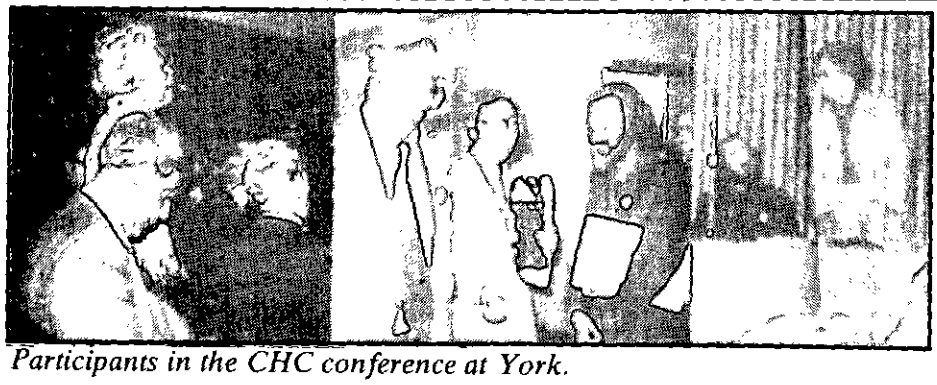
CHC NEWS

For Community Health Councils May 1976 No. 7



Participants in the CHC conference at York.

Complaints about CHCs—whose responsibility?

It was revealed that some patients with complaints are being turned away by CHCs. Mrs Jean Robinson of the Patients' Association told a CHC conference at York that her organisation had hoped to phase out its activities as CHCs got into their stride. However, many people were coming to the PA because their CHCs had refused to help them, so she thought there was still a role for the PA to play. She explained, in a hard-hitting talk, how she saw the role of CHCs as being to make rational assessments of the quality of medical care. Since there were few yardsticks available, CHCs should at least use the one they do have—patients' own opinions. The barriers that prevent complaints getting through and being properly investigated are very serious—and the 8 week time limit on complaints concerning family practitioners is the worst of all.

"The quality of GP care varies from the excellent to the unbelievably bad" she said, "and the Merrison Report shows that even doctors were horrified at the number of their practising colleagues who were alcoholics, drug addicts or mentally ill." She emphasised that sick doctors needed all our help and compassion. On the subject of hospital complaints she felt that the message being given to people is "sue or shut up." The level of litigation in the USA is too high, but in this country she thought it was "too low for safety".

"The question of clinical judgement is vital" continued Mrs Robinson, "and the Secretary of State's decision to ignore the Davies Committee's idea of Investigating Panels is scandalous." She urged CHCs to be active in helping people who wished to make complaints and to use the Health Service Commissioner fully.

Another speaker, Professor Margaret Stacey of Warwick University, thought CHCs should realise that patients are given very low status in the health service. "You should use every possible device to keep in touch with patients' opinions—including information and advice desks in hospitals, conducting surveys and ensuring that these are properly put to use to serve patients' interests, perhaps using help from local polytechnics and universities, and encouraging local voluntary organisations to keep in close touch with you." Professor Stacey urged CHCs to be concerned with the outcomes of medical treatment, and to ask for information—such as the comparative benefits of home care as against intensive treatment in a coronary care unit for patients with heart disease.

"The fact of doctor-induced disease is recognised, so ask a lot of questions, and insist that the answers are given in a form that you can understand." Jack Hallas, from the Nuffield Centre at Leeds, also spoke at the conference, and he thought CHCs would only succeed if they could work to change things for the better. "Consciously decide to set up an Executive Committee in your CHC so that the volume of boring business can be reduced, and members of the public can then get genuinely involved in discussion of issues that interest them." He also suggested that some people were more up to the job of being CHC members than others so ". . . have a shakeout, and replace the deadheads on your council" he said.

North Camden's choice: large inflatable toys.

CHCs spend their savings

CHCs in NE Thames Region have been deciding how several thousand pounds of NHS money should be spent in their districts.

This unique situation arose when the Regional Treasurer, Mr Donald Joines, realised that most of the CHCs would not need all the money allocated to them last year. Up to about £4000 would be saved by most of the 17 CHCs, but instead of losing it or spending it unnecessarily, he thought the CHCs should be able to pick on any health

continued on page 8

YOUR LETTERS

TRAVELLING EXPENSES

from Ian Webb, Secretary Northumberland CHC

Patients on or near Supplementary Benefit level cannot receive travelling assistance to health service facilities outside clinics, health centres and hospitals. Therefore patients travelling to see a dentist, optician, chiropodist etc. in health service premises will receive assistance, but those travelling to the same service outside hospital premises attract no support.

To add to this illogical situation, a patient can receive financial help to travel to every service in the health centre, but cannot receive any help to travel to a general practitioner's surgery held in the same health centre.

MPs for this region have raised this matter with the Secretary of State, as have the CHCs. The reply consistently given is that as far as health services are concerned, there are no plans to extend the travelling expenses regulations. The CHCs in the Northern Region feel strongly that the logic for the payment of travelling expenses should be extended to all health service facilities within the new and supposedly integrated NHS. We would very much appreciate any help and support that other CHCs can give in this regard, and would be pleased to hear of any progress other CHCs have had with this and other transport matters.

CO-OPT EX CHC MEMBERS

from John Milles, Secretary Winchester & Central Hampshire CHC

At the end of the year all CHCs will be saying farewell to half their present membership and welcoming a new intake in accordance with the Department's general directive. Some of the retiring members will no doubt be among the more active ones in CHC affairs and others will be the less active ones.

To overcome a certain feeling of loss to the CHC when an active member goes, my Council is endeavouring to make provision in two ways: firstly, members due to retire in December will be asked if they would like to be coopted from time to time on an ad hoc basis, e.g. for a special interest or study group: secondly, the RHA is being asked to recognise the principle whereby ex-members can be coopted and appropriate out-of-pocket expenditure paid to them from the CHC budget.

I need hardly emphasise that it takes time for a member to become effective and acquire the basic knowledge of what the NHS and social services are all about. It would therefore seem necessary to encourage ex-members who are willing and interested to keep in touch—this will hopefully be rewarding for them as well.

TIME OFF WORK

from Lady Marre, Chairman of the Steering Committee

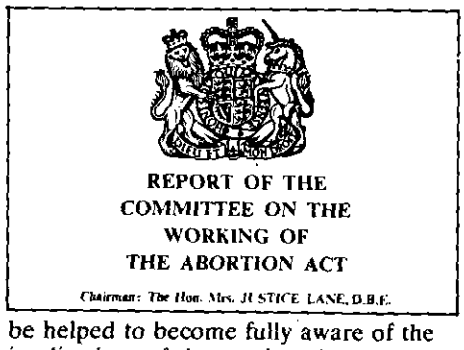
CHC members may be interested to know that unlike RHA and AHA members they will not qualify under Section 59 of the Employment Protection Act, which makes provision for employees to be given reasonable time off (unpaid) for public duties. This section of the Act is expected to come into operation towards the end of the year or early in 1977. CHCs were not included in the list of bodies covered by this Section, but it might be possible for an amending order to be made if the support of the Health Ministers could be enlisted. CHC members might well be able to be more effective if they were able to take time off work occasionally without risk to their jobs, and it might encourage a more varied and perhaps younger membership.

We have no means at the moment of making a collective approach, but I am writing to ask whether CHC members individually, or CHCs themselves would wish to make representations to Health Ministers about this.

If you wish to support such representations, I suggest you write to me c/o Kings Fund Centre so that they could be submitted together. If you have any supporting evidence for your views it will be helpful.

Abortion Counselling and the Lane Report

The DHSS has recently issued a draft departmental paper on arrangements for counselling of women seeking abortion. "All women who are considering abortion should have the opportunity to receive counselling" says the paper, which urges the health authorities, local authorities and others concerned to ensure that counselling is offered in all cases where it could be relevant, and that existing counselling services are adequate. The paper is based on the Lane Committee's recommendation that every woman seeking an abortion should be helped to become fully aware of the implications of the continuation, or alternatively the termination of her pregnancy.



In the light of the current abortion debate, it may be useful to look again at some of the main points from the Lane Committee's report on "The Workings on the Abortion Act" (HMSO, 1974). The major effect of the 1967 Abortion Act was to extend the grounds on which an abortion could be obtained, and to allow doctors to take into account a woman's actual or reasonably forseeable environment. (This includes, among other things, social and economic factors, her marital status, and her existing family). The Lane Committee concluded unequivocally that the Act works well on the whole and it should not be amended in a restrictive way: "The Act has relieved a vast amount of suffering. It has helped also to focus attention on the paramount need for more preventive action, for more education in sexual life and its responsibilities, and for the widespread provision of contraceptive advice and facilities."

The Committee's main reservation about the Act is that on its introduction the NHS was not equipped in numbers of staff and facilities to meet the demand for increased services, and that this has led to marked inequalities over the country in the provision of services. The Committee also found that in a small minority of the private sector the provisions of the Act had been flouted, but that more significantly, the private sector had helped to compensate for deficiencies in NHS provision. The Committee gave very serious consideration to the moral and ethical implications of the Act and concluded that "The great majority of abortions which have been carried out have been fully justified under the Act". The Report includes a number of suggestions for improving the operation of the Abortion Act in future, and it says hospitals, health authorities and central departments should keep their services under review so that the proper standards—which women are entitled to obtain—are in fact being provided.

The other major emphasis of the Report is on health education and, in particular, the need for accessible advice on contraception and family planning, and for improved and increased education on human and sexual relations in schools, and colleges.

Since the Lane Report was published in 1974, James White MP has introduced his Abortion (Amendment) Bill, which is now being examined by a Select Committee (see CHC NEWS 2).

Opinion Surveys in Hospitals

by Winifred Raphael

It is a curious phenomenon that those responsible for other people often believe they know what those others are thinking but, in fact, seldom realise all of it. Do parents always know their children's thoughts? Are employers completely familiar with their employees' problems? Do CHC members and hospital staffs fully realise the patients' opinions?

Patients often hesitate to express their views spontaneously, maybe out of gratitude, maybe out of fear (generally unjustified) of repercussions. Some research conducted in 4 hospitals obtained views on changes needed for the welfare of the patients. The priorities given by committees and staffs were very different from those given by patients in the same hospitals. The former mainly stressed the need for alterations in the physical surroundings while the patients wanted changes in the organisation of their daily life.[1]

CHC members need to utilise all methods to discover the patients' views—no one method is perfect but they can supplement each other. Opinion surveys have their limitations but undoubtedly give much valuable information that is difficult to get in any other way. The main advantages of patients' opinion surveys are:

(a) Views can be obtained from a typical sample of patients not only from those who are more vocal or have strong views, whether favourable or critical. The sample can be large enough to be statistically reliable.

(b) Comparisons are facilitated with other hospitals, between different groups within the same hospital, and before and after changes are made.

(c) The survey findings are a stimulus to action especially as priorities for change are indicated. Often changes desired by patients are matters of organisation needing little or no expenditure.

(d) Surveys are a boost for morale—patients like having their opinions sought, staff enjoy the appreciation of their work that is almost invariably expressed and the local community generally gets a more favourable view of the hospital if survey results are summarised in the press.

There are many types of surveys and choosing one to fit a hospital's particular needs is a matter for the expert.

1. Written or based on an interview. An interview gives richer results in terms of the variety of matters raised and willingness to criticise. However it needs a skilled person to conduct and summarise the results, and takes far longer.

2. Structured or free. 'Structured' means asking specific questions, 'free' allows the patient to discuss any relevant matters. This is not a true antithesis as in many surveys, whether written or by interview, specific questions are asked first followed by opportunities for the patient to add comments or raise other matters.

Winifred Raphael is an occupational psychologist and Survey Organiser for the King's Fund Centre.

3. Topics covered. These may concern all aspects of hospital life or be confined to special topics e.g. food, visiting arrangements, notice of admission.

4. Time of survey. There are considerable economies in both time and cost if the survey is conducted while the patient is still in hospital rather than at his home after he has left. Also, surprisingly, it has been found that he is more likely to give suggestions and criticisms while still in hospital. On the other hand, no information can be obtained while still in hospital on manner of discharge and aftercare.

In 1974 King Edward's Hospital Fund circularised all hospital groups and teaching hospitals in Great Britain asking whether they had recently conducted surveys of patients' opinions and, if so, what had been the resulting action. Particulars were returned of 173 surveys. About half of these were based on questionnaires that the King's Fund Centre had prepared for general hospitals and for psychiatric hospitals to apply themselves. The rest varied enormously in origin, purpose and type. The reports on action resulting from the surveys were particularly interesting and included changes in organisation, equipment, meals and patient facilities. Improved morale was frequently mentioned.[2]

When the King's Fund Centre realised the importance of devising patients' surveys that hospitals could apply themselves it first prepared one for general hospitals and issued the report on the results.[3] The second was for psychiatric hospitals and the resulting report[4] was also published. Both have been widely used in the United Kingdom and overseas. Questionnaires can be obtained from the Centre at cost price and full instructions for applying the survey are issued without charge.

A slightly different type of survey has been prepared for staff and patients at psychiatric units attached to general hospitals and reported on.[5]

A questionnaire for outpatients is in the course of preparation.

The Centre is glad to advise any CHC or hospital that it is considering whether to apply a survey. It is essential to gain the interest and cooperation of the staff before starting a survey and also to take the results seriously, introducing changes when practicable and reporting back to those mainly concerned.

A survey is not just an interesting exercise but essentially a tool for action.

1. *"If I Could Alter One Thing" by W. Raphael. Mental Health, April 1965.*
2. *"Surveys of Patients' Opinion Surveys in Hospital" King's Fund Project Paper No. 6. November 1974, £0.10.*
3. *"Patients and Their Hospitals" King Edward's Hospital Fund for London, 1973, £1.00.*
4. *"Psychiatric Hospitals Viewed by Their Patients" King Edward's Hospital Fund for London, 1972, £1.00.*
5. *"Just an Ordinary Patient" King Edward's Hospital Fund for London, 1974, £1.30.*

EDITORIAL

The intention to prohibit painkilling tablets from self-service sale in shops and pharmacies raises an interesting question. The DHSS has not consulted CHCs on this proposal, although it will amount to a reduction in pharmaceutical services to the public, particularly those living in smaller towns and rural areas. *(See p7)*

Of course, the intention is to protect the public from the dangers when painkilling tablets are taken carelessly or when children have unsupervised access to them. But can the Medicines Commission and the Pharmacists' and manufacturers' organisations alone know what is best for the public without apparently conducting any surveys or indicating the statistical evidence that supports their viewpoints?

Even if the Medicines Commission feels that its members are sufficiently expert, and that consultations with professional and other organisations are adequate to make recommendations, would it not encourage a more open style of decision-making on behalf of the public if the documents referred to statistics and evidence which CHCs, for example, could examine?

Since the 1968 Medicines Act was passed, there is no doubt that the regulation of the manufacture and supply of drugs to the NHS has been under much more effective scrutiny. But if the Commission and the Pharmaceutical Society of Great Britain mean what they say when they talk about "educating people to use medicines with due care", should they not be more open in their decisions about what is and what is not in the public interest?

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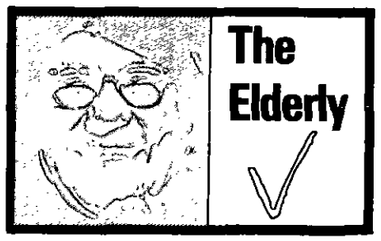
PRIORITIES!

Targets for the next four years

At the end of March the DHSS published its suggested priorities for the health and personal social services as a consultative document, inviting comments from CHCs and many other bodies. In about 80 pages, all the major services are considered, looking at what particular advances or restrictions each should experience over the next 4 years. The document opens with an introductory chapter explaining the reasons for stating priorities, and indicating the financial context in which the services will have to operate.

Then, after a chapter on the implications for staff, there are 7 chapters each considering a defined area of care: primary care (plus community

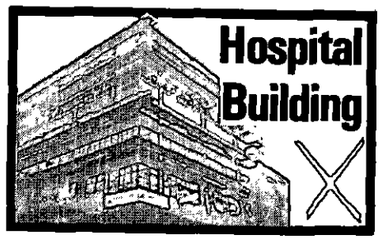


health and prevention); general and acute hospital services (plus the maternity services); the elderly; physically handicapped; mentally handicapped; mentally ill; children (and families with children); then a chapter on the personal social services, and finally a look ahead to the subsequent 5 years 1980-85.

This brief review can only draw attention to some of the document's main points, so CHCs will find it valuable to consider it in more detail, perhaps by each working group looking at those sections that are its special concern. The first major theme of the document is that health services and personal social services should be thought of—and operated—as complementary and interdependent. As you read, you find the edges between them blur, and your attention is constantly drawn towards the need and the real opportunity for integration. There is an explicit commitment to joint planning, and funds will be earmarked for joint financing. The second major theme is that the elderly are top of the priority list—partly because existing services are so unsatisfactory, but also because the proportion of people over 60 in the population is steadily rising, and their needs will increasingly have to be provided for. Next on the list are the mentally handicapped, closely followed by children and the mentally ill. The hospital acute services will receive a reduced share, and bottom of the list are maternity services.

The document also insists on the philosophy of "people before buildings" meaning that capital expenditure must continue to be restrained. So all but the most urgent new DGHs or those already underway are unlikely to happen in the short term. Nucleus hospitals are offered as the more economical and flexible substitute, although the health centre building programme is not to be jeopardised.

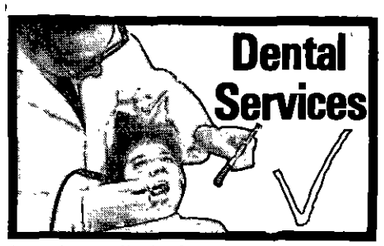
The manpower at the disposal of the health and personal social services is rightly seen as the most precious—and expensive—asset. The suggestion is for a target intake of 4000 students each year



into the medical schools by 1980. This should increase the number of British graduates in hospital posts and hopefully provide more potential GPs—who will be encouraged to take the special vocational training programme. The need for more practising social workers to have received professional training is recognised, but nurses will be sad to see that there are no expectations of implementing the Briggs Report's recommendations for the training of nurses, health visitors and midwives while the current shortage of funds prevails.

The industrial unrest in the NHS over the past 2-3 years is blamed for the lack of improvements in hospital waiting lists. The targets are for all urgent cases to be admitted within one month, and all other waiting list patients to be admitted in less than one year.

In the field of primary care, the key role of health visitors is particularly emphasised. AHAs should aim to



increase the numbers of health visitors (and home nurses) they employ. CHCs will be glad to see two further recommendations: (1) that GPs should "exercise better control over their deputising services" and (2) that financial incentives plus premises and equipment should be offered to dentists who are prepared to work in localities where it is difficult to obtain NHS dental treatment. The document also reaffirms the view

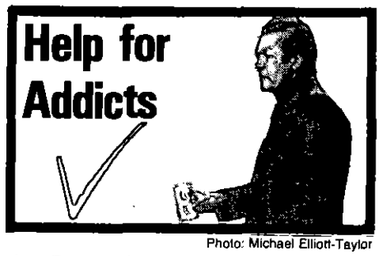


Photo: Michael Elliott-Taylor

that fluoridation is of positive benefit to dental health, and money will be earmarked for health authorities to use in introducing schemes. The restraint on maternity and acute hospital services represents a "difficult but challenging strategy", and there is special reference to the role of CHCs in relation to locally unpopular closure proposals. The hope is that CHCs will: " . . . support authorities where closures or changes of use can lead to greater efficiency and a better use of resources . . . local protests will only be given serious consideration if they are accompanied by realistic alternative solutions within the expenditure limits."

Services for the elderly should concentrate on enhanced domiciliary provision supported by acute geriatric units within general hospitals, and the replacement of the old long-stay geriatric hospitals by provision within community hospitals.

One of the recommendations for the disabled is the setting up of a spinal injuries unit in the south of England. The others refer particularly to domiciliary and residential services mainly provided by the local authorities. On the whole, the recommendations for the mentally handicapped and the mentally ill follow the policies set out in the two "Better Services" White Papers. There is also reference to the need for improving services for alcoholics and drug misusers. The services for children will be reviewed comprehensively in the report of the Court Committee, to be published in the summer. In the meantime the priority is "to maintain and consolidate services as far as resources permit." An interesting point is the commitment to substantial support for the playgroup movement.

The document admits that these national targets will not be mirrored in each locality, and that the vital issue for everyone will be to decide how, and how far community-based services in particular can be expanded. The implication is that we have to come to terms with the limited capacity of the health and social services to meet all our needs.

Photo: Glaxo Farley Foods Ltd.

Prevention and Health

What is preventive care and what degree of success can it really have? Do we merely pay lip-service to the need for more preventive services and health education, or is there a chance that more vulnerable groups can actually become better protected from risks to their health?

According to the Government, CHCs have a special responsibility for promoting developments in this area, and the recently published consultative document: *Prevention and Health: Everybody's Business* puts forward several ideas that CHC will want to think about.

The old favourites—smoking, alcoholism, car seat belts, obesity and fluoride are only part of the story, however. Promoting health does not only mean reducing the number of deaths from heart attacks, strokes and road accidents. It does not just mean smoking and drinking less, eating a balanced diet and taking more exercise.

Looking after health also implies the ability to recognise the difference between illness and health. It means knowing when to go to the doctor about a particular symptom, knowing what to do with the advice you get, and in some cases, knowing whether you can have any influence over some things that may happen in your body. The booklet says, " . . . where resources are limited, there is an unanswerable case for concentrating them where they can do the most good" but the question is, how to decide what qualifies as the most good.

The actions of the health service in "doing good" are not entirely praise-worthy because as the booklet points out, " . . . the growing complexity of medical investigation and treatment has increased the risk of disease and injury resulting from the actions of doctors, nurses and technicians."

Screening programmes are difficult to be sure about because some groups are at greater risk than others, so getting value for money implies restricting the programmes to them alone. What happens to the principle of equality of access to medical care then?

A very positive suggestion that makes good sense concerns the evaluation of statistics. If you know that local figures for a particular aspect of the health service exist, you can then proceed to compare them with those for other areas, other regions, other countries. Then you can ask why the differences between them exist and whether or how the causes of the difference could be influenced. That will enable you to see who is best placed to take the appropriate action.

Improving out ability to protect our health is not going to happen suddenly nor is it going to happen of its own accord. The booklet asserts that prevention is better than cure, but that the burden of deciding how to safeguard health when available resources are limited, rests essentially with the individual.

CHCs will want to read this booklet carefully and discuss its implications with different interest groups in their localities as well as with the health authorities themselves. Clearly there is a chance, with the currently receptive atmosphere in the health departments, to achieve some real advances in thinking about sensible ways to improve health education, so CHCs will want to be in the front line of the effort.

BOOK REVIEWS

AWAKENINGS

by Oliver Sacks. Penguin, 1976, £1.00

This is a remarkably extraordinary and exciting book which will leave you feeling quite changed once you have read it. On one level it is the story of 20 people who live in an institution near New York. Their bizarre lives are those of individuals who, in the 1920s, were the victims of a virus epidemic which was known as the "sleeping sickness". The symptoms of their illnesses have something in common with Parkinson's disease, yet they have suffered stranger and more extreme physical and emotional disorders than that syndrome alone produces.

Dr Sacks writes the stories of these people who were under his care in the late 1960s and early 1970s. The drug L-DOPA first became available during that period, and its arrival was heralded as a miracle—"the wonder drug"—that could at last cure Parkinsonism. His patients were each given L-DOPA — and expanded, exploded, took off and broke loose from the chains of the sleeping sickness. This was their "awakening" in which they found a normality of great depth and substance. Some short time later, in quite idiosyncratic ways, they each went through a period of troubles and difficulties — in many cases far worse than their original diseases had produced.

Finally, after these tribulations, they found their own ways of coming to terms with their need for what positive good the drug could do for them coupled with the damage and distress that it could create with equal or even greater force. This was their period of accommodation in which some have survived to live into their old age, while others died. What the book shows is that people really can experience extreme physical and emotional states within their bodies which, although appearing terrifying and intolerable to the reader, did not prevent them from keeping their sanity and stability—their place in the world. Sacks forcibly reminds us that our brains are chemical factories and control towers which contain our muscular movements, our thoughts, feelings and wishes, our sleep and our imagination for as long as we are alive. Some of these patients were apparently dead to the world—they had not uttered a word, exchanged a glance or physically moved for decades—for as long as 50 years. Yet the L-DOPA changed them as no-one could ever have predicted, and made them whole again, only to split them into greater or smaller fragments subsequently.

The book should be read not only by those who are professionally concerned with the disorders of the nervous system, but by anyone who wants to understand what can be meant by such concepts as health, illness, normality and cure. Dr Sacks demonstrates that "What we do see, first and last, is the utter inadequacy of mechanical medicine . . . " and that " . . . health goes deeper than any disease."

BIRTH WITHOUT VIOLENCE

by Frederick Leboyer. Wildwood House, 1975, £2.95

This beautifully designed and illustrated short book sets out some fascinating ideas on the birth of babies, which have made it a world-wide best seller in the past two years. It challenges conventional practices on the grounds that these are designed to satisfy only the mother, the doctors and

nurses—everyone except the baby. Dr Leboyer suggests that the birth process is a violent and shattering experience for the baby, and that several things should be done to minimise the shock resulting from this forcible expulsion out of the familiar safe environment within the mother to the brash world outside.

The birth should be conducted in a quiet room, not brightly lit, the umbilical cord should not be severed immediately, and the baby should not be held upside down by its ankle and slapped to make it cry. Dr Leboyer's agrument really rests on this cry. He feels it indicates the baby's distress, and should not be necessarily regarded as the natural requirement.

He says the sense of touch is all-important so the baby should be placed immediately on its mother's abdomen where it can feel her warm familiar shape, and, as the oxygen supply changes over in its own time, the cord can then be cut. The baby should not be wrapped up immediately, but after the mother has held and stroked it, it can be supported in a warm bath of water before being laid on its side in a warmed soft cotton cloth.

These are only some of the book's ideas—whether they are right or wrong is hard to say, but they certainly encourage a fresh look at the way we expect birth to be managed. It would be instructive to discuss some of them with obstetricians, midwives and mothers and fathers.

THE INCOMES OF THE BLIND

by Fred Reid. The Disability Alliance, 1975, £0.60

Blindness brings with it substantial additional living costs which are rarely offset by the current statutory concessions and allowances. "The Incomes of the Blind" provides a useful analysis of the meagre and often inequitable provision of financial assistance for blind people under the present system, and makes constructive recommendations for intermediate and longer term measures to alleviate the problem.

Written by Fred Reid, former President of the National Federation of the Blind, the booklet examines the inconsistent and unsatisfactory nature of the present situation:

"Provision for the blind is fraught with many anomalies which result in people who have exactly the same impairments receiving different benefits and, in many cases, no benefits at all." Those who are employed are allowed tax relief on £180 of their income. This is less in real terms than the £100 on which relief could be claimed when the measure was introduced in 1962. And many blind workers do not earn enough to warrant tax deductions being made in the first place.

Those on supplementary benefits are given a standard addition of £1.25 in respect of blindness. Again, this represents a decrease in real terms since the allowance was introduced. (The rate in 1948 was 75p; it has been increased in the 28 years since by only 66%. Standard rate benefits have increased by 700% in the same period.)

Blind workers with low earnings, married women, and many retired people receive no help at all. Mr Reid suggests that in the longer term, this piecemeal approach should be replaced by the introduction of a national disability allowance: a comprehensive supplement to the income of blind people (either a realistic blindness allowance or a disablement allowance payable to all registered blind people on the basis of the degree of limitation of their activities). Meanwhile, the government should take immediate steps to end the existing anomalies that give some blind people help and refuse it to others.

Joint care planning

Health Circular HC(76)18

This circular indicates a crucial development in health care planning by spelling out the activities required to get joint planning and financing going between the health and local authorities.

This method of collaboration is "vital to the Government's overall strategy of developing community-based services to the fullest extent practicable so that people are kept out of hospitals and other institutions and supported within the community". It particularly concerns services for the elderly, the disabled, the mentally handicapped, the mentally ill, children and families, and the socially handicapped such as alcoholics and drug addicts. The basic theme is to encourage true collaboration between health and local authorities so that each contributes to all stages of the other's planning, otherwise the authorities will not feel equally committed to joint plans.

JCCs must identify the client groups and services requiring joint planning and establish the priorities between them. When these have been agreed by the authorities, the JCCs should prepare guidelines for further action.

One Joint Care Planning Team (JCPT) should normally be set up by each JCC in order to co-ordinate plans and proposals from the heath districts to be considered by the JCC. The JCPT must specify both the priorities and the speed of the proposed developments.

Where health care planning teams (HCPTs) have already been set up, AHAs have to ensure that they are working on activities "judged locally to have the highest priority, particularly those bearing on joint arrangements".

The DHSS, in its guidance for 1976/77, suggests concentration on planning for the elderly, people who are mentally ill or

New health ministers named

David Ennals

The new ministerial team at the DHSS as announced by the Prime Minister in April is:

DAVID ENNALS MP (Norwich North)
Secretary of State for Social Services
(1968-70 Minister of State, DHSS 1970-73 Campaign Director, MIND 1974-76 Minister of State, Foreign Affairs)

STAN ORME MP (Salford West)
Minister of State (Social Security)

DR DAVID OWEN MP (Plymouth Devonport)
Minister of State (Health)

DR ERIC DEAKINS MP (Waltham Forest)
Parliamentary Under-Secretary of State (Health and Social Security)

ALFRED MORRIS MP (Wythenshawe)
Parliamentary Under-Secretary of State (Disablement)

Brunel Conference

Underlying many practical problems which face CHCs and those who interact with them is the basic question: What is the CHC supposed to be doing? Exactly where does it stand in relation to those responsible for planning and providing services? What activities are appropriate, which not?

Recent work at Brunel suggests that some progress may be possible, if it is assumed that the CHC's point of departure is the experience of people with some specific links to NHS services, rather than the more nebulous idea of 'the community'.

The conference is intended to provide up to 20 people (CHC members and others) with a *chance to work on problems:* it is not a teaching event, nor simply a forum for the exchange of views. The date is Monday 21st June. The fee, including meals and administration, is £13. Applications to Mrs L Drummond, HSORU, Brunel University, Uxbridge, Tel. no. Uxbridge 56461.

Funerals for still-born babies

Last year the DHSS asked health authorities to arrange that after any still-birth occurring in hospital, an offer be made to the parents by the hospital to undertake funeral arrangements on their behalf, free of charge.

Circular HN(76)18, issued in February, asks that similar arrangements be made with regard to still-births occurring in the community where the health authorities' services are involved, and suggests that the midwife attending the mother is in the best position to make such an offer.

Sale of Painkillers

Painkilling tablets containing aspirin, aloxiprin and paracetamol should be barred from open sale in shops, supermarkets and pharmacies. This is the suggestion put forward in a consultive document issued by the DHSS last month. If its recommendations are accepted, the maximum number of tablets in a pack will be 25, customers will have to ask the chemist for them. Packets will have to carry a warning of the dangers.

The sale of eyedrops and ointments in shops other than pharmacies will also be banned, and more medicines — such as digitalis and bromide — will be available only on prescription.

The Government's consultative paper is being circulated to medical, pharmaceutical and consumers' organisations. Pharmaceutical manufacturers have opposed the suggested changes on the grounds that accidents and overdoses will not be reduced as it will still be possible to buy several packets at one time.

It is also feared that small general shops and supermarkets might no longer stock analgesics if they feel that the new rules are too restrictive. This may have implications for people in rural areas where medicines can already be difficult to obtain.

See Editorial p5.

DMT Minutes

In response to a question from Laurie Pavitt, (Labour MP for Brent South) Dr David Owen said that the Secretary of State would not issue instructions to ensure that minutes of District Management Team meetings are sent to Community Health Councils.

Dr Owen said that the Department felt that the means by which CHCs are kept informed of the activities and deliberations of their DMT were best left for local agreement. He also pointed out that a directive was already in operation whereby a DMT spokesman should attend CHC meetings when invited, and answer questions in public session.

CHCs spend their savings

Continued from Page 1

service scheme they thought desirable to finance, with the agreement of their DMTs.

At Havering, the members decided to pick patient-oriented schemes, and chose the purchase of some large paddling pools for a hospital OT department catering for children with multiple handicaps, colour TV sets for old people's wards in a psychiatric hospital, and a lighting circuit for the discotheque run by the patients there.

Medical equipment appealed to Newham CHC and they were given a long list of items by the DMT, from which they chose nine. Of these, 2 medic baths and a ventilator/resuscitator were to go to St Andrew's Hospital, which the CHC regards as a considerably deprived unit.

The members of NE Essex CHC were not entirely in agreement about the arrangement, and they wondered whether the unspent money should simply be returned to the Region. Nevertheless, they decided that King's Fund beds, the construction of cubicles in a ward for terminal patients, wardrobe lockers and a geriatric chair lift were items worthy of their attention. North Camden CHC on the other hand used the opportunity to find amenity schemes by holding discussions with local NHS staff and inviting suggestions from outside people. They discovered that family health clinic staff had not been able to obtain a number of basic items, and the DMT readily agreed to provide these immediately from the regular budget.

The CHC chose new carpeting for the geriatric hospital, car coats that the men could wear on outings, and giant magnifiers to assist reading. They also took up a voluntary organisation's suggestion to buy large inflatable toys for mentally handicapped children, but at first the RHA refused this—since it was a donation to a body outside the NHS. However, the CHC persisted, and the RHA did manage to get DHSS approval. South Camden CHC has also nominated items which are less directly concerned with the NHS itself, and has chosen to make a contribution towards the cost of decorating a halfway house for ex-psychiatric patients, and towards the cost of a playbus for mentally handicapped children.

Not all the CHCs feel quite happy with this rather unexpected chance to decide how sums of money should actually be spent. Some were critical of a budgeting system which allows such an opportunity for underspending and thought it discouraged careful financial planning. They also found the time allowed for nominating these ideas for spending was too short. Others were delighted to be seen to be involved in providing amenities for local hospitals, and thought it was a good public relations exercise. The scheme may continue in future, since Mr Joines at the RHA feels it is important to give the CHCs a measure of "executive" power.

St. Augustine's inquiry brings wider changes

In addition to accepting the report of the St. Augustine's Hospital committee of inquiry, Dr David Owen has announced that the Hospital Advisory Service is to be renamed HEALTH ADVISORY SERVICE. It will still concetrate on long stay services, but will include social workers in its visiting teams, and will cover community services as well as hospital services. The new HAS will have direct and closer contact with the authorities involved at local level, particularly through active follow-up of the reports it issues after a visit.

It will resolve problems and difficulties locally wherever possible, but where matters give rise for concern, the HAS will be expected to make full use of its right of access to Ministers.

In next month's CHC NEWS there will be a special article on the HAS.

Let CHC NEWS know about changes in your Council's membership and staff. If there are appointments or retirements which your CHC would like mentioned in the paper, please ring 01-262 2641 Ext. 57.

Staff vacancies can be advertised free of charge in CHC NEWS.

Regional Security Units

At the same time, Dr Owen has also stated that there is a great shortage of specialised secure accommodation. Special financial allocations of £2.5m for capital and £4m for revenue spending will be made available to RHAs each year, starting this year, to assist them in improving this accommodation.

News from CHCs

- Local residents worried about the inaccessibility of their one remaining pharmacy decided to approach Rotherham CHC for advice. Secretary, Robert Payne, helped them to organise a public meeting, at which a Community Participation Committee was formed to collect data for an approach to the FPC.
- Mr J. Mather, Secretary of Barnet and Finchley CHC has produced a dictionary of National Health Service abbreviations, to help his members through the maze of initials they are likely to encounter in the course of their duties.
- Brian Marshall was appointed Secretary of South West Leicester CHC on 1st March.
- West Roding CHC's new Secretary, Jacqueline Castles, took up her appointment on April 20th.
- South Hammersmith CHC has a new Assistant Secretary. Linda Couldrey has been in post since April 26th.
- Enquiries to North Tees CHC have increased since they began a joint advertising campaign on local radio with five other CHCs in the area. Their 45-second advertisement describes how members of the public can make use of a CHC, and where they can find their local office. It is being broadcast on Radio Tees five times each week for six months, and is costing the CHCs £300 each.

Directory of CHCs

A Directory of Community Health Councils is being issued by CHC NEWS. It contains names, addresses and telephone numbers of all the Community Health Councils in England and Wales, and the names of their chairmen and secretaries. There are also details of regional groupings of CHCs and CHC secretaries.

Some of the information in this Directory is bound to become inaccurate, particularly as CHCs move into their permanent accommodation. Please notify the Editor of CHC NEWS whenever an entry needs updating — corrections can then be published in CHC NEWS for people to amend their own copies individually. The price of the Directory is 60p. Cheques and postal orders should be made payable to: "King Edward's Hospital Fund for London", and sent with orders to: The Editor, CHC NEWS, 24 Nutford Place, London W1H 6AN.