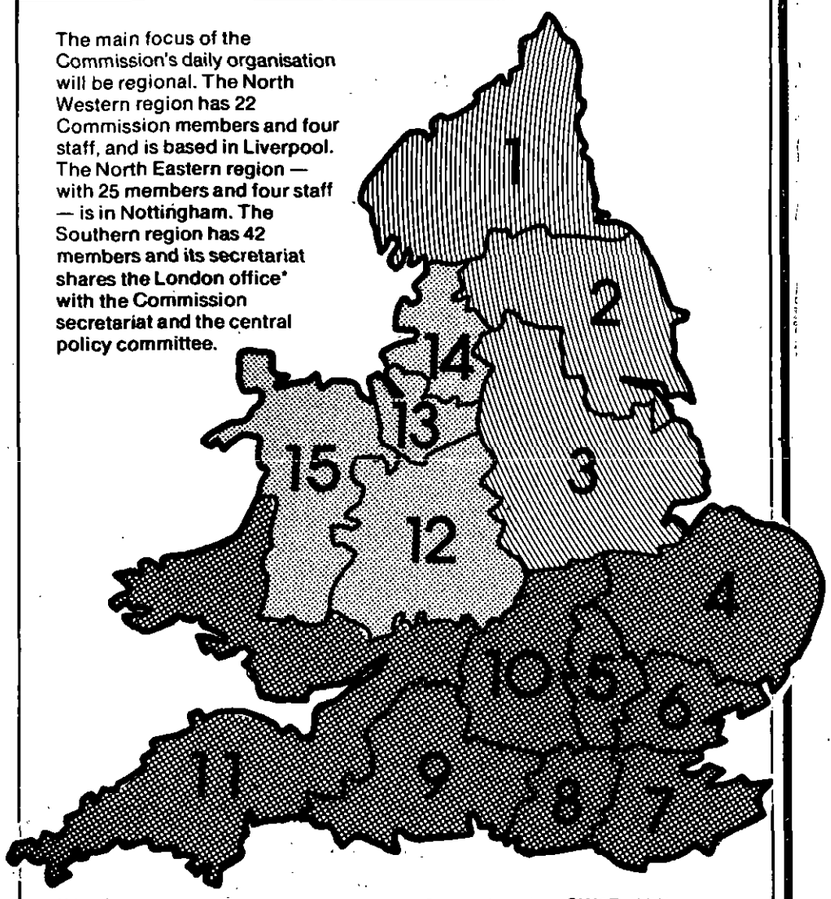
The largest group is of 23 psychiatrists, in recognition of the large medical opinion workload which will be supplemented by the panel of approved medical practitioners. The next largest group is of 15 lay members including four current CHC members — from Ceredigion, Coventry, Croydon and Medway — and a former CHC Secretary from York CHC.

There are 14 legal members, 13 nurses, ten psychologists and 11 social workers as well as three specialist members — an academic, an occupational therapist and a director of the International Hospital Federation.

The Commission is chaired by Lord Colville, who as a Home Office minister from 1972 to 1974 had special responsibility for people under licence at special hospitals and on parole. From 1980 to 1983 he led the UK delegation to the UN Human Rights Commission.

The Commission has a central policy committee which includes two psychiatrists, one person from each of the other groups of membership, and six co-opted members from each of the three regions of operation (see map). This committee is responsible for initiating proposals for the code of practice, and for the biennual report.

The constitution of the Commission's membership reflects the disciplines involves in mental health care and includes an important lay representation which is absent from other national review bodies. The lay element of the Commission could be a major step forward in acceptance by medical professionals of the positive contribution of a lay view to mental health and other health services. As a member of the Commission I look foward to the challenges facing it in the future.



The main focus of the Commission's daily organisation will be regional. The North Western region has 22 Commission members and four staff, and is based in Liverpool. The North Eastern region — with 25 members and four staff — is in Nottingham. The Southern region has 42 members and its secretariat shares the London office* with the Commission secretariat and the central policy committee.

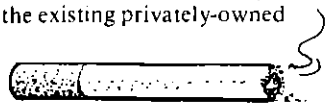
*Hepburn House, Floors 1 & 2, Marsham Street, London SW1P 4HW

THE SMOKING LOBBY...

by Sue McFadden

The smoking epidemic, now claiming about 95,000 lives every year, has been compared to the great cholera epidemics which struck London in the 19th century.

In four epidemics between the 1830s and 1870s, 110,000 people died, but the period also saw the beginnings of action on public health. The 1852 Water Act was an attempt to clean up London's water, the carrier of cholera. Unfortunately this act was weak and conciliatory to the existing privately-owned



water companies. At that time, 86 MPs were said to be shareholders in the companies.

The "libertarian" view was put in a leading article in the *Times* of August 1854 which inveighed against "the tyranny" of medical opinion of the day and protested — "we prefer to take our chance of cholera and the rest than be bullied into health".

This century's smoking epidemic is of a quieter but more devastating sort. It is more than 20 years since the Royal College of Physicians published its first authoritative report — *Smoking and health* — on the health consequences of smoking. Three more reports from the RCP, as well as publications of the US Surgeon General, the World Health Organisation, the International Union Against Cancer and others, initiated a downward trend in cigarette smoking in developed countries.

There are now more than nine million ex-smokers in the UK — but why, after 20 years' evidence about the detrimental effects of smoking, are there still more than 15 million smokers?

Social surveys have shown that six out of 10 smokers would like to give up. Seven out of 10 say that they have already tried to give up. Of all smokers who pore over the Health Education Council's literature, attend local health authority clinics or seek treatment from an acupuncturist or hypnotist, only 10 to 20% will become non-smokers at each attempt. Giving up smoking can be difficult, so what is being done to prevent the tobacco companies from recruiting new customers?

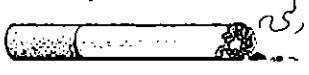
The tobacco industry spends £100 million a year on promoting smoking while health education receives less than £3 million a year.

The medical profession and its allies have pressed successive governments to enact legislation to stop tobacco promotion. Writing in 1980 to the then Secretary of State for Social Services, Patrick Jenkin, the conference of medical royal colleges and their faculties described the manufacturers' steadfast refusal to co-operate with effective action on smoking as "so determined that only wide-ranging powers will provide

...fag end of democracy

Government with any real chance of success".

The Government cannot have failed to understand the "health lobby's" point of view. In a letter to one of her constituents in 1980, Mrs Thatcher said: "My health ministers and I are in no doubt that smoking is the major preventable cause of illness and premature death in the UK and national and international medical opinion is strongly in



favour of a ban on all forms of advertising and promotion for tobacco."

When Mrs Thatcher's Government first came to power she appointed a junior health minister who understood the problems of combating smoking. In 1979 Sir George Young told the Fourth World Conference on Smoking and Health that "the solution to many of today's medical problems will not be found in the research laboratories of our hospitals, but in our Parliaments". (1)

In the negotiations for a new voluntary agreement which began later that year, he gained a reputation as a tough negotiator. He, and his senior, Mr Jenkin, produced a "shopping list" of real concessions they wanted from the industry. Almost a year of acrimonious discussions followed and during that time, according to the *Observer* newspaper, Sir George was "approached by Conservative whips and warned that if the companies were driven too far against the wall, the industry's support for the party would be in jeopardy". (2)

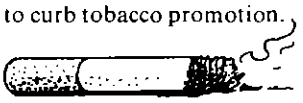
It was also reported that at a Downing Street reception, the Prime Minister's husband suggested to the health minister, Dr Gerard Vaughan, that sport would be hard hit if tobacco sponsorship was threatened. Dr Vaughan was said to have reported this conversation at the health department and recommended that a more relaxed attitute should be taken.

Soon afterward both Sir George and Patrick Jenkin were moved to other ministerial jobs, and the new health ministers who were appointed had a more "flexible" attitude to tobacco promotion.

More recently, an article in the *Observer* raised some "disturbing questions about the cosy relations that exist between the Government and the tobacco industry". It claimed that on the day of the publication of the RCP's fourth report, *Health or smoking?* (3), the junior health minister, John Patten, chose to meet with a tobacco industry-funded organisation, FOREST, "casting a revealing light on the Government's real attitude to smoking and health".(4)

The article disclosed that a candidate for a senior post at the Health Education Council wad vetoed by health ministers although he was a well qualified candidate and had the majority support of the interviewing panel. The candidate was Mike Daube, a former director of ASH — Action on Smoking and Health — and "no friend of the cigarette manufacturers". "There is considerable evidence," said the *Observer*, "to suggest that the tobacco industry lobbied hard within the department in a determined attempt to block the appointment."

The cause of health has had other champions at Westminster. Laurie Pavitt has 16 times brought forward Private Members bills intended to curb tobacco promotion.



But these have been obstructed by MPs who represent tobacco manufacturers or the advertisng industry.

On one occasion parliamentary time was denied to a bill because MPs took an inordinate interest in the Zoos Bill which preceded it — see *CHC NEWS* 68 page 1. Among the MPs most interested in zoos was Sir Anthony Kershaw, an advisor to British American Tobacco.

A leading article in the respected medical journal the *Lancet*, said: "Unfortunately, successive governments have taken more note of pressure from the tobacco companies than of concerted representation from the medical profession...(and) public opinion since most people believe that cigarette advertising should be banned."(5)

In 1982, two further voluntary agreements, one on advertising and another on sports sponsorship, were made between the Government and the tobacco industry. While straightforward tobacco advertising is in the province of the DHSS, its more covert brother, sports sponsorship, is "regulated" by the Ministry of Sport.

In December 1981, 10 eminent medical experts, eight of them presidents of medical royal colleges, wrote to Neil Macfarlane, the sports minister — an act that was hailed by the *British medical journal* as an

"event unprecedented in the history of public health in Britain". The letter expressed particular concern that the sponsorship of sporting events by tobacco companies would establish a paradoxical link in the minds of young people between tobacco and participation in sports.(6)

Mr Macfarlane was asked to consider evidence from Norway — where tobacco advertising and sponsorship has been banned since 1975 — that smoking among young people had fallen during a period when it might otherwise have been expected to rise. The letter's signatories offered to meet Mr Macfarlane but he apparently thought this unnecessary.

A leading article in the *British medical journal* a few weeks later said that the Government's decision to reject the advice of medical royal colleges and to enter into a new voluntary agreement with the tobacco industry showed "an irresponsible and cynical lack of concern to prevent illness and death".

"When the history of medicine in the 20th century comes to be written," it said, "members of the Government who allowed such an agreement will stand indicted as the guilty men of public ill health."(7)

References

1. G. Young — *The politics of smoking* in *The smoking epidemic* Proceedings of the fourth world conference on Smoking and Health, Stockholm 1980.
2. *Tobacco barons and health reshuffle* — Adam Raphael in the *Observer* 16 November 1981.
3. *Health or smoking?* — RCP, £3.95 from bookshops.
4. *A government health warning* — Adam Raphael in the *Observer* 4 December 1983.
5. *Voluntary agreements do not stop epidemics* — Leader in *The lancet* 1982, ii 855.
6. *Sponsorship of sport by tobacco companies — British medical journal* 1982, 284, 395-396.
7. *Tobacco sponsorship of sport: think again* — Leader, *BMJ* 1982, 284, 365.

Book reviews

The experience of infertility

by Naomi Pfeffer and Anne Woollett, Virago, £3.50

The authors of this book have both experienced the problems of infertility themselves, and the book is particularly concerned with aspects usually neglected in the medical literature.

Using their own and other women's responses, they discuss how infertility *feels*, and how it affects different areas of one's life. They describe in detail the processes involved, the investigations that are likely to be suggested and the options available to those who discover they are infertile. Medical information is presented very clearly and made accessible to the lay person, but is accompanied throughout with quotations which movingly convey what it feels like to go through these experiences.

I found this an excellent book, to be recommended to anyone facing the problems of infertility. Perhaps it should also be compulsory reading for the professionals involved in their care.

Juliet Metcalfe, former Member, Walsall CHC

How much are public servants worth?

edited by John Gretton and Anthony Harrison, Blackwells, £7.50

Over the last 20 years or so successive Governments have always, whether they have a formal incomes policy or not, sought to control the level of wages and salaries in the public sector. This has sometimes meant that the pay of health workers has become a battleground to help the Government to "set an example" to the private sector or as part of a cash limits policy.

This book provides both an historical survey of previous incomes policies and a statistical analysis of trends in the public sector labour market. It also looks in detail at the findings of the Megaw committee set up by Mrs Thatcher when she abolished the Clegg Commission and the Civil Service Pay Research Unit.

The book is somewhat unsatisfactory as it is a compilation of separate articles. But some interesting and convincing arguments are put forward. It is clear for instance that the most successful incomes policies are those based on the voluntary co-operation of the trades unions and that comparability exercises between jobs in the public and private sectors are an *essential* part of any long-term incomes policy.

But more should have been made of the way the Government now plans public spending and the problems that result. Public expenditure forecasts and plans used to be based on the level of service to be provided — the number of hospital beds, for instance — and money was made available even if the cost was higher than expected. The book tends to criticise this as being unduly complicated. Yet the present system is based on cash planning, which means that a higher pay settlement in the NHS than the Government has planned for leads to cuts in the level of services to keep within cash limits.

Such a system of planning may seem more simple but it inevitably leads to a declining standard of service.

Toby Harris, Chair, Haringey Social Services

What chance have we got

by Ann Birch, Manchester MIND, £2.95 (1)

Reflected images — self portraits of stress

from 42nd Street, £2 (2)

CHC NEWS often contains details of consumer views of health services via CHC reports or surveys, or through reviews of books compiled by professionals. These recent reports by voluntary organisations in Manchester give consumer views of the psychiatric and related services using the technique of extensive interviews printed almost verbatim.

The first publication explores the problems faced by psychiatric patients in relation to employment and unemployment.

The second report details the experiences of 11 young people in their search for understanding and support, and is published by a community mental health project for young people.

Both publications draw heavily on the individual experiences of people for whom the existing services are often not relevant. Every attempt is made to ensure that these views are not distorted by the interviewer and to convey the true feeling of what people want to say.

These excellent publications have caused me to ponder whether CHCs should not be exploring in a similar way the experiences of people using the NHS. Apart from work coming out of the women's movement this is generally an under-explored field.

1. Available from Manchester MIND, 102 Manchester Road, Chorlton, Manchester, price £2.95 inc post.
2. From Programme Co-ordinator Development Trust, 2nd Floor, Elliott House, Jacksons Row, Manchester M2 5WD, price £2 inc post.

Nick Harris, Secretary, Central Manchester CHC.

Books received

Alcohol, youth and the State — drinking practices, controls and health education by Nicholas Dorn (Croom Helm, £17.95).

Directory of non-medical research relating to handicapped people 1982 by Jane Whiteley and Jim Sandhu (Handicapped Persons Research Unit, Newcastle Polytechnic, No 1, Coach Lane, Newcastle upon Tyne, NE7 7TW, £10 inc post).

Enjoy sex in the middle years by Dr Christine E Sandford (Martin Dunitz Publishers in association with the National Marriage Guidance Council, £2.95).

We are updating the *CHC NEWS* list of book reviewers and would be pleased to hear from CHC members or staff who are willing to read and comment upon newly published books which we supply. Reviews must be short — no more than 250 words — and we cannot pay CHC people for what they write, but reviewers can keep the books we send them.

If you want to join our list of book reviewers please contact us at the address on page 2 — and let us know which are your particular areas of interest.

Scanner

Protect and inform

Following criticism from MIND — see *CHC NEWS* 85 page 11 — the little-known Court of Protection has issued a leaflet explaining its powers and function. The Court manages financial and property affairs of mentally ill and handicapped people, and is an office of the Lord Chancellor's Department. Aimed at relatives of those under its protection, the leaflet is free from the Court at 25 Store Street, London, WC1E 7BP.

Sterile variations

A collection of papers given at a 1982 conference on sterilisation — now published in booklet form by the Birth Control Trust — provides eight experts' views on techniques and procedures, advantages and after effects, the cost-effectiveness of sterilisation compared to contraception and unwanted pregnancy, and the contribution of private clinics in meeting the demand for male and female sterilisation. NHS sterilisation rates vary from 12 women per 10,000 aged 15-44 in one health authority to 167 per 10,000 in another, while vasectomy rates vary from 4 to 196 according to area. *Sterilisation — services, organisation, procedures* is £1.50 plus 17p post from BCT, 27-35 Mortimer Street, London W1N 7RJ.

Community groups need information, office facilities, professional advice and a lot more to make them strong and effective, and resource centres can provide practical services and support in a locality to a range of small voluntary organisations. Resource centres for community groups *is a comprehensive guide to setting up and running centres. It includes sections on management, training, choosing equipment, publishing bulletins, and providing research support and information. By the Community Projects Foundation and the Calouste Gulbenkian Foundation, it costs £3.25 inc post from CPF, 60 Highbury Grove, London N5 2AG.*

GP prescriptions

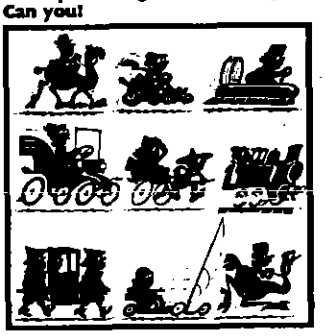
An average GP could save £1000 per year by prescribing the generic equivalents instead of brand names for just six commonly-used drugs — Mogadon, Valium, Indocid, Aldomet, Lasix and Inderal. A two-year project by the department of general practice at St Mary's hospital, London studied the effects of providing a randomly-selected group of GPs with information about their prescribing habits and costs. The study group prescribed fewer drugs, more of the cheaper drugs and fewer new, expensive drugs than a control group. Many frequently-used drugs cannot be prescribed generically, while many drugs with available generic equivalents are used infrequently, say the researchers, but by using generic equivalents of the "big six" GP s can make significant savings on their drugs bills. *Prescribing — a suitable case for treatment, occasional paper 24* costs £3.75 inc post from the Royal College of General Practitioners, Publications Sales Department, 8 Queen Street, Edinburgh EH2 1JE.

...and hospitals

More than 70,000 operations are performed each year in the 350 GP hospitals in England and Wales, and their important contribution to medical care should be supported, says an RCGP survey of the scene. *General practitioner hospitals — occasional paper 23* makes a plea for adequate resources and training, more provision of minor casualty services, and GP hospitals in larger urban areas as well as the rural sites where they are most common. Price £3 inc post from RCGP's publications sales department — address as above.

Fares to hospital

Some patients get their fares paid Can you!



Attractively-presented new DHSS leaflets include: which benefit? (FB2), help for families on a low wage (FIS1), fares to hospital (H11), free milk and vitamins (MV11), and benefit payments during hospital stays (NI9). Amendments to NI12 and NI16A explain new rights for married women claiming benefits.

The travellers' way

A survey of gypsy and traveller families has found a disturbing difference in the health status of traveller children when compared to the general

Parliament

Transplant records

A record number of kidney transplants were performed in the UK in 1982 — and 1983 is expected to break that record of 1,030. Despite this, the Government is to launch a new publicity campaign early this year to increase awareness of the importance of organ donation and the benefits of transplantation. It is also funding, as a pilot project, the appointment of a number of consultants as part-time transplant advisers to improve hospital liaison procedures. In addition the DHSS has written to all RHAs requesting details of their current plans for developing both kidney transplantation and renal dialysis provisions. The latest figures on people being treated by dialysis in England and Wales show NE Thames region with the highest number of patients at 476 — 128 per million of the population. SE Thames tops the transplant table with 486 patients with a functioning transplant — 139 per million of the population — all by 31 December 1981. (John Patten, written answers to Lewis Carter-Jones and Bernard Braine, 30 November).

Abortion contracts

West Midlands tops the list of regional health authorities in England contracting out their abortion services to private agencies. It contracted out 2,944 in 1982 — a rise of 1,254 on 1981 — compared to 642 in South West Thames, the nearest figure of any other authority. North East and North West Thames, and Wessex didn't contract out at all in 1981 but in 1982 NE Thames sent two, NW Thames sent one and Wessex sent 641 women to private agencies. The five other English regions and Wales did not contract out to private agencies. (Kenneth Clarke, written answer to Jo Richardson, 24 November).

Griffiths and CHCs

The Griffiths report has implications for CHCs but suggests no radical change in their role. The report stresses that the interests of patients and the community should be central to the approach to management in the NHS and recognises that CHCs provide one of the channels through which their views can be derived. Guidance on implementation of their report awaits consultation with health authority chairs and other relevant bodies including CHCs. (Kenneth Clarke, written answer to David Heathcoat-Amory, 13 December).

Prescribing profits

A small increase in the number of prescriptions compares to an almost doubling in cost of drugs prescribed by doctors and dispensed by NHS pharmacists since 1978. In the last five years the number of prescriptions has increased from 307.8 million to 311.7 million, yet in the same period the cost of drugs rose from

population. An estimated 60 to 70% of traveller mothers with children under 10 in the area of the East Anglia regional health authority — 265 women — were interviewed about their experiences of pregnancy and the health of their children, and their access to amenities was noted. Although caravans were well-kept and clean, 30% of families had no direct access to water on site, while 58% of families were on sites with no lavatory facilities. The survey found that all but one of 239 children under 5 were born in hospital — 24% had been ill in the first week of life.

Stillbirths, at 113.9 per 1000 total births, were 17.2 times the national and 20.3 times the East Anglian rates, while perinatal deaths were 12.1 and 13.7 times higher at 142.4 per 1000 live births. Most mothers claimed they were not told the reasons for these deaths, but the researchers conclude that they were mainly socio-environmental causes. Serious illness or injury had affected 55% of the under-5s and immunisation rates were very low.

While the East Anglian experience cannot be generalised across the UK, the survey concludes that health care for travellers should be examined and living conditions should be improved.

The health of traveller mothers and children in East Anglia is £1 plus 16p post from Save the Children, Mary Datchelor House, 17 Grove Lane, Camberwell, London SE5 8RD.

Put a name to it

A useful glossary of medical terms from the Royal Association for Disability and Rehabilitation ranges from algesia to visceroptosis in explaining basic doctor-speak. *What is it?* is designed for people working for the welfare of physically disabled people, and costs 25p plus 17p post from RADAR, 25 Mortimer Street, London W1N 8AB.

A revised guide to Government funding programmes illustrates the scope of ministries' grant-giving — the Department of Energy funds insulation projects for disabled and elderly people, the Department of Transport is funding an advice unit on community transport schemes — and describes organisations such as the Development Commission and the Housing Corporation, which allocate Government funds. It also includes money from local authorities and from Europe, advice on applying for grants, and a list of further reading. Government grants — a guide for voluntary organisations *is an NCVO practical guide from the Bedford Square Press. Price £3.50 from bookshops or £3.95 inc post from Macdonald and Evans Distribution Services, Estover Road, Plymouth PL6 7PZ.*

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: Mr WAR South
Page 3: North East Yorkshire CHC Tel: Scarborough 369556
Page 3: Calderdale CHC Secretary: Miss BJ Stott
Page 4: Leeds East CHC Chair: John Crowley
Page 4: Bassetlaw CHC Chair: Dr ME Finch
Page 8: Tunbridge Wells CHC Chair: Mrs PJ Darbyshire
Page 10: Winchester CHC Chair: Mr EE Young
Page 11: Oxfordshire CHC Chair: Mr CR Saunders
Page 11: Weston CHC 55 Oxford Street, Weston-super-Mare, Avon BS23 1TR. Tel: unchanged
Page 14: Chorley and South Ribble CHC Secretary: Andy Beckingham
Page 18: Mersey Regional Group of CHCs Secretary: Frank G Rose c/o Liverpool Eastern CHC. Chair: Sheila Fleetwood
Page 18: North Western Regional Association of CHCs Secretary: Nick Harris c/o Central Manchester CHC

Health circulars

HC(83)21: asks regions to monitor districts' progress in transferring children out of mental handicap hospitals, offers development team advice on service plans and describes the additional funding scheme.
HN(83)24: introduces CONCODE — a code of guidance on contracts for construction and maintenance works.
HN(83)30: presents quarterly bulletin of NHS publications.
HN(83)32: explains revised VAT declaration for opticians.
HN(83)33: announces three-year "sustained national drive" to intensify rubella immunisation programmes.
HN(83)34: advises on fees arrears for hospital eye service dispensing.

£519.5 million in 1978 to £934.3 million in 1982-83. (Kenneth Clarke, written answer to Frank Dobson, 15 December.)

Since 1976 actual profits for drug companies from sales to the NHS have increased fourfold. They have risen from £57 million in 1976 to an estimated £200 million in 1983 and DHSS estimates of "notional profits" are even higher. Profits dropped in 1979 when they were cut back to £87 million from £100 million in 1978. But in 1980 they increased to £108 million and have risen steadily since. The Government expects its new measures, announced before Christmas, to reduce profits and produce savings of £65 million in 1984-85 and more than £100 million in later years through reduced price increases and cash rebates from drug companies. (Kenneth Clarke, written answer to Michael Meacher, 16 December).

Hypothermia rise

Deaths among people aged 65 and over where causes recorded include hypothermia are on the increase. Apart from the peak of 613 recorded deaths in the winter of 1978-79, the latest figures show a steady rise. In 1979-80, 367 deaths were reported with 417 in 1980-81 and 552 in 1981-82. There is no definitive list of cold-related diseases beyond hypothermia but there is increased risk with cold to people suffering a wide variety of conditions. (John Patten, written answer to Andrew Bowden, 21 November).

Govern the disabled

The government will continue to promote the integration of disabled people despite its opposition to Bob Wareing's private member's bill — see *CHC NEWS* 92 page 3. They intend to press ahead with what they are doing on social security benefits, access, transport, employment and education and deal with the practical problems which affect specific disabled people. The independent Access Committee for England is to be funded by the DHSS and relevant organisations are being consulted about its role. The Government has also welcomed the progress of television companies in adding subtitles to some programmes. (Tony Newton, oral answers to Bob Wareing and John Hannam, 13 December).

Advice for men

Of the 53 advisory committees appointed by the Secretary of State, 18 have no women members and 16 have only one. On two committees women outnumber men — the standing nursing and midwifery advisory committee and the working group on trials of early detection of breast cancer — while the maternity services advisory committee has equal numbers of male and female members (John Patten, written answer to Harriet Harman, 15 November).

News from CHCs

□ The controversial proposals to privatise domestic, catering and laundry services in the NHS have brought a strong statement of condemnation from **Paddington and North Kensington CHC.** Their local district health authority rubber-stamped the Government's pproposals at its December meeting despite opposition from some authority members, the CHC, health staff and local people. The CHC says "damage will be done to standards of patient care if the NHS loses control of these services. There is a great danger that private contractors may initially provide a reasonable standard of service, and then standards will slip. By this time the NHS will have lost its own skilled and experienced workforce." They go on to add "more people will be forced into poverty, which has been shown to be linked to ill-health, by this move ... the NHS cannot afford the administrative time and effort which will go into putting contracts out to tender and which would be better spent on improving services to patients."

□ **Waltham Forest CHC** has just published the results of its survey on well woman centres — and the idea has received a resounding yes from local women. Their questionnaire, which was answered by 850 women over a six-week period, included sections on what health checks and counselling women wanted, how much they wanted a centre and a breakdown of the demand for a centre among the different age groups.

The results showed that vagina and breast checks were regarded as the most important, stress and depression were the areas where counselling was most desired and 66% of women would be interested in informal, self-help discussion groups.

An overwhelming 90% of women said they would use a well woman centre and 87% would be willing to travel to do so as well. The responses came mainly from the 25-34 and 35-44 age groups with the smallest number of replies from the 15-24 and 65-plus age ranges.

The survey, undertaken following a special conference organised by the **Association of CHCs** in 1981, complements one completed by **East Cumbria CHC** and gives a spotlight on an urban area.

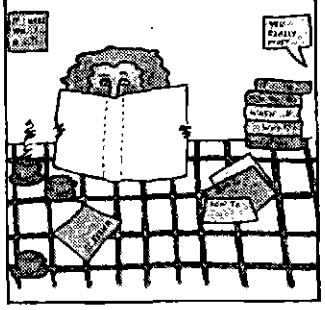
The CHC now hopes to take the survey to its district health authority and press for a commitment to the project.

□ NHS workers have got the thumbs up in Hertfordshire at the end of a successful "Big thank you to the NHS" month run by **South West Herts CHC.** More than 100 nominations were received in the month leading up to Christmas with some workers receiving more than one nomination. Among them were ones for the "whole NHS" and for "a very kind vampire" who turned out to be a local haematologist. Doctors and nurses were top of the list with whole wards being nominated and others included porters, dentists, ambulance staff, social workers, receptionists and even a treasurer. Each person will receive a special certificate with a citation explaining why they were nominated.

The "thank you" idea originated in Manchester at the end of 1981 when the city's three CHCs came up with the first "Thank U month" and now it has spread to 12 out of the 17 CHCs in the North Western region. Whereas the Manchester version judges the nominees and picks a winner, **South West Herts** insists that everyone is a winner and does not differentiate.

□ a long-planned cervical screening project initiated by **Hull CHC** found an enthusiastic response from local women when a week's visit from a mobile screening van coincided with October's revelations of possible links between cervical cancer and the pill. Queues formed each morning and women waited between two and three hours for cervical smears — some had made special journeys to the van because they could not find screening services close to home. The CHC wants more screening weeks and has recommended that the van should visit hospitals to offer a service to nurses. But the ultimate aim is a well women service, and the CHC will cite support for the idea gained at its women's health day held in June.

Having a baby in Calderdale - What you need to know



□ **Calderdale CHC** *has produced a comprehensive leaflet for potential mothers to guide them through pregnancy. Entitled* Having a baby in Calderdale — what you need to know, *it starts with a visit to the doctor at the first signs of pregnancy and ends with employment rights for mothers who want to go back to work. Sections on before the baby is born, a calendar of pregnancy and after the birth give a detailed rundown on every step a mother will take. It also includes a useful list of addresses and contact numbers for advice such as health groups, family planning units and pregnancy testing services.*

□ The Government's proposed changes to the Optician's Act have come under fire from **Northumberland CHC.** A letter from the CHC to their four local MPs gives a guarded welcome to the introduction of competition in supply of private lenses but attacks the restriction of NHS glasses. It says "we believe that on principle a reasonable pair of basic glasses should be available on the NHS. First and foremost poor sight is a medical condition and as such a pair of glasses is the 'treatment' required." The letter goes on to say that the competition is unlikely to produce cheaper frames but will mean more expensive lenses for those with worse sight. "This seems to us to be a most retrograde step. Those who will benefit will be those with the least bad sight now buying private frames." The CHC reckons the new measures could mean a 200-300% increase in the cost of frames for those with the worst sight.

□ Two major inquiries are underway into the Prince Charles hospital, Merthyr in Wales. The hospital, which was at the centre of an admissions row last year, has at least 20 women on its waiting list for breast cancer checks who have been delayed for up to three years. **Merthyr and Cynon Valley CHC** has demanded an urgent inquiry and Secretary Bryn Williams commented: "It is a damning indictment that women have had to wait so long." The 20 women who have breast lumps have been told they must wait for biopsy operations and consultants say they should have had a wait of no more than two months for such operations.

The **Association of CHCs in England and Wales** has called a special general meeting to discuss its financial position following the first full year of operation without DHSS grant support. A special standing committee of ACHCEW — meeting on 1 February — will examine budget figures and economy plans, and will formulate proposals for future action to take to the SGM on 25 February in London. CHCs will be invited to send two delegates to the SGM and will have one vote per CHC on the proposals for debate.

CHCs may wish to convene special meetings in February to discuss these proposals — which will be circulated immediately after the standing committee.

Meanwhile CHC Chairs and Secretaries have been asked to complete a questionnaire to help assess the level of financial year of 1983-4, for both ACHCEW and *CHC NEWS.*

Some CHCs may have not received their copies of December's *CHC NEWS* as several packages have been returned to us after coming apart in the post. Please contact us if you have not yet received December's issue, or if you received too few copies — we will supply extra copies as needed.