CHC NEWS

4

NOV 1975

NUMBER 4 CHC NEWS NOV 1975

CONTENTS

CHC NEWS IS EDITED BY RUTH LEVITT AND PUBLISHED BY THE KING'S FUND CENTRE, 24 NUTFORD PLACE, LONDON W1H 6AN. TELEPHONE 01-262 2641.

EDITORIAL

Although problems in certain parts of the NHS are making newspaper headlines, CHCs are of course concerned with a much wider range of issues, and on a continuing basis. This issue of CHC NEWS contains two items which draw attention to the difficult task that CHCs face in arguing for local improvements in services at a time when the national economic climate imposes very considerable constraints on real growth. The key factor for CHCs and health authorities alike becomes one of establishing priorities.

As Dr David Owen said in his speech (p. 5) CHCs give the NHS a public lobby and a public voice. But as the Resource Allocation Working Party says (p.14) Ministers must resist local pressure that could undermine DHSS policy for redistributing the means to provide health care more equally across the country. What path can CHCs therefore reasonably take ?

It appears that their proposals will stand the best chance if they are aware of the assumptions on which health authorities make decisions between competing demands. Equally, CHCs themselves need to offer well thought-out and documented evidence for urging the health authorities to select particular courses of action. Decisions on hospital closures are very relevant here, since CHCs have to judge their acceptability in terms of their effects on the future quality of local services, whilst the DHSS is more concerned with getting the overall balance of services right.

Another important recent issue in this is the White Paper: "Better Services for the Mentally Ill." Although it supports the need for great improvements in community care, it does not pretend that resources are likely to be adequately available for this, for some years to come. Health and local authorities are therefore once again required to do the best they can with limited resources at their disposal.

It might seem that the Royal Commission on the problems of NHS manpower and financial resources will be able to solve some of these dilemmas. At any rate, by the time its report is published, the economic climate will, with luck, be somewhat more positive.

RUTH LEVITT

YOUR LETTERS

WHAT SHOULD CHCs BE CALLED ? from W.J.C. Rossiter, Secretary East Roding CHC

At the last quarterly meeting of Secretaries in the North East Thames Region, members unanimously deplored the difficulties which they have come to learn from their daily work are being experienced by the public in understanding the role and indeed the title of Community Health Councils. These difficulties seem to us to arise largely from the current proliferation of public bodies which include all or some of the following words in their titles - "community"; "health"; "council".
Our members felt that although it might necessitate amending legislation, the title "Community Health Council" should be amended. The group felt that the most suitable alternative title would be the term used in Scotland - "Local Health Council". Another alternative suggestion was simply "Health Council", prefixed by the name of the district in both cases. We are particularly anxious to ask through CHC NEWS for the views of other CHCs in other regions on this matter.

CHCs CAN BE LISTED IN POST OFFICES from Mr E. Bidgood, DHSS

Post Office Headquarters have informed us that they have recently issued instructions to all Crown Post Offices (i.e. not sub-post offices) that particulars of addresses of Community Health Councils may be included in the list of addresses of local organisations and local Government Department offices which is displayed on Crown Post Office notice boards. It will be up to each CHC to inform Head Postmasters of their addresses for this purpose.

PATIENTS' RIGHTS UNDER THE MENTAL HEALTH ACT from Derek Smith, Secretary North West Leicestershire CHC

May I notify other CHCs that under the provisions of Section 36 (2) of the Mental Health Act, 1959, patients detained in hospital may freely correspond with the following list of persons:

> The Minister of Health; any Member of the House of Commons; any officer of the Court of Protection; the managers of the hospital; any other authority or person having power to discharge the patient under this part of the Act; any time when the patient is entitled to make application to a Mental Health Review Tribunal; the European Commission for Human Rights.

In order to seek an amendment to the existing legislation, my CHC has written to Mrs Barbara Castle and Mr Alf Morris, bringing this matter to their attention and requesting that CHCs be included in the list of persons to whom patients may correspond and where necessary might direct their complaints, since CHCs have a duty to act as "the patient's friend" and give advice, on request, as to how and where to lodge a complaint. This CHC hopes that other CHCs will support them in their efforts by similarly writing to either or both of the Ministers named above.

RENEWAL OF REGISTRATION FOR DISABLED PEOPLE

from Dennis Baker, Secretary
Northampton CHC

Northampton CHC was very disturbed to learn that disabled persons whose disability is not of a permanent nature and whose period of registration is shortly to expire should, according to form DP.32 "... be prepared to pay the doctor's fee ..." for obtaining up-to-date medical evidence of their disability required by the Disablement Resettlement Service. The CHC has learned that medical evidence of disability can be produced in a number of alternative ways which do not cost anything to obtain, such as a doctor's note, pension book or other evidence. Furthermore, disabled people have the option of a free medical examination arranged by the Regional Medical Service of the DHSS at no cost to themselves. There was still the problem, however, of how many disabled people were aware of these alternatives. The CHC wrote to the Secretary of State for Employment suggesting that alternative means of producing evidence of disability should be fully explained by altering form DP.32. The Chairman of the Manpower Services Commission replied, welcoming this suggestion and agreeing that the Disablement Resettlement Service could be more helpful in giving alternative examples of acceptable evidence. The Commission is arranging for the letter accompanying form DP.32 to be amplified at the next reprint, and is arranging to remind Disablement Resettlement staff to inform disabled people, who call at the Employment Office, of the various types of acceptable evidence. The staff should emphasise that form DP.32 completed by the patient's GP should only be required when satisfactory evidence cannot be obtained in any other way. This conclusion to the CHC's efforts in long and protracted negotiations was achieved through the active and generous help of local MPs.

DR DAVID OWEN'S TALK TO A CHC CONFERENCE

Dr David Owen, the Minister of State (Health), spoke to a gathering of over 200 people drawn from CHCs, the health services and the local authorities, at a conference on October 9th in North London organised by Haringey CHC. He made a plea to CHCs to look beyond their own immediate concerns now, because during a period in which the NHS had to cut back on spending, demands for resources to be allocated in one sphere would mean that another area would be forced to make sacrifices. He asked for everyone to participate in choosing realistic priorities both within the health services and between the health and personal social services. CHCs could help by sitting down to discuss the range of problems rather than only arguing a special case. Special pleading had become the besetting sin of the social services and the role of a sheer critic was useless. He was, rather, in favour of involving CHCs by giving them responsibility and information - and information was the key to understanding. He urged CHCs not to join every lobby, and, on the issue of hospital closures, he said the blunt truth was that the country had got too many hospitals in the wrong places, and some would just have to close to release more money.

Talking about acute services, Dr Owen said that some centralisation was a good thing, and it was absolutely crucial that acute hospital facilities were rationalised and concentrated. He cited the problem of locating accident and emergency departments and said that he

would personally prefer to travel 10-15 minutes in an ambulance to a good casualty department which had the full diagnostic and operating facilities than to go to a nearer one which could not cope with emergency surgery and therefore would require him to travel to the nearest emergency operating theatre and be delayed for another hour. Beds should not be regarded as the personal acquisition of consultants, nor should people expect all hospitals to remain as they had been for the last 50 years.

Moving on to long term care, the Minister admitted that providing adequate services for the mentally ill, the physically and mentally handicapped and the over-80s presented daunting problems. The demographic problem of the elderly was serious and growing, and we ignored it at our peril. If the health and personal social services could be planned as one, and thought of as a whole, particularly in relation to these particular groups, then progress could be forthcoming. For its part, the Department was looking at ways of moving towards real community care through the cross-financing of health and local authorities.

In relation to primary care, Dr Owen said that a high standard of general practice was essential if we wanted really good primary care, and he was therefore encouraging vocational training for GPs. GPs would have to also lessen the load on hospital acute services by avoiding unnecessary referrals, if funds were to remain available to keep the health centre building programme going.

Dr Owen emphasised that there was no greater priority than to have district profiles, since the allocation of funds had to be made on parameters of objectively defined needs, and these parameters did not yet exist. He agreed that more should have been spent on the NHS in the past, but pointed out that last year an injection of an extra £600m had increased the percentage of GNP spent on health by as much as 0.5% (from 4.9% to 5.4%). This extra sum had rightly gone to the greatest area of need - staff salaries - and not a penny of it had gone to new buildings or services. The way to run the service more cost-effectively, the Minister explained, was to have a far greater devolution of decision-making. The central function of Government was to allocate resources, but the DHSS and the Regions needed to be brought closer together. As the regions handed over more decision-making to the areas, they needed to be able to regard NHS management from both a regional and an extra-regional perspective, and the Department needed equally to learn how to use the great experience of the regions. Any decisions of management would be acceptable if people saw them as representative, and the action that had been taken on the "Democracy in the NHS" paper would help, both in the fusion of interests between the health and personal social services, and in staff representation in management. The arrangements represented a hybrid form of democracy since there were no elections to the health authorities or the CHCs, but the grafting on of local authority democracy and the selections of the CBI and trade unions were important features.

On the particular problems of London, the Minister agreed that there were some difficulties arising from the four wedge-shaped Thames regions. There needed to be thinking across boundaries in a mood of give and take, and although he favoured coterminosity, the pressure to constantly change district boundaries would prove disruptive. The major teaching hospitals were an important resource, and it was a fact of history that so many were grouped closely together. The London Coordinating Committee had been set up and it was planning mergers between the undergraduate and postgraduate teaching hospitals. Much could be done, but Dr Owen said that we should not lose sight of the need for specialised centres of excellence - on a regional basis - even though this would require patients to travel. He wanted the London Coordinating Committee to become a very powerful body for London planning as a whole - but a separate health authority for the GLC area did not have to be set up. People

in other regions tended to forget that although London as a whole was overbedded, the Thames regions had areas of considerable deprivation, and there was a great need for resources to be spread more equitably between them.

Finally, Dr Owen said that despite the financial problems, the NHS would get through the years ahead if there was working together - and the CHC/DMT relationship was particularly important for this. He said that CHCs could give a public voice and a public lobby to the health service - and this is something that the health service had lacked in the past. Standards of care in the NHS would be maintained if people were prepared to change their practices - even with no extra money, the NHS would be alright as long as the best practices within it were maximised and people were prepared to take a flexible view of priorities in their areas.

CHCs AND HEALTH CARE PLANNING TEAMS

by Bernadette Fallon

When the draft circular on Health Care Planning Teams was issued in January 1975, its paragraph referring to Community Health Councils: "Councils should have opportunities to learn of and contribute to the work of HCPTs" - was widely interpreted to mean that CHC members might be invited to join the Teams. Feelings regarding this possibility were very mixed. Some welcomed it as a real opportunity for the views of the community to be put forward in the early stages of planning decisions; at the other extreme it was seen as unnecessary interference by 'amateurs' who were not qualified to give an opinion on such matters. Somewhere in-between was the fear expressed by some CHC members of a loss of the Councils' autonomy, of becoming too caught up in the machinery of NHS administration.

Nine months later, it is interesting to look at what the circular gave birth to. I set out to talk to people from CHCs which had representatives on HCPTs to find out how it was working. Here I encountered some difficulty, as at present, HCPTs are at work in very few districts. Indeed, in some places, there seems to be a reluctance to set them up, perhaps due to the current financial state of the NHS. And even where Teams are working, I found a very small number which included CHC members or even observers.

However, in cases where there is a CHC representative on a Team, there seems to be general satisfaction about the situation. One Secretary told me, "It's a real opportunity to inject the community view at grassroots level." He stressed that any CHC member who is a member of a Health Care Planning Team is required to express not his own opinion, but that of the community as ascertained by the CHC; if that view is ignored in the deliberations of the HCPT, or is not properly taken into account, then the CHC member must file a minority report. Then, when the report of the HCPT is considered by the CHC, the community view can be restated. In this way the CHC gets a double opportunity to make its recommendations. He added that it had not yet been necessary for this to happen, as in general the 'professionals' on the Teams were very willing to take the community view into account.

It was generally agreed that the CHC representatives had at first been viewed with some suspicion by the rest of the Teams. But those I spoke to were at pains to emphasise that this was only in the very early stages of membership, and that it was now felt that CHC representatives had a genuinely valuable contribution to make to the work of HCPTs. They stressed how important it was that the CHC members of Teams should be really well-informed about their subjects; considerable damage could be done to the reputation of a CHC by the appointment of a member who was not fully able to contribute. There now seems to be a good deal of mutual respect between CHC representatives and the other members of the Teams. In one case a Team held a special session to provide their new CHC member with background information about local services. In another case the CHC representative has been appointed chairman of his HCPT; he is chairman of a voluntary organisation dealing with the section of the population with which the Team is concerned, and therefore very well qualified for the post.

In the early days of CHCs the fear was often expressed that the Councils' independence would be eroded by membership of, or even too close contact with, the health service authorities. I asked the CHC representatives I talked to if they felt this was happening at all through their membership of HCPTs. None felt their autonomy to be threatened, although some had been apprehensive about it at first. Indeed, they now saw no reason for this fear - it was repeatedly stressed that they acted as a channel for the expression of the community view to the HCPT; that they were fully briefed by the CHC as to what this view was; that they were free to dissent and to make a minority report; and that when reports from HCPTs were brought to the CHC for consideration, they did not feel obliged to defend what the Team had decided. If the CHC had had a slight change of view from that which it had authorised the member to give to the Team, he simply reported back that change of view. I heard no one who mentioned any disadvantages in CHC representation on HCPTs. It would be interesting to hear from anyone holding such views; this research has been largely carried out in the north of England, and it may be that opinions are different elsewhere.

On the other side of the picture, there are CHCs in whose districts HCPTs have been set up, but who have been excluded from membership or even observership. No one was able to give any definite reasons for this, but those to whom it has happened feel a strong sense of grievance, especially where neighbouring CHCs have members on Teams. The Secretary of a CHC in this situation told me that her Council's contact with the Teams was minimal, and this made it almost impossible for the CHC to have any say in planning at the early stages. The CHC was presented with plans which had already been finalised, about which it was too late for them to express their views.

It seems that, where HCPTs exist, it is advantageous for CHCs to be represented on them. In this way the Teams gain from their access to community views, and the CHCs gain by being kept informed of what is happening in the district, by being able to make the community voice heard in questions of planning, and by building up relationships of mutual respect with the professionals in their health care district.

HOW DO YOU MAKE CONTACT WITH THE PUBLIC ?

Two CHCs describe their different approaches to the problem

Ivana T Cooke, Secretary South Hammersmith CHC

I was very impressed at a recent conference for London CHCs, when representatives were invited to describe the unusual and pioneering activities in which they were engaged. Very impressed. "We have working parties on the elderly .... the handicapped .... the mentally ill" announced one speaker proudly, to be followed by dozens more. It was obvious that most CHCs are tackling the problems of their (impossible) role in very similar ways. I'd like to discuss a possible fringe activity which I think nevertheless important. And, far from suggesting that South Hammersmith CHC is a noble pioneer in this line, I hope that many of you are involved in similar ventures, and that we can exchange ideas.

Our members decided long ago that they did not want the CHC to cower behind the skirts of the DMT in hospital buildings, nor to escape from those difficult disabled people by ascending to the fifth floor of an office block. Instead they chose a shop close to Hammersmith Broadway - one of the main London intersections. A large roundabout, three tube lines and several bus routes guarantee that we're much in the public eye. Sizable double windows give us a handsome display area, and we considered carefully how to use this. After all, even people sheltering from the rain or eating their fish and chips in our doorway are part of our target audience.

We felt that we should not only publicise our own existence, but that we should also participate in health education, given our desire to see an emphasis on preventive medicine. When we moved into the shop, Hammersmith Environmental Health Education Unit was starting a safety campaign about drugs, and we offered to take part. We expanded the Borough material with a Health Education Council poster of a foetus, captioned "Keep all medicines out of reach of children". The result was devastating. Not only did crowds of passers-by stop and study the display, but a neighbour accused us of pornography ! Nothing like splash headlines in the local papers to get a CHC noticed. Even Mary Whitehouse was amused.

Our next effort was an anti-smoking campaign, and over 130 people called in for the Health Education Council leaflet "How To Give Up Smoking" and information on a course we recommended. It was obvious that this was a topic of intense concern, and we felt this was a most worthwhile project. Future plans are to widen our scope beyond the narrow definitions of health. Our windows can be used to attempt some form of public education about the problems certain groups face. In a changing society it is surely important to help the "normal" appreciate the difficulties encountered by the handicapped, the dyslexic, the mentally ill ..... and CHCs should be aware of those difficulties, otherwise what is the point of all our working parties ? So we hope, for example, to illustrate the access one, and - the other side of the coin - to remind the public of the wide range of sports participated in by the disabled.

Obviously we can provide simple information related to health by display techniques - the location of chemists' shops open on Sundays, times family planning clinics are open, availability of other services, the right to refuse an induction. But detailed information is best in the form of a leaflet which can be taken away. This led us to a decision to have a leaflet rack and to stock it with information which again extends beyond health. Discussions with local advice agencies revealed that free material is readily available on a multitude of topics of public

concern - how to get legal aid, or a rent rebate, what to do about faulty goods, allowances one is entitled to, etc. It is appalling how ill-informed people are on their rights, and CHCs are an obvious contact point for combating this. We're not competing with CABx or other advice organisations - indeed, we cooperate closely - but sometimes a leaflet can answer a question or indicate the existence of a previously unknown benefit. Shouldn't every CHC stock leaflets on citizens' rights ?

Doubtless many of you, like South Hammersmith, have had queries outside the health field: a disabled woman wants someone to take down her curtains for cleaning .... someone's loo has been blocked four days .... another person's house is plagued with ants .... a mother wants to register her baby. "I've no idea, I can't help" is a lousy response from the public relations angle. Perhaps the most startling proof that the public were beginning to, accept us as an advice body was when a woman appeared and unhesitatingly asked, in flowing Spanish, where she could have a passport photo taken !

We hope that we are contributing to local needs, and, if you aren't already engaged in similar activities, we urge you to consider them. We will gladly send you a list of the sources we've found useful and we would be interested to know what activities you have been involved with - just send us your Annual Report !

South Hammersmith CHC
42 Fulham Palace Road
London W6 9PH

Mrs Irene Watson, Secretary Hull CHC

In an attempt to reach the largest number of individual members of the public in one operation, the Hull and Beverley CHCs on North Humberside combined their efforts to mount a display at the Hull Show. This show is staged annually in August, in a large public park in the city, and it is an important event in the area, catering for a very wide range of interests and attracting people from very far afield.

The display consisted of:

(a) a large map of the Humberside area with the four Health Districts indicated in colour.

(b) a board 8' x 4' depicting at the left side a caricature of an injured patient; in the centre a cut-out map with the Hull and Beverley districts clearly marked, and location tapes from the map to photographs of some of the main hospitals, and at the right hand side a Yorkshire regional poster over which a text sought the public's views and criticisms of the Health Services.

(c) two smaller boards carried coloured photographs depicting various services available in the hospitals and health centres, e.g. geriatric and maternity services, with additional photographs showing the ancillary services, domestic, catering, etc., that are essential for the smooth running of the Health Service units.

The stand was manned by the Chairmen, Vice-Chairmen, staff of the two Councils, and a few of the Council members on a rota system. The space allotted was a small standard size - 10' x 10'.

To keep costs down, much of the display material was begged or borrowed; transport was arranged through the good offices of the Area Health Authority; the small amount of joinery work that was required was kindly undertaken by patients at a mental handicap hospital and tradesmen at a Hull general hospital. Professional advice about exhibitions in general was offered by the AHA staff and was much appreciated. The local authority very kindly agreed that we could have the site free of charge, so that the only cost involved was for the canvas cover over the portion of the marquee which we were allotted - £14 - plus the cost of leaflets and handouts. Both Councils already had their own publicity material but in addition it was decided to have 2000 combined leaflets printed. These double-fold leaflets carried a brief resume of the Councils' remit plus the addresses and telephone numbers of the Councils' offices and the names and addresses of all the members. We had hoped to obtain the cooperation of a local TV and Radio firm in loaning us cassette recording equipment so that prepared tapes explaining the work of CHCs could be played. In return they would be given some publicity. However, the local firms approached were not willing to do this, and, in the event, members of the public who came to the stand were more inclined to talk about the Health Service and discuss their problems than to listen to tapes. The literature, on the other hand, disappeared rapidly.

In order to determine whether in fact the exhibition had been worthwhile, the Hull CHC Secretary and her assistant spoke to a cross-section of those visiting the stand and completed questionnaires. The pattern of the interviews was to spend a fair amount of time with a relatively small number of people rather than having a few words with many. Of those interviewed, 70% were not aware of the existence of CHCs, 30% were aware of CHCs and understood their function. After visiting the stand the majority of those interviewed stated that they understood the role of CHCs much better, and gave the unsolicited opinion that the establishment of these Councils had been long overdue. Some other comments that were noted included:

> Doctors should be more communicative with their patients; there should be more support for elderly patients living alone; there was objection to prescribing being done by GPs' receptionists; there was anxiety over the prospects of some small rural units being closed, e.g. maternity; more attention should be paid to the case and social work of the psychiatric services; there was concern over orthopaedic waiting lists; it was felt that the elderly received more attention in a Social Service home than in a private nursing home, from the point of view of increased activity, but there was a shortage of places; when a patient is called to go into hospital, sufficient notice should be given to allow for any particular circumstances, viz. making arrangements for an elderly relative in their care.

It is a fact that although, fortunately, there are many people with active social consciences, the majority of the members of the public will remain fairly dormant as regards ideas for improving the health service until such time as they themselves are affected. The exceptions to this are the people who already have particular interests in certain areas of health care. We feel the exercise did achieve a fair amount of publicity for CHCs, and as a result, next year we intend to mount a more dynamic and eye-catching display.

ACTION ON LOCAL TRANSPORT PROBLEMS

Several CHCs are aware of difficulties in getting to and from hospitals where the transport services are not ideal. Here, two CHC secretaries describe how they are taking positive action. In the first case, the CHC has decided to ask patients' relatives about their experiences in visiting the hospitals from rural areas, while in the second case, the CHC has acted through its links with the local authority.

Gil Gray, Secretary, North East Essex CHC

This CHC felt that there was a definite problem with transport in our district, and to make sure this was factually true, we decided to write to the 90 Parish Councils and various voluntary organisations, e.g. WRVS, Age Concern etc., to get evidence from them about the nature of the problem. A small committee of the CHC was formed to study the problem in depth. It realised that "transport" is a general term covering different features, and therefore subdivided this into sections, i.e. transport to out-patient clinics, admission to hospital, etc. In the first instance we are concentrating on the difficulties that people living in rural areas face when trying to visit their relatives and friends in hospital. We devised a questionnaire with some help from a training institution and a social psychologist and have put it to the District Management Team for their approval. We felt this was necessary since CHC members will then go into the district's hospitals and ask a random sample of people for their views. We hope to analyse the response from the questionnaire and bring any shortcomings that emerge to the attention of the relevant health authorities and the bus company. At this stage we do not yet have any statistical information, but we hope that after the end of November, when the survey has been completed, there should be many interesting facts from people's responses which will enable us to make a convincing case for the need for improvements in the liaison between the hospital and the bus company over visiting hours and bus timetables.

John Wardle, Secretary, North Tees CHC

At the same time as the inauguration of North Tees CHC, the 1000-bed North Tees General Hospital was being commissioned, replacing two general hospitals, a geriatric hospital and a children's hospital. One of these hospitals and the geriatric hospital were situated in the centre of the conurbation of Stockton, Thornaby, and Billingham. The new District General Hospital was sited on the north west perimeter of the conurbation. One of the first aspects of health care brought to the attention of this Council was the difficulty of public access to the new hospital.

The public transport system in North Tees is basically a radial system emanating from the centre of Stockton and consequently, anyone travelling from one district to another must normally first travel to the centre. This poses difficulties for out-patients, visitors and staff, both in time and cost, (approximately one hour and 30p single, instead of approximately twenty minutes and 15p). The radial bus service from the centre of Stockton to the hospital is, however, very good. During its handling of this matter, the Council has learnt a great deal about its role, potential, and methods of working:

Firstly, and most obviously, it realised that initial discussions and research into this problem were not ideally suited to a full Council meeting. The Council consequently set up a small

group of members which it termed the Transport Group. The group comprised both local authority, voluntary and Regional Health Authority appointed members.

Secondly, the Council learnt that to be effective it must have a full liaison with the District Administrator to ensure that in this instance, CHC and DMT were not "pulling in opposite directions".

Thirdly, the Council realised the strength of its influence within the local authorities. The responsibility of running the bus service is that of a Joint Transport Committee set up by the local District Councils. In a way the CHC was taking the place of the formal Local Authority/ National Health Service links that had yet to be established. As one of the principal beliefs of this Council is that liaison between the NHS and local authorities should be extremely good, the Council was in a position to set an early example. A concept alien to the National Health Service did however arise in that on the CHC, councillors represent community interests whilst on the local authority they both represent community interests and are responsible for managing the services. Some councillors pointing out inadequacies of public transport might have to seek the cash to subsidise services which may not pay their own way.

This CHC has always disliked the aims and concepts created by the tag "Watchdog" and of "complaints bureau". It felt that its role is far wider than this and that its duty was to represent community interests by ensuring that management bodies were aware of, and take into account, these interests. In a small but significant way, the public transport issue demonstrated early on that complaints and watchdogging were far from the be-all and end-all of Community Health Councils. The Council's policy is that its main source of power is through the influence gained from its ability to reflect true public opinion, and it feels that this will be more successful by having good relationships within the community and with staff and management. The public transport issue was the first to bring DMT, staff and community together and was such that it helped to form the base of a proper relationship.

One problem encountered was that the role of the CHC was to represent community interests to the AHA and the Council should not, therefore, approach a local authority directly. This was, however, settled satisfactorily and it was agreed that as an autonomous body the CHC could approach the local authority direct if it so wished. I would emphasise that these various explorations into the role of the CHC should be seen in a historical context as the Council's attempt to find its niche.

The situation as it stands at the moment is that the public transport authority is investigating the demand on one route, it hopes to alter several routes when one-man buses are introduced, and it intends to provide an evening visitor bus. The Council has also approached the County Council, asking whether it would be prepared to subsidise one of the services if it proves to be uneconomic.

NOTES

FIRST INTERIM REPORT OF THE RESOURCE ALLOCATION WORKING PARTY
ALLOCATIONS TO REGIONS IN 1976/77 DHSS, August 1975

This document sets out a comprehensive national policy for allocating money to the NHS in 1976/77. It is a particularly important proposal to all those concerned with the future of the NHS because it suggests new rules which the DHSS should follow to cut the cake more fairly than in the past.

The basic argument is that since the growth of the economy as a whole is seriously restricted for the moment, the NHS cannot expect to get an ever-rising share of public money - as it has done in the past. The effect of being allowed to spend less money than it wants forces the DHSS to impose a system of rationing. Ministers have recognised that this rationing needs to be fair, and they set up a working party in May to suggest tangible and positive breaks with the historical - and inequitable - system of resource allocation.

The working party's interim proposals certainly do grasp the nettle of devising a "fairer" system of allocating resources. They say that a more equal opportunity for access to health care of people at equal risk can, in the given circumstances, only be achieved by a programme of cutting allocations to the better-off regions and raising allocations to the worse-off regions, over a period of years.

For 1976/77 the working party suggest that the four Thames regions and Mersey should actually have to reduce their revenue expenditure so that the remaining nine regions can benefit financially. The league table of regions starting with the most under-provided one is:
(1) Trent (2) East Anglia (3) Wessex (4) West Midlands (5) North Western (6) Northern (7) South Western (8) Yorkshire (9) Oxford (10) SE Thames (11) NE Thames (12) SW Thames (13) Mersey (14) NW Thames.

In painting this picture of relative disparities between different parts of the country, the working party have devised a formula which the DHSS can use for a number of years. It takes into account the population served in each region, the existence of groups such as the elderly and the handicapped who make particular demands on health care resources, the workload handled in each hospital, and the teaching and research activity carried out at certain centres.

But perhaps the most important paragraph of the report, as far as CHCs are concerned is the final one which says that the proposals will only stand a chance of success if ".... Ministers are prepared to take a resolute stand when politically sensitive cases or those which are otherwise contested, for example by CHCs, are presented for decision." The implication for CHCs is clear - when authorities want to close units they regard as uneconomic, CHCs should realise that their opposition, in the light of the need to spend limited money as effectively as possible, will only make sense if it is coupled with suggestions that are seen to propose alternative measures for saving.

DEMOCRACY IN THE NATIONAL HEALTH SERVICE
Health Service Circular (Interim Series) HSC (IS) 194 September 1975

CHCs will, by now, know of the decision to allow one of their members to attend AHA meetings, and they may already have attended as observers. The circular that explains the detailed implementation of the Secretary of State's decision on the "Democracy in the National Health Service" paper of May 1974 has recently been issued, and it also covers provision for altering the proportion of local authority nominees on health authorities.

The circular says that CHC observers should be invited to meetings of the AHA, and they should not automatically be excluded from the "confidential" part of the meeting, although the AHA may exceptionally decide that it would be improper of the CHC observer to be present for a particular item. Papers from the AHA can be discussed between the CHC observer and his or her CHC, although the discussion should be in private where the material requires it - AHAs can indicate which of their papers may require this treatment.

The circular goes on to emphasise that CHCs should not have their independent status in any way impaired on account of their sending an observer to AHA meetings. In the words of the circular, the point of having CHC observers is: ".... to ensure that /CHCs'/ voice is clearly heard at the point of decision making ..." as well as to strengthen the development of mutual understanding between CHCs and AHAs.

The rest of the circular is devoted to the mechanics of obtaining additional AHA appointments by local authorities, in line with the decision to have one third of all members drawn from local government. It says that local authorities are normally expected to nominate elected councillors, and that there is a special need for younger people. The term of office of certain RHA and AHA members is being extended, and details for altering local government nominations to RHAs and for making appointments from those working within the NHS to the health authorities will be given in due course.

MRS CASTLE'S STATEMENT ON CUTTING THE COSTS OF NHS ADMINISTRATION

On 29th September, Mrs Castle wrote to all the Chairmen of RHAs and AHAs stressing the need to reduce costs of administration of the NHS in the present economic climate. These are some selected points taken from her letter:-

"There is, as you know, widespread concern about the increase in costs of administration following reorganisation. Part of this increased cost has arisen from the desirable purpose of introducing consultative and advisory bodies and from the servicing of Community Health Councils."

"It is common ground between us that there needs to be greater devolution within the NHS and ..... there is an urgent need for greater devolution from Region to Area ..... To those who advocate the total abolition of regional tier, I would only say that in the past both Governments have always seen the need for some regional organisation to help administer the NHS."

"(A number of Authorities) may believe that the boundaries or the number of districts should be changed. However, staff interests have understandably expressed concern about the possible effects of large-scale changes at this stage, and while I could not contemplate discouraging Authorities from considering necessary changes in the normal course, it is obviously essential

that there should be early and full consultation with staff about any proposals for change. There is no intention of altering the existing relationships between Area and District ... or of departing from the concept of the district as a natural management unit for the delivery of health care."

FORTHCOMING EVENTS

The following conferences are being held at Brunel University:

2 - 4 December 1975 — INVOLVING THE PUBLIC

This seminar will examine the social and political context of public involvement in physical and social planning, present examples of different methods of organisation for participation, and describe the different approaches and techniques being developed to involve the public.

The seminar is designed for those with an interest in initiating new policies for public involvement and for those who already have responsibilities in this field. It should therefore be of interest to senior officers concerned with planning, education, social services, health services and housing, and other areas where public involvement is of importance, as well as to those concerned specifically with public information. The number of participants will be limited to about 25. (Fee:£90. Enquiries to Maureen Dixon, Course Director, Brunel University, Kingston Lane, Uxbridge, Mddx.)

5 February 1976 — COMMUNITY PARTICIPATION IN THE NHS

This conference will concentrate on issues of CHC organisation and relationships: what are the appropriate means of representing consumer views ? What information do CHCs need, and how can they get it ? What is the role of the CHC member ?

The conference is likely to be of interest to CHC members and secretaries, DMT members and other NHS staff concerned with CHCs and anyone interested in community participation in the NHS.
(Fee:£13. Enquiries to Mrs L. Drummond, BIOSS, Brunel University, Kingston Lane, Uxbridge, Mddx).

BOOK REVIEWS

LIVING IN HOSPITAL The Social Needs of People in Long Term Care
by James R Elliott, King Edward's Hospital Fund for London, 1975, £2.50.
(Available from: Research Services Publications Ltd., Victoria Hall, Fingal Street, London SE10 ORF.)

"... The lay member visiting or supervising a hospital finds himself in a particular difficulty. Faced with the sight of hundreds of people shut off from the community in their wards and departments, the visitor soon realises that he cannot easily comment on the professional quality of medical or nursing care, or of the work of paramedical departments. He tends to fall back on examining and reporting on the physical facilities, the standard of decoration, and so on. Very quickly he finds that the hospital authority and its officials know only too well the physical imperfections of the facilities, and have for years been struggling to attract enough money to long-term care to enable something to be done. Baffled, the visitor decides to talk to the staff, or to the residents, but not being too sure of the fundamental purpose of his visit, and fearful of overstepping the limits of his authority, he relapses into small-talk in the hope of satisfying himself that all is well ...."

To anyone connected with CHCs who can see themselves in that extract, Living In Hospital should prove an interesting read. It highlights many of the undesirable aspects of long term care which can undermine the quality of life for the residents, and poses some straightforward but searching questions that can be posed in assessing a wide range of institutions catering for different kinds of residents. The text is arranged under 4 main headings: reception and daily living, social climate, relationships and medical, nursing and organisational problems, and the book ends with some practical suggestions for action.

THE HEALTH CARE DILEMMA
Office of Health Economics, 162 Regent Street, London W1R 6DD, 1975, £0.25 plus postage.

Through very careful definitions of "illness" and "the process of becoming ill" this pamphlet suggests that the health service is unable to meet the demands made upon it within its allotted resources, because there has been a misconception about what health care actually should involve. Personal difficulties that are really of a social or emotional nature are being incorrectly placed alongside purely medical problems, and as a result, inappropriate medical action is being taken in cases where other techniques (which would not make demands on the NHS) ought to be employed.

Above all, however, people have been misled into expecting that a state of pure normal health exists and that they should demand care from the health services so that they may attain or maintain this state. In fact, the pamphlet painstakingly illustrates that normal healthiness does not exists in a way that can be defined, and that what is needed is a fresh approach among health care providers and consumers in which people learn how to care sensibly for themselves, and doctors take care not to confer diagnostic labels onto their patients, so "creating" illness where it did not previously exist, in the patient's mind.

Whether one agrees or not with these arguments, the pamphlet correctly raises questions concerning our assumptions about health care provision, and should make a valuable contribution to CHCs' assessments of their own role in expressing expectations of the health services' capabilities.

POVERTY AND DISABILITY
THE FINANCIAL NEEDS OF DISABLED CHILDREN by Jonathan Bradshaw
published by the Disability Alliance (96 Portland Place, London W1) 1975, £0.50 each.

The Disability Alliance is producing a series of pamphlets in 1975 and 1976 which aim to present the facts about the poverty and low incomes endured by many of Britain's disabled. They hope that the public will then be able to judge for themselves the case for a comprehensive disability income. The pamphlets therefore contain many statistical details which make it possible to grasp the scale of the problem. For example, a 1968 national survey showed that there were over 1 million handicapped people and over 3 million impaired people in the community, many of who have incomes below the poverty line. In terms of employment opportunities, a 1974 survey showed that 60% of firms required under the Disabled Persons (Employment) Act to employ a quota of registered disabled people were failing to do this. Comparisons between incomes of disabled and non-disabled people, and between people in the more and less severe categories of disability show the tendency towards relatively lower incomes for the disabled and the severely disabled, respectively. Furthermore, war or industrial injury disablement pensions are paid irrespective of earnings or national insurance entitlement, whereas people whose disabilities may be equally or more severe are not allowed these terms if their disabilities originate elsewhere. The invalidity allowance, on the other hand, is calculated in terms of the age of onset of incapacity instead of the degree of disablement.

In the case of the income needs of families with disabled children, the statistics are less accurate, partly because there has been no national study and partly because the range and severity of handicaps is so varied. But there is overwhelming evidence that many families have to spend large sums caring for their handicapped child. The attendance allowance has been made available at two rates to eligible families, and it has, for them, provided enormous help. Nevertheless, the administration of the attendance allowance has come in for some criticism, particularly in relation to the criteria for eligibility. The Family Fund has also enabled a section of those families with handicapped children to receive real cash benefits. Both pamphlets go on to state the case for a comprehensive income scheme for the disabled, and suggest short term supplementary measures which could be introduced to tackle the problem, as they see it.

STEERING COMMITTEE A brief note by Mr PJ Torrie, Secretary.

(It is hoped that fuller details will be available for the next issue)

CHCs will be interested to know that the following resolution was unanimously agreed after a long discussion:

"The Steering Committee can state that, all CHCs having been consulted, 70% wish that an Association of CHCs be formed, 45% of them without delay. Against the formation are 9% and 21% wish to defer their decision.

Having received these views from CHCs, and taking into account the very difficult financial situation, the Steering Committee would wish to recommend that the Secretary of State arrange to call a meeting in the autumn of 1976. At this meeting each CHC would have the opportunity of expressing its views on health service matters in general, and be given the opportunity to consider and, if agreed, to endorse the setting up of a national body. The objective would be to establish this body after the election of members to CHCs in early 1977.

The Steering Committee propose to continue to meet as required during 1976 to draft the necessary papers for this meeting, in the light of the many observations put to them by CHCs.

CHCs generally have welcomed CHC NEWS and the information services provided through the King's Fund, and the Steering Committee recommends that this arrangement should, if possible, be continued."

The Steering Committee and the Secretariat are aware that individual CHCs have spent much valuable time considering the Steering Committee's proposals and they are very grateful for the evident care that has been given to this matter.

A majority of CHCs in Wales felt they would be better served by the existing Welsh Association of CHCs. They hoped the Welsh Association could work closely with any English Association, and they hoped they could continue to receive CHC NEWS and information services.

The Steering Committee has also set up an informal panel from its membership to help with advice on the activities of CHC NEWS and the information services.

Note The letters and articles published in CHC NEWS express the views of the authors only, and are not necessarily shared by CHC NEWS or any other party.