CHC NEWS

1

MAY 1975

This is the first issue of CHC NEWS - a temporary newsletter for community health councils. The idea arose from discussions between individual CHCs and the Department's two advisers, Lady Mary Marre and Councillor Ken Collis, and subsequently the King's Fund agreed to sponsor a newsletter until the end of 1975. What happens after that depends partly on the report of the Steering Committee (for the National Council for Community Health Councils). If they recommend a National Council should be set up, then this new body might wish to continue providing the newsletter. If this does not happen, then CHCs may wish to approach other organisations who would sponsor future issues, or they might wish to discontinue the newsletter for the present.

We hope to have the next issue of CHC NEWS ready in July, and then further issues should appear in September and November. Three copies of each issue are being sent to all CHCs in England and Wales, and the health authorities will also receive copies. As there are only limited facilities for producing CHC NEWS, we hope it will be possible for Secretaries to photocopy all or parts of it for their members to see.

The success of CHC NEWS depends on the relevance of its contents for CHC members and secretaries, so we do hope you will be forthcoming with your criticisms, suggestions and contributions. In this issue we have included summaries of recent DHSS circulars, a guide to some recent publications, and reports of useful work done by CHCs. Please write in and let us know whether this is on the right lines, and do tell us which other topics and publications you would like to see covered. Future issues will also have a section in which your letters will be published, so you should drop us a note of your questions, thoughts and theories as soon as you can.

The editor of CHC NEWS is Ruth Levitt. She is a member of the CHC for the north-east district of Kensington Chelsea and Westminster AHA, and has previously worked on patients' attitude surveys in South Hammersmith district. A regular contributor to CHC NEWS is Bernadette Fallon, research assistant at the Nuffield Centre for Health Service Studies in Leeds.

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INFORMATION PLEASE

If the address we used on the envelope was incorrect, or if you are changing your address, please let us know by returning the form below. This will ensure that you receive the next edition of CHC NEWS promptly, and it will also help us to compile an up-to-date directory of all CHCs.

COMMUNITY HEALTH COUNCIL .....

ADDRESS .....

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TELEPHONE NUMBER .....

SECRETARY .....

CHAIRMAN .....

CHAIRMAN'S PERIOD OF OFFICE ENDS: .....

Please return this form to:

CHC NEWS
c/o KING'S FUND CENTRE
24 NUTFORD PLACE
LONDON W1H 6AN

PRESS CUTTINGS

We hope to include more reports of CHCs' activities in the next issue of CHC NEWS, and it would be extremely helpful if you could send in copies of any articles that appear in your local papers referring to your community health council. If you think it is a good idea, we can start a collection of all the cuttings you send in, and they will build up into a unique account of the early history of CHCs.

YOUR LETTERS

In future issues of CHC NEWS we will print your questions, comments, problems and ideas. If there is anything you have done that other CHCs would be interested to hear about, or if you have a problem they may be able to help you with, please write in, and we will print as many as there is room for.

The address for your letters and press cuttings is :

CHC NEWS,
c/o King's Fund Centre,
24 Nutford Place,
London W1H 6AN.

A NOTE TO CHC SECRETARIES

As you may find CHC NEWS too long to photocopy in its entirety, may we suggest you keep one copy in your office for reference, and circulate the other two around all the members. In addition, you may wish to photocopy certain items from the 'office copy' that will be of specific interest to particular members.

MALE MIDWIVES

by L.D. KIMBER, Secretary, Sunderland CHC

Most, if not all, Community Health Councils received a letter from the Royal College of Midwives headed "Equality for Women - Government Proposals to end Sex Discrimination - Midwives should be a Special Exception". This said that the College was deeply concerned by the Government's intention to introduce legislation which would allow men to train and practice as midwives. They then went on to list a number of reasons why they thought male midwives would not be acceptable, using the headings of:-

(a) The unique role of the midwife

(b) The evidence that many women and their husbands would not accept a man for the full range of a midwife's duties and

(c) The added expense to the National Health Service because extra staff would have to be employed to chaperone male midwives.

To start with, members of Sunderland Community Health Council were merely asked to discuss the proposals with their friends, associations, organisations and acquaintances with particular emphasis on the second point about husbands and wives not being willing to accept male midwives. About a fortnight later, two members from different Community Health Councils appeared in a local news programme on television, one expressing a view in favour of male midwives and the other expressing views against them. During the interview it became evident that they were not necessarily quoting the views of their Council but merely of themselves as individuals, and when one of the members was asked how he had formed his opinion he said he had discussed it with his two daughters. This struck us as being not quite the correct way of representing the community's interest in a service which obviously affects a great number of the public, for example, in Sunderland Area Hospitals there were 4,215 births and a further 236 attended by midwives in their home last year.

THE SURVEY

It was therefore decided that I should arrange a small sample survey in the Ante-Natal Clinic of the main General Hospital and, since it coincided with our planned visit, the Maternity Hospital. The survey itself was very easy to conduct in that, having decided the questions to ask, one merely had to go and ask the questions while the patients were standing in a queue waiting for their routine weighing, or ask them during the visit to the Maternity Hospital.

The questions and responses were as follows:-

1. At General Hospital - sample 130 women

	Yes	No	Don't know
Would you object to a male midwife delivering your baby ?	18 (13.8%)	104 (80.0%)	8 (6.2%)
Would you object to a male midwife giving you ante-natal and post-natal care in your home, which might include examinations of your breasts or vagina and giving advice on breast feeding ?	18 (13.8%)	104 (80.0%)	8 (6.2%)
Do you think your husband would object to male midwives, either in hospital or at home when you might be alone ?	6 (5.0%)	106 (88.0%)	8 (6.7%)
Do you think that male midwives should be chaperoned ?	18 (13.8%)	104 (80.0%)	8 (6.2%)

2. During tour of Maternity Hospital - sample 51 women

	Yes	No
Would you object to having your baby delivered by a male midwife ?	2 (4%)	49 (96%)
Would you object to a male midwife giving you post-natal care at home, including intimate examinations and advice ? Should they be chaperoned ?	2 (4%)	49 (96%)

3. At Ante-Natal Clinics - husbands who had come with wives - sample 37 men

	Yes	No	Don't know
Would you object to male midwives looking after your wife at the time the baby was born ?	1 (3.1%)	31 (83.6%)	5 (13.3%)
Would you object to male midwives tending your wife at home and giving her intimate examinations and advice ?	1 (3.1%)	31 (83.6%)	5 (13.3%)
Do you think your wife would object to a male midwife ?	5 (13.3%)	26 (70.3%)	6 (16.4%)
Do you think male midwives should be chaperoned ?	-	30 (80.5%)	7 (19.5%)

The survey in the out-patient department was carried out partly by the Secretary and partly by a Regional Administrative Trainee who was at that time attached to the Secretary for work with the Community Health Council. The survey in the Maternity Hospital was conducted by the four members of the visiting group and they reported their findings to the Secretary. The Council in fact had a meeting midway through this exercise as, in order to get a wider representation, it had been decided to check the ante-natal patients on two separate days.

OPPOSITE RESULTS TO JOURNAL SURVEY

It was found that the results were extremely different from those put forward by "Nursing Times" which found that 63% of mothers said they did not approve of men being allowed to train as midwives. It was evident from the answers that the expectant families of Sunderland had a greater respect for the morals implied by nurse training than is found in certain other parts of the country and most of the husbands in particular who were asked if they thought a male midwife should be chaperoned gave a stock reply "they are properly trained nurses aren't they ?"

Some people also felt that north eastern women have a more realistic and down-to-earth attitude to childbirth. Among the elaborations given by women as to why they would prefer male midwives, some reasons kept cropping up time and again including "men can be more sympathetic to a woman's needs than a woman often is" and "we accepted male doctors so why should we not accept male midwives ?". Other Community Health Councils in this region tended to produce the same sort of result, using various methods from stopping people in the street to arranging a phone-in on a local radio station.

"Nursing Times" gave no indication of how old the people they questioned were, merely saying that 63% of mothers were opposed to the idea of male midwives. No doubt, as with all other organisations, the Royal College's committees include the middle-aged nurse who may have dedicated herself to a career and therefore does not know the problems of parenthood, or may have left her children behind her long ago and has not kept in touch with changing attitudes. Certainly, looking into the historical books, the arguments they have put forward in some cases are very similar to those put forward when women doctors were first proposed (and of course women, when visiting their male doctor, only hinted at their illness rather than gave definite effects and symptoms, because of the embarrassment).

PRESS REACTION

Having collected the information and put it in tabular form, it was decided that it should be sent:-

(a) to the Royal College of Midwives, who had requested our support in the first place and

(b) to the M.P.s who covered the Sunderland Area and who would, in the long run, have the final vote on the Bill to be laid before Parliament.

Some local papers had taken the issue up following our meeting when the preliminary results had been disclosed from the out-patients' session, and from the local press it appeared in the national press, and finally we sent details of our survey to other national papers. By strange coincidence, two of the national papers printed an

article during the week the Bill had its formal first reading in Parliament and Sunderland local papers carried a very detailed article on that particular day. The article also appeared at the time when Barbara Castle stated that she accepted that male midwives should be chaperoned but refused to accept that they should be outlawed altogether. From the national press came a number of enquiries. We had letters from Community Health Councils in the Midlands and in Yorkshire asking for details of our survey, and also letters from various people both within Sunderland and again from as far away as the Midlands. Apart from the obvious divergence between individuals' views, one fact came out very clearly from the letters and correspondence, and that was that midwives themselves are opposed to the idea of male midwives, although whether they feel this because of justifiable professional reasons or because they feel insecure at the prospect of males taking part in midwifery, is not apparent. During my correspondence with the local paper, it would seem more likely that mothers-to-be would have to receive the services of a female midwife when they wanted a male, rather than the other way round, as had been suggested.

The press coverage we got on this particular item started in the middle of February and spread itself out over some seven weeks, partly because one of the local Women's Page Editors printed her personal feelings against male midwives which prompted the Council, and indeed members of the public, to send letters in reply which she printed almost in full, and this kept the item going for quite a long time. It was obvious that the matter was of great public interest once it had been aired and the fact that we had actually undertaken a survey made it even more newsworthy.

CONCLUSIONS

In retrospect, I think we made only one mistake and, to some extent, that was forced upon us by the constraints of time during which we had to reply. Ideally, given the time, we should have consulted various other groups such as pre-school play groups, mother and toddler groups, nursery school groups etc., where the membership would have been able to reflect the current opinions of young mothers and mothers-to-be. Time unfortunately forbad this because we only woke up fairly late in the day to the fact that members are not necessarily the best people to comment

on this sort of item. This approach would certainly have helped to publicise the work of the Community Health Council.

However, "Male Midwives" certainly achieved its objective in Sunderland, where the Council is based in very temporary offices away from the Town Centre and are without adequate telephone provision, therefore delaying its publicity drive. The sort of publicity given to us on this question, meant that a fair number of people were able to learn of the existence of Community Health Councils and some of the work that they do.

It appears that in England there are no courses to allow men to become health visitors, because they all insist on midwifery experience. Unless the courses are changed the introduction of male midwives might lead to the introduction of male health visitors, who no doubt could perform a very useful and much needed service without recall to midwifery. This idea only serves as another example of how a Community Health Council can help to spotlight shortcomings in our health services - by discussing with all members of the community, aspects of health care which arise from specific points, which they themselves might be individually opposed to - but can in fact see long-term advantages to their particular interest.

Obviously, despite our survey, we cannot say "you must have a male midwife" and any suggestion of imposing, on an individual patient, a midwife against their choice, could only damage the reputation of the Community Health Council. "Male Midwives" has, however, opened up a far more important aspect of freedom. Barbara Castle has accepted that the patient has the right to choose whether she has a male or a female midwife. I wonder if this freedom of choice might be extended to other areas, such as the right to see a different consultant or to go to a different hospital, etc.

GUIDE TO CIRCULARS

A great deal of information about official plans and policy in the NHS can be gathered from the official circulars issued by the DHSS. In this first number of CHC NEWS, we are covering circulars that touch on the vital topics of planning and cooperation, as well as one on a new encouragement to the development of community hospitals.

COMMUNITY HOSPITALS

Their role and development in the National Health Service
Health Service Circular (Interim Series) HSC(IS)75 August 1974

This DHSS memorandum starts with a foreword from Barbara Castle and John Morris (the Secretaries of State for Social Services and for Wales). They state three reasons for the development of community hospitals along side existing or planned district general hospitals:

(a) travelling distance; many people, especially in country areas, live a long way from the district general hospital, with inconvenient journeys by public transport.

(b) identification with the local community; many of the small hospitals were originally built through local subscription. Many patients and staff prefer to be nearer their families, and voluntary help is more forthcoming for work that is within the community.

(c) the needs of specific patient groups; there are some people who cannot be cared for at home, yet they do not need the specialised services and equipment of the district general hospital.

The health authorities have to consider how many community hospitals are needed in their districts, and whether new buildings will be erected or whether existing local hospitals can be converted for this new use. But they expect many existing local hospitals will be closed to make way for new district general hospitals, so local residents should definitely receive an explanation where this occurs. Proposals

for new community hospitals should be put to the local population at an early stage, and community health councils will be closely involved in comment and discussion of the plans.

The rest of the memorandum discusses the role and function of community hospitals, the scale of provision, their size and location, and includes some detailed guidance on services, facilities, operational policies and staffing.

Role and function

Community hospitals (which are not the same as local or cottage hospitals) offer out-patient, day patient and in-patient care for people who cannot receive adequate care in their own homes, or for those who do not require the highly specialised services and investigations of the district general hospital, or for those who should not be isolated from their families and community through hospitalisation. The facilities can act as a bridge between hospital care and the work of the primary care team, and to that extent, community hospitals should have close links with the local health centres, and with the consultants from the district general hospital.

Geriatric patients, some chronically sick and disabled people, those with terminal illnesses, those requiring minor medical or surgical treatment or dental treatment could all be seen at the community hospital.

Scale of provision

In terms of the numbers of beds per 1,000 population, the memorandum recommends that community hospitals could provide:

(a) up to 10 beds per 10,000 population for geriatric and elderly demented patients

(b) up to 5 beds per 10,000 population for general medical and preconvalescent patients

(c) up to 50% of the geriatric day places

(d) all the day places for elderly demented people

Size and location

The community hospitals will have between 50 and 150 beds depending on which part of the district they will serve, although in South East Wales the isolated communities may require a number with less than 50 beds.

In rural areas they will be sited in towns which are centres for the surrounding population. In cities the site may be either close to or removed from the district general hospital site. Some existing local and cottage hospitals can be converted, where they are appropriately situated and of sufficient size to house the day-care and other facilities. Others will have to be closed, and new purpose-built community hospitals developed. The availability of staff should be considered when deciding where to locate the site of a new community hospital.

Services and facilities

The memorandum lists items that are appropriate:

1. Treatment rooms for general practitioners (as they would have in the surgery or health centre).
2. Facilities for general anaesthesia suitable for dental or minor surgical procedures.
3. Facilities for treating minor injuries.
4. Comprehensive dental care for all longstay patients, and for short stay inpatients requiring acute dental care.
5. Outpatients' or day patients' normal care by general dental practitioners.
6. Rehabilitation for geriatric inpatients discharged from the district general hospital.
7. Care for those geriatric inpatients who cannot respond to rehabilitation but who still require continuing medical or nursing care.
8. Short term care for patients normally cared for at home, in order to give temporary relief to their families.
9. Antenatal and postnatal clinics.
10. Care of physically disabled people who would be too isolated from their local environment if admitted to the district general hospital.
11. Outpatient clinics for the mentally handicapped.
12. Psychiatric day care facilities.

13. Outpatient psychiatric clinics.
14. Simple radiological investigations.
15. Visiting pharmacists.
16. Physiotherapy.
17. Occupational therapy.

Staffing

The idea is for staff already living in the locality to work at the community hospital.

Doctors and dentists: none resident, but 24 hour on-call cover will be arranged by the general practitioners and consultants concerned. The local GPs are responsible for the day-to-day care of the patients. Dentists and hospital consultants will hold clinics at the community hospital and see certain inpatients.

Nursing: the 24 hour nursing service will be provided by qualified nurses living locally who work either full-time or part-time, with support from nursing auxiliaries and assistants. The nurses will be an integral part of the nursing service in the district, and there may be some interchange between them and the nursing staff of the health centres.

Other staff: full or part-time radiographers, occupational therapists and physiotherapists will also be needed.

The community hospital would be administered as an integral part of the DMT's responsibilities.

PLANNING IN THE NHS

As CHCs are well aware, one important aim of the NHS reorganisation is to greatly improve the future planning and provision of health services. The role that CHCs will play in the planning system is crucial, and members will probably be most effective in representing the views of users of the NHS in planning discussions if they are themselves clear about the way the system works. We are therefore including in this issue of CHC NEWS a guide to the official literature on the planning system,

together with some other references that explain some of the implications of the new arrangements. Some of the official sources mentioned below are not yet published, so later issues of CHC NEWS could discuss them in more detail, if this would be helpful.

Official sources

1. MANAGEMENT ARRANGEMENTS FOR THE REORGANISED NATIONAL HEALTH SERVICE H.M.S.O. 1972 (known as the Grey Book)

   This was the first detailed account of the annual planning cycle that appeared. It states the argument for preparing comprehensive plans at district level and describes what they should contain and the degree of detail that is required. It shows how the plans that each level makes will be scrutinised by the one above it, as a means of control.

2. REVIEW OF HEALTH SERVICES AND RESOURCES: PLANNING TASKS FOR 1975/76 DHSS CIRCULAR DS 85/75 7 MARCH 1975

   The circular contains several very important items. Firstly, it lists the tasks that the authorities must carry out in respect of the coming year (i.e. 1976/77): these include

   (a) the setting up of planning groups by RHAs and AHAs
   (b) a review of existing plans and discussion of strategic proposals for 1976/77 to 1985/86 with the DHSS, by the end of August
   (c) RHAs to issue strategic planning guidelines to AHAs by mid-September
   (d) AHAs to consult with CHCs and other bodies on area proposals by the end of November
   (e) RHAs to consider these and submit regional plans to the department by the end of December.

   The circular goes on to say that the Department will soon be discussing with the authorities the possibility of altering the arrangements for making capital and revenue budget allocations. It also says that it will be announcing proposals for the introduction of a standardised scheme of hospital design.

3. NATIONAL HEALTH SERVICE PLANNING SYSTEM
HEALTH SERVICE CIRCULAR (INTERIM SERIES) HSC (IS) 126 MARCH 1975

This circular reiterates the arguments for an effective system of planning in which members and officers of the health authorities participate fully as well as CHCs. It distinguishes between strategic plans (10-12 years ahead) and annual plans (up to three years on) and explains how the DHSS' own planning system works. It announces further official publications (listed below) which will be published in the coming months.

4. GUIDE TO PLANNING IN THE NATIONAL HEALTH SERVICE
(ready late April/early May)

This provides a stage-by-stage description of the planning activities in the annual cycle, and is intended to be used by the health authorities as a working document for 1976/77 - the first year of the new scheme. It will be revised in time when the system has been elaborated further.

5. STRATEGIC PLANNING; REGIONAL PLANNING (ready late summer)

These two documents will be issued to health authorities for their further guidance, and will be amended in the light of the authorities' experience.

6. GENERAL INFORMATION LEAFLET (ready late summer 1975)

Less detailed information about the way the planning cycle operates will be issued by the DHSS to help members of CHCs and other statutory bodies (i.e. JCCs, Local Advisory Committees and Joint Staff Consultative Committees); these will explain the different roles that these bodies play in the whole system.

7. CONSULTATIVE DOCUMENT (later in 1975)

The DHSS is currently preparing a consultative document about the strategies and priorities for health and personal social services in the next 10 years.

HEALTH CARE PLANNING TEAMS

Draft Circular

It should be noted that this circular has been issued in draft form only, and that therefore its proposals are not presented in their final form, and are recommendations only.

The circular suggests that the role of Health Care Planning Teams (HCPTs) is to assist District Management Teams in carrying out their tasks of managing and co-ordinating most of the operational services of the NHS and formulating policies and plans. Each HCPT will be concerned with a group defined in terms of people with particular characteristics or problems, rather than in terms of the users of particular services. HCPTs should consider the whole range of health and related services which its health care group needs to use. They may include people with specialist knowledge from outside the health service, and their role will be advisory, not executive.

It is likely that at first Teams might be set up for one or more of the following groups; the elderly, children, the mentally ill, the mentally handicapped, expectant and nursing mothers, the young physically handicapped - whatever is most necessary locally. It is for the AHA, with advice from Area Teams of Officers and DMTs, to decide which Teams should be set up. Each DMT then decides the membership and scope of the Teams in its district. The circular recommends that only people with a continuing concern across the whole field covered by the Team should be permanent members of it; others can be co-opted temporarily. Teams can seek help from anyone else as necessary. A suggested basic membership is:

The District Community Physician (or his representative), responsible for co-ordinating all the Teams in his district;

A consultant in the main specialty or specialties concerned;

A GP with a special interest in the group;

Two nurses with appropriate expertise in primary and specialist care for the group concerned;

A social worker with appropriate experience;

An administrator - normally the one who assists the District Community Physician on information services.

Teams should select their own chairman, and members be appointed for not more than three or four years.

The task of HCPTs is to work out proposals for improving the overall provision of health care for their groups, both long and short term. The DMT must consider the plans and proposals made by the Teams and allocate resources for all district services (not just those considered by HCPTs) with the approval of the AHA.

In the long term (which in this context means 10 years or more), Teams will consider ideas for the broad pattern of services necessary and feasible for their groups. Within this framework, medium term development (3-10 years) can be planned. In the short term (up to 3 years) Teams will need to concentrate on what can be done to change and develop existing services, taking into account existing resources. They will be expected to formulate proposals for consideration in annual District and Area reviews and revision of plans and to discuss current problems in services for their groups and how to solve them, including improvements in the co-ordination and organisation of these services generally.

The function of the Team is advisory, but through their work the members may see ways in which they can improve the operation of services in the course of their everyday work. They may also be asked by DMTs to report on the effects of any changes in services.

The circular stresses the importance of good communication between the HCPT and the DMT and officers of Area and Region to ensure that HCPTs have available all information relevant to the matters they are considering.

The circular looks at the working of a HCPT for the mentally ill and mentally handicapped, and then discusses the relationship of HCPTs to Area and Regional planning and Joint Consultative Committees. The Team's channel of communication

with Area and Region is through the DMT. Proposals of JCCs will be translated into guidelines for the DMTs and HCPTs. In formulating regional plans and guidelines RHAs will take into account the expert knowledge of HCPTs, perhaps including some HCPT members in regional health care planning groups.

With regard to CHCs, the circular says that they should be involved in the formative stages of development proposals, including the preparation of district plans. They should have opportunities to learn of and contribute to the work of HCPTs. Various means of achieving this are suggested; HCPT members might attend CHC meetings, or CHC members could be asked to comment on papers prepared by Teams and could in turn ask Teams to consider their own ideas and suggestions.

The circular also makes suggestions for the working of HCPTs, and for the membership of Teams to cover different interest groups.

JOINT CONSULTATIVE COMMITTEES

Collaboration Between Health and Local Authorities: Reports of Working Party

NHS Reorganisation Circular HRC (74) 19

The main point brought out in the summary which this circular gives of the Working Party's report is that it recognises the importance of health and local authorities being free to devise their own arrangements for working together, taking into account their local circumstances. The aim is "to create an atmosphere of ready and informal co-operation at officer and member level so that the two sets of authorities can, despite their differing functions and structures, co-ordinate their services for the benefit of the people in their area."

The bodies set up to put this collaboration into practice are the Joint Consultative Committees, to provide a link between each Area Health Authority and the "associated services" (the county, district, and London borough councils whose areas match or fall within the AHA area, plus in Inner London the ILEA and City of London). The JCC's function is to advise the two sets of authorities on co-operation with one another and on planning and operation of services of common concern.

The proposed normal pattern is that in metropolitan districts there should be a single JCC for all services, and in non-metropolitan counties there should be two JCCs; one with the county council, for social services, education, and other county services; and another with all the district councils, for environmental health, housing, and other functions.

GUIDE TO SELECTED READINGS

Many CHCs are currently working on ways to assess the quality of health services in their districts, so we thought it might be helpful to include in each issue of CHC NEWS details of some sources of information that might be of assistance, as well as summarising the contents of some of the more important DHSS circulars.

*GENERAL REFERENCE BOOKS

DEPARTMENT OF HEALTH AND SOCIAL SECURITY ANNUAL REPORT 1973
Cmnd.5700. £0.79 H.M.S.O. (Report for 1974 should be ready in July 1975)

HEALTH AND PERSONAL SOCIAL SERVICE STATISTICS 1974
(DHSS) £3.00 H.M.S.O.

THE HOSPITALS AND HEALTH SERVICES YEAR BOOK 1975

The Institute of Health Service Administrators, 75 Portland Place, London W1N 4AN.
£13.20

ORGANISATIONS RELATING TO THE HEALTH AND PERSONAL SOCIAL SERVICES

King's Fund Centre, 24 Nutford Place, London W1H 6AN.
(enclosed with next issue of CHC NEWS)

*BOOKS ABOUT SURVEY RESEARCH

SURVEY METHODS IN SOCIAL INVESTIGATIONS
by C.A. Moser and G. Kalton. Heinemann Educational Books, 1971. £1.75

QUESTIONNAIRE DESIGN AND ATTITUDE MEASUREMENT
by A.N. Oppenheim. Heinemann, 1966. £0.90

* We suggest that CHCs ask their local public library to obtain the more expensive books (they may already stock them) if they do not want to buy them themselves.

CIRCULARS ABOUT STANDARDS OF PROVISION

The DHSS has over the past few years issued statements of "minimum standards" that would be acceptable in National Health Service institutions caring for the elderly, the mentally handicapped, and the mentally ill. Although CHCs may have their own views about appropriate standards, it may be useful to know the official position, and this is set out in the following circulars:

1. CARE OF THE ELDERLY IN HOSPITALS AND RESIDENTIAL HOMES
   HM (65) 77 15 September 1965

2. INTERIM MEASURES TO IMPROVE HOSPITAL SERVICES FOR THE MENTALLY HANDICAPPED
   DS 340/71 28 December 1971

3. MINIMUM STANDARDS IN HOSPITALS FOR THE MENTALLY ILL
   DS 86/72 22 March 1972

4. MINIMUM STANDARDS IN GERIATRIC HOSPITALS AND DEPARTMENTS
   DS 95/72 29 March 1972

All these circulars, and the one mentioned elsewhere in CHC NEWS can be obtained from your Regional Health Authority, or direct from:

CENTRAL STORES,
DHSS DEPOT,
PRIMOSE MILL,
CLITHEROE,
LANCASHIRE BB7 1BP.
(Telephone 0200 22187)

5. In addition, the DHSS and the Welsh Office published a White Paper:
   BETTER SERVICES FOR THE MENTALLY HANDICAPPED
   H.M.S.O. 1971 Cmnd. 4683

6. The DHSS also issues guidance from time to time about the recommended provision of hospital beds for certain specialties. These are being revised at present, but the current overall figure for planning purposes is 2.0 to 2.8 beds per one thousand population. This allows for variations in local circumstances.

THE MERRISON REPORT

On 16th April the Merrison report was published, and as it proposes alterations in the requirements for allowing doctors to practise, and in the rules under which they can be disbarred from practising, CHCs may be interested to see this summary of its contents.

In November 1972, Sir Keith Joseph set up a committee to consider what changes need to be made in the existing provision for the regulation of the medical profession, what functions the regulating body should have and how it should be constituted. The committee was chaired by Dr.A.W.Merrison, Vice-Chancellor of Bristol University, and its report was published under the title:

Report of the Committee of Enquiry into the
Regulation of the Medical Profession .
(Cmnd. 6018 HMSO £1.75)

The report contains a number of proposals to change the structure and functions of the General Medical Council (GMC) which is the existing regulating body, so the present arrangements should briefly be mentioned.

The GMC is a statutory body (established in 1858) whose duty is to protect the public through the supervision of medical education, by keeping and publishing annually a register of duly qualified doctors, by taking disciplinary action in cases of criminal conviction or serious professional misconduct, and by publishing the British Pharmacopaeia (which contains standards for medicines and articles used in medical and surgical practice). The GMC receives no grant from public funds but derives its income from the fees paid by doctors when obtaining registration. It is not an association or union for protecting professional interests. It has 47 members, 8 (including 3 laymen) are appointed by the Queen on the advice of the Privy Council, 11 members are elected by postal votes of the profession in England, Wales, Scotland, Northern Ireland and Eire, and the remaining 28 represent each of the universitites that grant medical degrees and the various Royal Colleges.

WHAT THE REPORT SAYS

The Merrison report suggests that the largely negative role of the GMC should be replaced by a more positive one, in which it should determine educational and assessment standards up to and including registration, and, in the area of professional ethics, should seek to lead the way on such controversial issues as transplantation, as well as dealing with misconduct by doctors in a more humane and sensible way.

It appears that over the years, the GMC has tended to become influenced by the NHS in its determination of professional standards, whereas the committee strongly believe that the GMC should be wholly separate from the NHS authorities. They suggest that membership of the Council should be independent and predominantly from the profession itself. Specifically they propose that the members elected by the medical profession should outnumber the rest by 10; the rest should be drawn from the medical educational bodies (as before) and 10 laymen should be put up by the Privy Council.

The report further proposes a new system of registration for doctors that would have three stages:

(a) "restricted registration" on graduation

(b) "general registration" after two years' graduate clinical training

(c) "specialist registration" - the GMC will institute a new specialist register, which will include general practice as a specialty.

On professional misconduct the report says that the GMC should determine a doctor's fitness to practise on the basis of his conduct and condition as contained in the existing medical legislation, and they do not favour a code of conduct as such. The committee was critical of the methods for investigating complaints and suggest a new Complaints Committee should be set up; one of its duties would be to prepare fuller guidance on the nature of professional misconduct.

In order to perform all these newly defined duties, the GMC would need a larger

income and organisation, yet the report says it should continue to be financed mainly through its income from registration and retention fees paid by doctors.

The report, if implemented by the government, could bring about a major reform of the medical profession, which would, of course, have consequences for the care of patients. Although we have only been able to summarise the report's main recommendations, we hope you will write in to CHC NEWS with your views about the regulation of the medical profession, and the successes and failures of the Merrison report.

STEERING COMMITTEE

PROPOSED NATIONAL COUNCIL FOR CHCs

A Note by Mr. P.J. Torrie, Secretary

The Steering Committee is now established with the following terms of reference: "To submit proposals to the Secretary of State for the constitution of a National Council for Community Health Councils, its functions and establishment".

The membership of the Steering Committee is as follows:

Lady M Marre (Chairman)
Cllr K Collis (Vice-Chairman)
Mr G S Bessey (Northern)
Mr J L Rosen (Yorkshire)
Mr E H Grosvenor (Trent)
Mr G D Farrow (East Anglia)
Cllr H Beck (NW Thames)
Ald. Mrs J Engwell (NE Thames)
Mrs A S Gann (SE Thames)
Mr D N Hoult (SW Thames)
Mr J J Thring (Wessex)
Mrs K B W Wickham (Oxford)
Dr E W Woodward (South Western)
Cllr Mrs D Robinson (West Midlands)
Cllr Mrs G I Bourne (Mersey)
Canon W H Bullough (Northern)
Cllr W Evans (Wales)
Mr E Roberts (CHC Secretary)
Mrs R J Gunter (CHC Secretary)
Miss B P Urquhart (CHC Secretary)
Mr C H Wilson (DHSS)

The inaugural meeting was held on April 29th. Lady Marre welcomed the members and said that it was hoped that at this meeting it would be possible to form ideas about the broad lines along which the committee might wish to proceed. The greater part of the meeting was spent in an initial and wide-ranging discussion of a paper submitted by the Secretariat which set out both a variety of possible functions for a National Council and different ways in which such a council might be formed.

The next meetings of the Steering Committee will be on June 25th 1975 and September 23rd 1975.

PUBLICITY

by Bernadette Fallon

"You can influence tomorrow's Health Service"
"The CHC needs you"
"The Health Service is yours"

These are just a few of the slogans used by CHCs to publicise themselves and their activities. It was widely recognised in the early days of CHCs that publicity was of the greatest importance if CHCs were to be effective. Perhaps the time is now right to take a look at the first year of publicity, and to try to assess how well it has worked.

The problem that has been with CHCs from the start is - how to get publicity ? Generally speaking, most CHCs appear to have followed much the same pattern. The starting point has been a poster, usually accompanied by a leaflet. Posters vary in size from a single A4 sheet upwards, and in composition and content from a page full of writing to brightly-coloured cartoons and drawings. They are displayed in hospitals, doctors' waiting rooms, health centres, shops and offices, and leaflets containing more detailed information and a list of members' names and addresses are usually provided for interested people to take. Some CHCs have invited the art departments of local colleges to design posters for them. In most cases, too, Regions have issued general posters, with a space for each CHC's name and address.

When CHCs began, the hope was often expressed that the local press would take an interest in them, would attend meetings, and would give them good (and free !) coverage in local papers. In the event press coverage has turned out to be, at best, patchy, and at worst, actually harmful. Reporters have a nasty tendency to pick out the one delicate and controversial issue discussed during a meeting and headline it as a shock report or a scandal, and in some cases this has led the CHC concerned

into an uneasy relationship with Area or Region. The difficulty has been in many cases that the first few meetings of the CHC were essentially introductory and exploratory - a chance for the members to get to know one another. This was in no way newsworthy, and the local reporters who turned up faithfully to the early meetings soon found that there was nothing to report, and stopped going. It is now the task of the CHC to woo them back, by demonstrating that matter of importance are now being discussed at meetings in a lively and informed way. National press reports of CHC activities have so far been very limited indeed.

Many CHCs have been able to have their names and addresses, and sometimes other details, included in locally available sources of information such as local handbooks issued to council tenants, local guidebooks, and information spots on local radio and TV.

This is all routine publicity. Whether or not it is having any impact is very hard to assess, yet it can be a fruitful exercise for aCHC to set out to find out if its routine publicity is getting through to people. This might be done in the form of a small informal survey, simply asking a number of people - say in a shopping centre or busy street - whether they have heard of CHCs, and if so, what they think the CHC does. A recent small survey conducted in a large city found that 19 of the 94 people questioned had heard of CHCs; of these, only 7 had even a rough idea of what they did (other ideas ranged from "Keep city clean, sweep streets" to "Set up family planning clinics" !). If very few people are shown to know anything about CHCs, obviously existing publicity is not having the desired effect, and steps must be taken to consider how to improve or extend it. There is little point in confining publicity activity to putting up posters if it has been shown that no one reads them. Such a survey can be in itself a publicity exercise; when people admit to having no knowledge of CHCs they can be given a brief explanation of what they do.

Some efforts at publicity have been proved, by the response they have evoked, to be successful. These have in general been "one-off" events, brought about by the timely seizing of an opportunity. Recently a CHC chairman went on local radio to talk about the work of his CHC, at the apparently unpromising hour of 9 o'clock

on a Sunday morning. The number of 'phone calls received during the broadcast was so great that the programme was turned into a "phone-in", with the chairman answering people's queries over the air. Since then that CHC has received about a dozen more calls about the programme. Again on radio, a recent Radio 4 "phone-in" was on the subject of the health service. A CHC member telephoned to talk about her CHC, with the result that about ten people contacted the CHC in the next couple of days.

However successful individual publicity exercises may be, though, the fundamental problem remains the same. Until they become ill, people are not interested in the Health Service. It is part of the CHC's function to show people that by taking an active interest in the ongoing and future state of the NHS they are ensuring that; should they ever need to use it, it will be as they would wish to find it.

PARLIAMENTARY QUESTIONS

Since Parliamentary questions often contain extremely important statements of policy or details of administration that are difficult to find elsewhere, we thought it might be of interest to include some in CHC NEWS. Please let us know if there are specific topics you would like to redd about in further issues.

MATERNITY UNITS

Tuesday 25 March

PQ 1924/1974/75
Han Ref Vol 889
Col 232-4

*3 Mrs Joyce Butler (La. Haringey, Wood Green)

To ask the Secretary of State for Social Services, how many hospital maternity units are now inducing labour in confinements as an administrative convenience; what guidance is given to mothers in regard to the effects of this procedure on themselves or on their babies; and what provision is made in such units to decline induction if there is no medical need for it.

DR DAVID OWEN

Induced births as a percentage of all hospital deliveries in England and Wales have risen from 13.7 per cent in 1963 to 31.5 per cent in 1972. The reasons for this increase are being investigated. I would expect the use of this procedure to be fully discussed and agreed with the woman herself, who would have the same right to refuse induction as she has to refuse any other form of treatment offered to her.

Mrs. Butler: I thank my hon. Friend for his reply. Will he consider issuing guidelines to hospitals on the advice and help they should give to mothers who are experiencing the procedure, in view of the great disquiet which is felt among women about this whole process ? Will he also consider - I understand that he has a survey in hand - advising hospitals to go slow on the special induction procedure while the survey is being undertaken and until its results are known ?

Dr. Owen : We are hoping to have the initial results from the survey in the middle of the summer. When I receive those results I shall give thought to the question of issuing guidelines and taking the advice of the professional and other advisory committees that are available to us.

Sir B. Rhys Williams : As this is a widespread practice even when the condition of mother and baby does not seem to require it, should we not study the side effects even more carefully? Is it not possible that there may be some danger where the skills and facilities available are not necessarily of the very best?

Dr. Owen : The most important thing to do is to determine the facts, I share the concern of many hon. Members about a superficial trend, but there are many facts and many reasons behind this matter and we need to establish these before we make any definite policy changes.

Mrs. Knight : Does the Minister realise that many people are worried by the rise in the figures he has given us - namely, from 13 per cent, in 1963 to 31.5 per cent, now? Is it not the case that in some hospitals the figure is high as 50 per cent? Does the Minister recognise that most women believe that the delivering of babies is not a nine-till-five, Monday-to-Friday business? Does he appreciate that pregnant women are worried that their well-being and the well-being of their children is being placed second to social convenience? Are there any statistics to disprove the view that is still held by many doctors that to interfere with the natural process of childbirth can be justified only where medical reasons make induction necessary?

Dr. Owen : That only reinforces the need for facts. Women rightly regard childbirth as a natural process. They regard it as a process not without discomfort but essentially a normal process. Before we intervene we have to judge carefully the grounds for intervention. There is an old physician's prayer which says "From inability to leave well alone, good Lord deliver us".

Mrs. Colquhoun: In view of the very unsatisfactory nature of his reply, does my hon. Friend accept that we must have an urgent inquiry into a situation in which women are being asked to have their babies only during office hours.? We do not know what detrimental effect this will have on the women or on the babies. Does my hon. Friend appreciate that serious concern is felt by many people on this issue ? Will he give an assurance that the House will have an opportunity to debate the matter ?

Dr. Owen: I do not know why my hon. Friend is dissatisfied. I have told her that I share the concern that is felt. In fact, I shared that concern even before the programme which aroused a great deal of public controversy appeared on our television screens. We have instigated inquiries and surveys to establish the facts. As my hon. Friend has said, we do not fully know all the facts. We want to examine the situation so that we do not reach conclusions on unsubstantiated foundations. There is justifiable concern about the possibility of induction taking place for administrative convenience. The facts are not yet fully established and it will take time to do this. I share my hon. Friend's concern.

FLUORIDE

Friday 21 March 1975 — PQ 2063/1974/5
Written Answer — Han Ref Vol 889
Wednesday 26 March 1975 — Col 196-7

15 Mr. Kenneth Lomas (La. Huddersfield West)

To ask the Secretary of State for Social Services, if she will make a statement of guidance for those responsible on the advantages, or otherwise, of fluoride being added to water.

DR. DAVID OWEN

Fluoridation is a fully established public health measure for protection against dental decay and the Health Departments have published detailed evidence of its safety and effectiveness in the reports of the Fluoridation Studies in the United Kingdom and the Results Achieved after Five and Eleven years respectively (Reports on Public Health and Medical Subjects Nos. 105 and 122).

FLUORIDATION

Monday 24 March 1975
Written Answer

PQ 2049/1974/75
Han Ref Vol 888
Col 15-16

W 84 Mr. Toby Jessel (C. Twickenham)

To ask the Secretary of State for Social Services, which authorities now have the power to decide whether to put fluoride into the water supply; and with what constraints.

DR. DAVID OWEN

Under the National Health Service Reorganisation Act 1973 each health authority is fully responsible for deciding in respect of its own area whether it wishes fluoridation to be introduced and, if so, for approaching the appropriate regional water authority. My right hon. Friend the Secretary of State for the Environment would expect a regional water authority to give effect as soon as it reasonably could to a health authority's request for fluoridation, provided this was acceptable to any other health authority whose area would receive supplies of the flouridated water.

WATER FLUORIDATION

Tuesday 25 March 1975

PQ 1933/1974/5
Han Ref Vol 889
Col 241-2

* 9 Mr. Toby Jessel (C. Twickenham)

To ask the Secretary of State for Social Services, if she will take steps to promote the dental health of children, following the report by Professor Douglas Jackson on the results of water fluoridation in Anglesey.

DR. DAVID OWEN

This report provides further evidence of the efficacy of fluoridation of water supplies in protecting children against dental decay. I am sure that health authorities will bear it in mind when exercising their responsibility for deciding whether to introduce fluoridation in their areas.

Mr. Jessel : As the Anglesey result shows a reduction in decay of over 80 per cent.-plus in front teeth and 40 per cent. for other teeth, will the Minister go further than to say that the result shows efficacy and add that he regards it as proved that fluoridation of about one part per million reduces dental decay dramatically? Will he draw the results to the attention of all health authorities and ask them what action they intend to take?

Dr. Owen : I confirm that my feelings accord with those of the hon. Gentleman as to the efficacy of fluoridation. The Government have announced that they will produce later this year a consultative paper on preventive measures, including preventive dentistry. It is likely that the paper will deal with effects of fluoridation. The information will be made available to health authorities and this House and we can then discuss the issues.

Mr. Bryan Davies: Does my hon.Friend agree that fluoride can occur naturally in water almost to the level suggested as a health preservative measure for teeth ?

Dr. Owen: This is the case. This is why research on the safety of fluoridation is probably the most extensive to have been conducted into any public health measure and why health authorities should seriously consider exercising their responsibilities in this matter.

Sir John Hall: Does the Minister agree that ingestion of fluoride for the purposes of preventing dental decay is effective only for young children up to the age of about seven years and not for adults ? Is there not a less wasteful method of helping to prevent dental decay than to introduce fluoride into the public water supply which everybody has to drink whether they need fluoride or not ?

Dr. Owen: Experts in numerous countries who have been considering this matter have concentrated on the school population and the under-five population. However, the advice that one consistently gets is that the most effective way of introducing this preventive health measure is by the fluoridation of all water supplies.

NURSING AND AUXILIARY SERVICES

Tuesday 25 March 1975

PQ 2010/1974/5
Han Ref Vol 889
Col 80-1

*44 Mr. William Molloy (La. Ealing North)

To ask the Secretary of State for Social Services, if she is satisfied with recruitment for the nursing and auxiliary services for the NHS.

MR T ALEC JONES

Despite a continuing increase in recent years in the number of nursing staff employed in the National Health Service, the level of staffing is still not satisfactory in all fields. In the professions supplementary to medicine (chiropodists, dietitians, orthoptists, radiographers and the remedial professions) and in speech therapy, staff shortages persist, although the latest figures show modest increases overall in the numbers employed. It will be some time yet before an assessment can be made of the effect upon recruitment of the substantially improved rates of pay which have been negotiated following the Reports of the Committee of Inquiry chaired by Lord Halsbury into the pay of all these professions.

WEEKLY COST OF CARE

Tuesday 25 March 1975

PQ 1931/1974/75
Han Ref Vol 889
Col 239-40

* 7 Mr. Lewis Carter-Jones (La. Eccles)

To ask the Secretary of State for Social Services what is the weekly cost of care, both running and capital, in acute hospitals, chronic hospitals, Part III accomodation, and within the person's own home respectively.

DR. DAVID OWEN

In 1973-74 average costs per week were :

£ 110 in acute hospitals
£ 87 in long stay hospitals, and
£ 22 in Part III accomodation

Costs of care in the home are not available.

I will, with permission, circulate further information in the OFFICIAL REPORT.

Mr. Carter-Jones: I thank my hon. Friend for that reply. Will he take it from me that evidence exists that caring for the chronically sick at home is much cheaper and is what the patient requires ? Will he immediately shift some of the scarce resources away from hospital to local authorities in joint consultation with all concerned ? Will he accept that this would result in a substantial number of people who are chronically sick being able to spend the rest of their lives comfortably with their loved ones at home ?

Dr. Owen: The Government's policy is to enable the elderly, the mentally ill and the mentally handicapped to be cared for as far as possible in the community rather than in hospital and to improve the standard of hospital provision for those who must stay there. It is difficult to achieve this at a time of financial restraint. I agree that a great deal depends on joint planning between local authorities, particularly the social service department and housing department, and area health authorities.

Mr. Boscawen: In this time of financial restraint, would it not make much more sense to put greater emphasis on some of the domiciliary care allowances such as invalid care allowance, which has recently been introduced ? Should not this be spread much more widely and be made available to more people to keep them out of hospital ?

Dr. Owen: I agree that it would make more sense. We shall bear in mind any positive suggestions that are made. We are constantly looking at ways of improving domiciliary services and of keeping patients in their homes. This is an important matter on which hon. Members on all sides of the House are in agreement.

Following is the information:
For acute hospitals the costs per patient week are running costs excluding capital, as the capital costs of hospitals, many of which were constructed before the start of the National Health Service, are not identifiable for costing purposes. The classification "chronic" is not used for hospitals but a figure for long-stay hospitals is provided.

In 1973-74 costs in Part III accommodation per week per resident were £19 for running expenses and £3 for servicing capital loans, before deduction of the income from charges.

Care in the community is provided mainly by the Family Practitioner Services, the Community Health Services and Personal Social Services, but the cost of these services, insofar as they are provided in the home, cannot be expressed in terms of a weekly cost.

MENTAL HOSPTIALS

Monday 24 March 1975
Written Answer

PQ 2037/1974/75
Han Ref. Vol 888
Col 13

W79 Mrs. Lynda Chaler (C. Wallasey)

To ask the Secretary of State for Social Services, what expenditure would be necessary to overcome the lack of basic resources, considered a necessary minimum, in mental hospitals in Great Britain.

DR. DAVID OWEN

It is not possible to make reliable estimates centrally of the cost of achieving all the minimum standards set for hospitals for the mentally ill and the mentally handicapped. However the cost of employing the additional medical, nursing and domestic staff, chiropodists and dentists still required at the end of 1973 to achieve the relevant standard in hospitals for the mentally ill in England is estimated to be between £1½ and £2 million per annum at current earnings levels.

SPECTACLES

Thursday 20 March 1975
Written Answer

PQ 1992/1974/5
Han Ref Vol 888
Col 510

W 59 Mr. Toby Jessel (C. Twickenham)

To ask the Secretary of State for Social Services, if she will take steps to deal with the shortage of optical glass and reduce the waiting period for spectacles; and if she will make a statement.

MR. T. ALEC JONES

There is no shortage of optical glass. Long waiting periods for some spectacles have resulted from the combination of a significant increase in demand, labour disputes in the lens manufacturing industry last autumn and manufacturing difficulties encountered by one of the principal United Kingdom suppliers.

Adequate supplies of single vision lenses are now available from the manufacturers but normal supply of solid bifocal lenses may not be resumed before the end of this year and until then I regret that waiting periods for some prescriptions are inevitable. We are keeping in close touch with the manufacturers.

PRESCRIPTION CHARGES - EXEMPTION

Wednesday 26 March 1975
Written Answer
Thursday 27 March 1975

PQ 2101/1974/1975
Han Ref: Vol 889
Col 265

143 Mr. Richard Luce (C. Shoreham)

To ask the Secretary of State for Social Services, if she will exempt from prescription charges those suffering from chronic bronchial asthma.

DR. DAVID OWEN

Extending exemption to people on the grounds of chronic illnesses poses practical problems but we have their needs in mind in considering further steps in the progressive abolition of prescription charges as soon as the resources available to the health service permit.

PRESCRIPTION CHARGES

Tuesday 25 March 1975

PQ 2018/1974/75
Han Ref Vol 889
Col 82

* 51 Mrs. Lynda Chalker (C. Wallasey)

To ask the Secretary of State for Social Services, when she proposes to reduce and abolish prescription charges.

MRS. BARBARA CASTLE

We began on 8 April 1974 by extending prescription charge exemption to children aged between 15 and 16 and women aged 60 to 65; we continue by refraining from increasing the charge despite increases in wages and prices; we shall make further progress when economic circumstances and the resources available for the health services permit.

VASECTOMY CLINICS

Tuesday 25 March 1975

PQ 1934/1974/5
Han Ref Vol 889
Col 242-3

* 10 Mr. Philip Whitehead (La. Derby North)

To ask the Secretary of State for Social Services, if she has now completed her review of how many area health authorities have established vasectomy clinics for the provision of vasectomies under the NHS; and how many have not.

DR. DAVID OWEN

Not yet, Sir, but a preliminary assessment indicates that 38 area health authorities have vasectomy clinics. Those without have facilities for vasectomy in general surgery and other units in hospitals.

Mr. Whitehead : Will my hon. Friend undertake that this review will be carried out as quickly as possible, because the figures he has given suggest that some area health authorities are not yet honouring either the letter or the spirit of the 1972 legislation?

Dr. Owen : I shall let my hon. Friend know as soon as I can. These figures are only provisional, being based on oral inquiries. We have still to receive many of the returns for which we asked. As soon as they are available I shall let my hon. Friend have the breakdown.

Mr. Fell : What facilities are available for advising a patient who wishes to have a vasectomy about the serious nature of the operation and the alternative to having it?

Dr. Owen: Vasectomy would not be undertaken by other than a qualified medical practitioner. It would be up to him to make clear to the patient all the different factors behind making a decision.

CHCs - SECRETARIES

Tuesday 18 March 1975

PQ 2026/1974/5
Han Ref Vol 889
Col 192

14 Mr. William Molloy (La. Ealing North)

To ask the Secretary of State for Social Services, what consideration was given to providing for a proportion of secreatries to be elected from community health councils to serve on the National Steering Committee; on what criteria two secretaries have now been appointed rather than elected; by whom these appointments are made and with what methods of consultation; and if she will make a statement.

MRS. BARBARA CASTLE

I considered it appropriate for the Steering Committee which will operate for only a few months prior to the formation of a National Council to be composed primarily of members of CHCs, and I have invited the CHCs in each of the fourteen health regions in England to nominate one member. I also considered that CHC secretaries have a useful contribution to make and that it would be appropriate for the Steering Committee to include two Secretaries of English CHCs. It would not have been practicable to ask over 200 CHCs to elect two Secretaries and I intend to make two appointments after considering names suggested to me by the three training centres which have organised training for CHC Secretaries and all other sources of advice which are open to me.

THREATENED HOSPITAL CLOSURE

A Report from Bexley Community Health Council

BACKGROUND

Hainault Hospital has been used for a number of years mainly as a G.P. maternity unit, and has now been closed as such. (It is being used temporarily to house a school for handicapped children while their own school is under substantial repair). Erith Council (the local authority) is concerned about the future use of the site : is it surplus to their requirement so can it be sold, either for private development or for use by the local authority, or are the medical needs of the community such that the site should be retained, and to what use should it then be put?

THE CHC ACTS

The CHC responded to this situation by issuing a questionnaire to general practitioners and consultants and other interested persons within the area. This questionnaire was designed to ascertain the needs of the community as disclosed by the very real practical experience of these professionals, and sought opinions on the relative merits of :

1. A post-operative and short-term care unit
2. A psychiatric day hospital
3. A psychogeriatric unit

There was also an invitation for comments to be made on other possible alternative uses.

The response was large and 55 written replies were received. In order of priority, the first choices were :

psychogeriatric unit	33
psychiatric day hospital	9
post-operative & short-term	8
others	2
don't know	3

An analysis of the second choice which was designated shows a preponderance for the Psychiatric Day Hospital.

Many of those consulted accepted the invitation to comment of which the following are an example :

A Consultant Psychiatrist : "The psychiatric services in the area are extremely poor compared to the national average. The opening of the new Queen Mary's Hospital even after its completion will not improve the services for the northern part of the area, especially for day care, as Queen Mary's is on the border of the area".

Consultant Geriatrician : "I fully endorse the policy of the C. H. C. a Psycho-Geriatric Day Hospital is not expensive or difficult to organise apart from transport".

General Practitioners : "Psycho-Geriatric problems with no unit available as at present, disrupt the community more than any other. If the short term care unit was opened - geriatric cases would need to go in".

"Why not just for geriatrics - this is the greatest need in the area for G.P.'s".

"Anything which will improve the totally inadequate geriatric services will be welcome".

"Short stay Geriatric Unit to enable the family looking after the aged relative to have a holiday or in the case of illness in the relatives looking after them".

Psychiatric Social Worker: "The need for a Psychiatric Day Hospital in this area is an urgent priority. The lack of this resource in modern treatment of mental illness cripples the service offered. Many patients could avoid in-patient treatment and separations from their families if a Psychiatric Day Hospital was available.

General Practitioner: "Permanent long term Psycho-Geriatric Unit very essential in area".

There were also suggestions that the Unit could be run as a department of Erith District Hospital and a compromise solution was suggested that there should be a short stay unit for about twelve residents combined with day care patients.

One general practitioner supported the Psycho-Geriatric Unit and the Psychiatric Day Hospital before the other alternatives but suggested one of his own "Routine annual psychiatric assessment of AHA, RHA and other committees and members of Parliament": A preventative medicine project which perhaps we cannot yet afford !

GAPS IN LOCAL SERVICES

The CHC considered memorandum HM (72) 71 issued by the Department of Health and Social Security "Services for mental illness related to Old Age". It noted that the recommended standards are by no way achieved in the Bexley District, particularly with regard to psychiatric day hospitals and psychogeriatric units for long or short term care close to the community. The closeness of Hainault Hospital to an old persons home may well encourage extension of occupational therapy and social activities which are recommended to stimulate interest and enjoyment in the patients. Because of the size of the building, the unit would of necessity be a small one, but this need be no difficulty, and could even be an advantage. The CHC also noted that although there is some slight provision of a holiday service in the area, (whereby the elderly are taken into care while those who care for them have a holiday) there is still an overwhelming need to increase this facility. The use of Hainault Hospital would be a way of extending the holiday service and would thus be of much benefit to the community.

RECOMMENDATIONS TO KEEP THE HOSPITAL

The CHC also looked into the availability of support services and had discussions with a health district engineer, so that their case for changing Hainault Hospital into a psychogeriatric unit was based on well-researched propositions. They concluded that there was a great shortage of beds for psychogeriatric patients, and with an increasingly ageing population even more are going to be needed. In the district, most of these beds are provided at the general hospital, and increasing the allocation in mental hospitals is not thought desirable. No matter how much adaptation Hainault Hospital would need, and despite its size, any increase in the number of beds would be a valuable asset. The main psychogeriatric unit could still be at Bexley Hospital while some of the patients who require mainly nursing care and no elaborate investigateive facilities could be at Hainault Hospital, under the care of attending GPs. The advantage of decentralising units includes the possibility of having patients nearer their homes and relatives, and higher hopes of recruiting nurses locally. The survey has also shown that there is a need for a psychiatric day hospital, and this can be set up in any building relatively easily. Whatever the outcome, there is an overwhelming medical opinion in the district that Hainault Hospital should be claimed for psychiatry or mentally handicapped patients, and the staffing planned later.

BOOK REVIEWS

NHS REORGANISATION: ISSUES AND PROSPECTS

The Nuffield Centre for Health Service Studies, University of Leeds, 1974, £1.50.

In the first months of 1974, some of the staff of the Nuffield Centre for Health Service Studies gave a series of public lectures on the reorganisation of the National Health Service. They have published these talks in a book that is amongst the more exciting things to have appeared on the subject recently. The essays discuss some of the concepts and ideas that are present in the health service today, such as, the demand for health care, team management, the authority structure of the NHS, and the meaning of "community".

In the essay on community health councils, Malcolm Johnson suggests that the National Health Service can be seen as an elaborate "social gift", this idea being expressed, for example, in Aneurin Bevan's vision: "From each according to his means, to each according to his needs". CHCs are in a position to see that the giving and receiving operates in an acceptable and sensitive way.

Jack Hallas describes the new structure in some detail - he shows how the DHSS, Regional and Area Health Authorities can be seen as "instruments" for allocating and reallocating resources, while the district management teams and health care planning teams are all about what actually happens to the health care client. He suggests that these two aspects interlock at AHA level, where "observers will look for early signs of the effectiveness in the reorganised structure".

Keith Barnard explores ways in which staff from different parts of the NHS may react to the reorganisation. He points out that participative management (much emphasised by the DHSS) was used as a way for some of the former regional hospital boards and hospital management committees to overcome resistance to change rather than to give staff the opportunity to take part in the decision-making process. Many staff may, for good reason, be resistant to accepting the changes brought about by

reorganisation, and Barnard says that unless managers become skilled in handling these problems, and in assisting their subordinates to adapt to the new arrangements in a thoughtful and supportive way, the working of the health care system will be in serious danger.

Robin Gourlay looks in detail at the significance of the name "team" being used to describe decision-making units (e.g. district management TEAM, area TEAM of officers, health care planning TEAMS) instead of the more familiar word "committee". He shows that there are quite specific attributes which team members, as a group, need to possess and develop in order to function effectively and successfully. They need to communicate properly with each other and be sensitive to the mechanisms which may distort this, and they need to participate individually to provide appropriate internal control for the group. They also need to keep looking at the way they are working and keep their goals clearly in view. In addition, they should be able to manipulate any conflict that will (inevitably) arise so that it can be used as a positive force. They need to be aware of each other's loyalties and obligations to other groups, and finally, should develop the ability to make decisions through consensus. This last point is discussed fully in the context of the preceding ones, and thus becomes a much more comprehensible notion. Understandably, 'consensus management' has seemed to many people to be a rather mythical or fanciful idea, but Gourlay is able to demonstrate what it can mean in practical terms. Indeed, although he does not mention it, a number of these points may be helpful in developing the style of CHCs' own working groups.

Kenneth Lee looks at the economics of the reorganisation and shows the type of judgements and decisions that are involved in trying to "make the best use of limited resources" in the NHS, and illustrates how difficult it is to actually measure the way progress is going in any objective way. The remaining two essays in the book deal with planning and the demand for health care respectively, and are equally helpful in explaining and adding detail to otherwise ambiguous topics. Perhaps a serious difficulty at the moment is this matter of being able to understand apparently important phrases and concepts, because their instigators have defined them inadequately. It is a relief, therefore, to know that these essays go a long way to filling the gaps.

HEALTH SERVICE PROSPECTS

eds. I.Douglas-Wilson and Gordon McLachlan, The Lancet / Nuffield Provincial Hospitals Trust, 1973, £6.00

This book was published to mark the 150th birthday of the medical journal The Lancet, and it consists of essays by different authors about the health care systems of different countries in Europe, America and the Third World. Of particular interest is the one by Gordon Forsyth, on the United Kingdom. He divides his material under sub-headings which are a good indication of the scope of his essay: government, population and vital statistics, resources and manpower, income, expenditure and social security, finance, effectiveness and organisation, problems of hospital control, developments in general practice, research and development, coordination and reorganisation. This covers the major points necessary to get a good picture of what the NHS actually is, and the environment in which it has to operate.

Forsyth's view of the reorganisation is that the hopes or fears entertained of the new structure are extravagant, since the same people are providing and managing the services as before, and the existing deficiencies are probably less susceptible of improvement through mere administrative change than through adjustments in deep-rooted professional attitudes. He thinks that future developments in the administrative relationships between the various sectors of health care will be severely conditioned, as they were in the past, by attitudes to the role of the hospital, the function and status of general practice in an era of expanding medical technology, the scope of doctors' responsibilities in the face of a nationally organised, publicly accountable health service, and, underlying all these, the profession's approach to its own objectives and values, and its willingness to question these. He is concerned about whether the new machinery for collaboration between the health and local authorities will be suitable for the task, but he concludes that the quality of the NHS will continue to depend on the morale of those providing the services and their understanding of the social forces which act upon them and their work.

FORTHCOMING EVENTS

"ON THE NATIONAL HEALTH"

This series of television programmes about aspects of the National Health Service and some of its problems is going to be shown again this summer. The first programme will be on:

SUNDAY 8th JUNE at 11.30 a.m. on BBC 1

and the following nine programmes will be shown at the same time on every subsequent Sunday until 10th August.

The BBC have produced some notes which accompany the programmes, and these can be obtained (free) from:

EDUCATIONAL BROADCASTING INFORMATION (30/BC),
BBC,
LONDON W1A 1AA.

The BBC will also be able to sell colour video tape cassettes and black and white films of the programmes to anyone who is interested. The details are:

(a) PHILIPS ½ INCH COLOUR VIDEOTAPE CASSETTE
(b) SONY ¾ INCH COLOUR VIDEOTAPE CASSETTE
(c) 16 mm BLACK AND WHITE FILM

PRICE: £105 per programme
£950 for all ten programmes
(prices do not include VAT)

There is a 3-4 week delivery time, and you should write to:

Mr. RON CRAFTS,
TELEVISION ENTERPRISES,
VILLIERS HOUSE,
THE BROADWAY,
LONDON W5 2PA.

(Telephone 01-743 8000 ext. 394)

If you want to get copies of the programmes more cheaply, the BBC advise you to borrow or hire a VIDEO CASSETTE RECORDER, (e.g. from a university or college) and tape the programmes each Sunday on to your own videotape cassettes. (The BBC's own videotape is not available, because it is 2 inch size whereas most machines available are usually 1 or 1½ inch).

SEMINARS AND COURSES

COURSES FOR CHC SECRETARIES

For the moment, the last training courses for CHC Secretaries are those at the Manchester Business School:

Sunday 4th May for 1 week
Sunday 15th May for 1 week

SEMINARS FOR CHC MEMBERS

Each Regional Health Authority was obliged to provide opportunities for new members of CHCs to attend seminars or courses which would introduce them to the workings of the reorganised NHS.

If members would now be interested in organising further seminars on specific aspects of their work, they may find it helpful to contact the Regional Training Officer.

The Nuffield Centre for Health Service Studies in Leeds expects to be organising some one-day meetings on such topics as community hospitals, the health care planning concept, and the problems of confidentiality. There are other centres in London, Manchester, Birmingham, Bath and Leicester who may well be able to arrange these with you,