CHC NEWS

For Community Health Councils

June 1976. No. 8

Photo: Chris Davies

CHC member on Royal Commission

Ann Clwyd, member of Cardiff CHC, has been appointed to the Royal Commission on the NHS. She was a member of the Welsh Regional Hospital Board from 1970—74, and is concerned that the health service management should be properly accountable to the public. She is hopeful that CHCs' influence will grow in the future, but *feels that their impact so far, particularly* on the public, is not yet sufficient.

Ann Clwyd is a journalist and broadcaster, Welsh Correspondent of the Guardian, and has fought two elections as a parliamentary candidate. CHCs have been invited to submit preliminary evidence to the Royal Commission. The terms of reference are: "To consider in the interests of both of the patients and of those who work in the National Health Service the best use and management of the financial and manpower resources of the National Health Service". Evidence should be sent to The Secretary, Royal Commission on the NHS, Commission House, 20 Grosvenor Hill, London W1X 0HX.

GRANT GIVEN TO CHCs FOR EXTRA STAFF

Worthing CHC has just got seven new *members of staff — and their wages are* being paid by the government! They will be working on a special survey of community care for the elderly, and the project lasts for 13 weeks.

The survey has the approval and support of the AHA, DMT, FPC and Local Medical Committee, who have undertaken to use its findings and phase them into their plans for local services for the elderly. The questionnaire has been designed with help from experts at Graylingwell Hospital and Sussex University.

This remarkable opportunity has arisen because of the government's Job Creation Programme. It was launched last October and lasts until next March, with a total grant of £70m (unless there is a decision to extend it). The aim is to alleviate the worst effects of the high rate of unemployment, and the programme operates through the Manpower Services Commission. Short-term jobs of social value for those unemployed people who would particularly benefit from and be willing to undertake such work is the theme of the Job Creation Programme (JCP).

Action committees have been set up in the 10 areas of Great Britain, consisting of local employer, trade union and local authority representatives to consider each application.

Sponsors (people or organisations wanting to take advantage of the JCP) have to fill in a detailed form stating what kind of work will be undertaken, how many and what types of employees are required, what worthwhile service the project will provide for the community, what training and further education opportunities it will provide for the employees, the hours, wages and other costs of the project, the arrangements for supervision and financial control, any materials and equipment, and so on.

If the area Action Committee approves the application then the sponsor has to recruit the employees from the unemployment register, and accept full responsibility for them during the course of the project. The full cost of wages and National Insurance contributions will be reimbursed by the Manpower Services Commission into a special bank account that sponsors have to open for the purpose. Up to 10 per cent of the wage costs will, in addition, be paid towards administration and materials for the project.

The priority conditions for acceptance of a sponsor's application are: (1) that the project should provide benefits to the community; (2) that it should provide short-term work for people who would otherwise be unemployed, particularly those under 20 and over 50 years of age; (3)

Continued on page 12

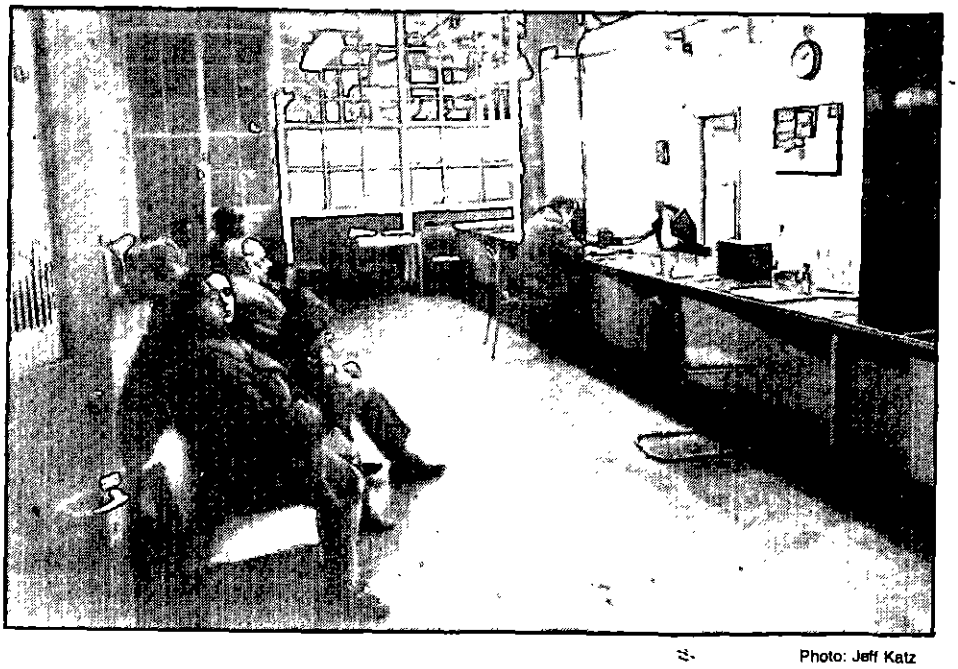


Photo: Jeff Katz

YOUR LETTERS

NEW FORMAT OF CHC NEWS

from Ivana T. Cooke, Secretary South Hammersmith CHC.

I was rather disappointed in the new-style CHC NEWS. Although initially the "tabloid" appearance is certainly more attractive, I think it encourages us to treat it as a newspaper — and no one reads every word of a newspaper. Previously I used to study the sober magazine in the belief that every word would do me good; now I'm tempted to skim through. A list of contents was useful for checking back, too. I find the confusion of type-styles visually irritating: a small page cannot carry half a dozen sizes and designs, and the thick lines are also distracting — especially when they are at the top and bottom of a page. Photos can add to the jumbled appearance by fragmenting small articles.

Possibly there is the dilemma of trying to produce something to interest the "occasional" CHC member, as well as to give meaty information for the Secretary and Assistant. I feel that your editorial policy may be forced to choose between these two, and I wonder what other people think?

CHCs' ROLE AT ENQUIRIES

from W. Ashworth, Chairman Burnley, Pendle and Rossendale CHC.

This community Health Council and other CHCs in the North West and the North West Association of CHCs have plugged away for some time now to persuade the Government to tell us its intentions about the Davies Committee Report, so we were glad to see the recent statement of Government views and your reference to it in your April editorial.

There is another related issue which is important. This is what role the CHC can or should play at hospital enquiries. During a hospital enquiry in our district where the circumstances had arisen before we had been established, we discovered that we had no right even to attend, let alone participate. Not only does this seem wrong in principle, but it certainly affects the public credibility of CHCs.

As a result we have suggested to the DHSS that CHCs ought to have the right to attend and to take part in various ways in such enquiries. The Department has promised to consider this suggestion and we think that CHCs generally ought to give this topic careful and serious study before other CHCs find themselves in our difficult position.

CLOUD-CUCKOO LAND

from Pauline Phillips, Secretary East Herts CHC

Your article in the May issue of CHC NEWS intrigues me. In just what cloud-cuckoo land is Professor Stacey living? CHCs can, of course, ask for information about comparative costs of home care as against intensive care for heart patients — but what will they do with the answers? GPs will continue to keep patients at home, or send them to hospitals, according to the dictates of their own clinical judgement, and consultant physicians will continue to exercise **their** clinical judgement with regard to admission, treatment and discharge of these as of all other patients. If it has proved impossible, in spite of lengthy attempts, to get the medical profession to agree on standardised medical records, is there any likelihood of achieving any greater success in a field more closely associated with day-to-day patients care and the excercise of clinical judgement?

NATIONAL CONFERENCE OF CHCs

from T. J. Hutton, Chairman Harrow CHC.

I write in support of the views expressed by the Chairman of Kings CHC in her letter appearing in the April issue of CHC NEWS. It was with incredulity and dismay that I read the Minutes of the Steering Committee setting out the arrangements they proposed to make for the Conference, from which it seems that the sole purpose will be to agree a constitution.

Surely the major questions to be determined are: (1) Do the majority of CHCs want a National Body? If so, (2) Do they want it now? Consideration of the draft constitution will only be required if the answer to both questions is affirmative. It would be damaging to the reputation of CHCs if an Association was foisted on them irrespective of their wishes, or if it proved to be a body which a majority could not support or from which many resigned because of disagreements. I am not prepared to concede that the Steering Committee knows better than individual CHCs what is good for them, but I am quite willing to abide by the wishes of the majority.

I urge its members whom I believe to be well-intentioned, dedicated and gullible people, to stop acting as if they wished to steam-roller all opposition and to allow CHCs a free discussion at the Conference on the fundamental issue, which is whether or not a National Body is wanted by early 1977.

NATIONAL ADVERTISING

from John Holden, Secretary King's Lynn CHC.

The Secretaries of the East Anglian Region of CHCs at a recent meeting discussed the need for some form of national advertising for CHCs. It was pointed out that the Scottish Home and Health Department have shown initiative by producing a leaflet and posters which can be used by all Local Health Councils and it is felt that there is great need for a similar central publicity campaign in England.

CHC BUDGET

from Minnie Kidd, Chairman St. Thomas's CHC.

The St. Thomas's CHC recently wrote to the Regional Health Authority with the following statement: ". . . that in order to control and manage its own resources, the St. Thomas's CHC requests the South East Thames RHA to finance the Council by way of an annual grant based upon estimates prepared by the CHC, the amount of which shall be announced by the beginning of a financial year, and that following such arrangement resolves: (i) to open its own banking account (ii) to have submitted to it periodic financial statements, and (iii) to include an audited statement of accounts in its Annual Report.

In reply, the RHA stated that the provisions of the NHS Reorganisation Act 1973 (Sec. 47 and S.I. 2217) Reg. 17, precluded any departure from the present arrangements. We would like to know if other CHCs are interested in controlling and managing their own resources in the way described, and what action they have taken on this question.

PRIORITIES?

from Dag Saunders, Secretary Salop CHC

There can be little doubt that the recently produced consultative document "Priorities for Health and Personal Social Services in England" is of major importance to CHCs. This document will inevitably form the basis of considerably detailed discussions at district and area level. It would therefore seem unfortunate that copies of this document were not sent to CHCs for distribution to members, although it is understood that copies should have been available to all members but owing to printing difficulties they are still not able to give a date as to when these will be available.

Although final comments are not requested by the Department until the end of October, the Department expects that RHAs will be able to outline the main points coming forward from the Regions and Areas during June. This would now seem to be totally impossible as far as CHCs are concerned and councils may well feel the need to request a change of timetable on this matter.

We welcome all letters from our readers but request that they be kept short so that as many as possible can be included. We reserve the right to cut any contributions for reasons of space, and particularly those over 150 words.

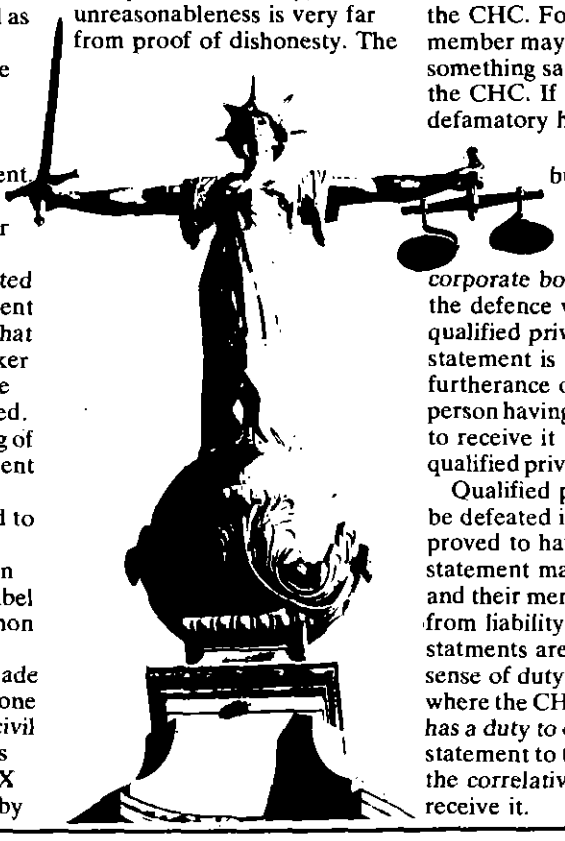
The Law of SLANDER & LIBEL

by Alex Kelly, Barrister at Law, part-time Lecturer in Law at The Nuffield Centre for Health Service Studies.

Sometimes a member of a community health council becomes aware of criticism of a doctor, a nurse, indeed of anyone in the National Health Service. The matter of complaint may appear to have implications beyond the particular case and yet the outcome appear uncertain. It may be that for an individual member to raise the matter in the CHC meeting would require that he make a statement defamatory of the officer whose behaviour is in question. In such cases it frequently happens that the person uttering the defamatory statement cannot prove it to be true. Does this then imply that CHC members must not make statements the truth of which cannot be proved? If so, then the field for legitimate criticism would be greatly narrowed. We frequently have to make statements which we honestly and on reasonable grounds believe, yet for the truth of which we lack sufficient evidence. This does not mean that we are ever entitled to tell a lie. We are not, however, required to be able to prove the truth of a statement in order to be entitled to utter it. In short we may be privileged to state that which is false but not dishonest.

We have been hinting at the law of slander and libel, the two species of defamation. Defamation may be defined as the element of a statement which causes a person to be held in contempt or to be shunned. It is commonly asserted that a defamatory statement is a false statement, this does not appear to be correct. Defamation true or false remains defamation. What can correctly be asserted is that a defamatory statement is presumed to be false and that on proof of its truth the maker of the statement will not be liable to the person defamed. To amount to the civil wrong of slander or libel, the statement being defamatory must be published or communicated to a third party (i.e. a person other than the defamed). In slander spoken words, in libel written words, are the common means of communication.

Once a person (X) has made a statement defamatory of one person (Y) to W, then the civil wrong of slander or libel is complete. How then may X defend himself if charged by Y? He may allege the truth of his statement; or he may claim qualified privilege; or, in a matter of public concern, he may plead fair comment. The first exerts on the defendant a heavy burden of proof; for he must prove his statement to be at least substantially true. Fair comment on a matter of public knowledge (e.g. a theatrical performance or the activities of a public figure) applies particularly to newspapers. The comment must be fair, but that only means "honest" however vituperative and unreasonable. Of course, that a statement is unreasonable may be some ground for doubting the speaker's honesty, but unreasonableness is very far from proof of dishonesty. The defence of special importance to individual members of community health councils is Qualified Privilege.



"Privilege" is absolute or qualified and means immunity from legal liability for a defamatory statement. Only persons can be defamed or defame. A CHC is in law a person and could be liable for libel or slander, provided the defamatory statement should be imputed to the CHC as such rather than to an individual member.

Where an individual member makes a defamatory statement he or she may be liable personally as where the statement is not imputable to the CHC. For example, a member may report to a friend something said at a meeting of the CHC. If the statement is defamatory he or she may be liable personally, but the statement could probably not be imputed to the CHC as a corporate body. In any event, the defence will be one of qualified privilege: if the statement is made in furtherance of a duty to a person having a proper interest to receive it the defence of qualified privilege will be valid.

Qualified privilege can only be defeated if the defendant is proved to have made the statement maliciously. CHCs and their members will be free from liability only when their statments are made from a sense of duty in circumstances where the CHC or the member has a duty to communicate the statement to the person having the correlative interest to receive it.

Surgical Appliances

Orthotic appliances are designed to control deformities, protect tissues and restore function. In the past, people suffering from poliomyelitis and bone TB were the commonest users of orthotic appliances. Today, strokes, cerebral palsy, spina bifida, fractures and skeletal abnormalities are the main causes. Appliances include surgical shoes, calipers and corsets, and 90 per cent of them are manufactured by commercial contractors, the rest being provided by hospital workshops. It is estimated that during 1974 over four million appliances (including repairs and alterations) were provided under the NHS in the UK.

On 7th May a conference on the Orthotic Appliance Service was called jointly by the DHSS and National Fund for Research into Crippling Diseases. It discussed the need for an improved teamwork approach and development of training opportunities for orthotists — the skilled fitters of appliances.

Miss Peggy Jay (Chairman of the British Association of Occupational Therapists and author of the Consumers' Association's "Coping With Disablement") reported on a survey she had conducted into what patients thought about their surgical shoes, lumbar supports and long leg calipers. One third of the sample had no wearable appliance — or one only, even when they needed a second appliance and were clearly entitled to one under NHS regulations. Many felt their appliances were old-fashioned and ugly, and drew attention to their disability rather than minimising their handicap. Patients felt that orthotists were sometimes unwilling to alter an uncomfortable or ill-fitting appliance, because it would cost their firm money; many patients were altering their own appliances. Several thought their appliances would work better if they had direct contact with the person who made it and would later repair it. Finally, those patients who had worn their appliances for a long time felt there had been a lack of adequate medical supervision.

The conference sought to bring orthopaedic consultants, orthotists, manufacturers and DHSS officials together to improve understanding and education. Alf Morris, Minister for the Disabled, stated in his opening address that the DHSS would be reviewing with RHAs and AHAs the state of the orthotic appliance service with a view to improving its quality and encouraging good practice.

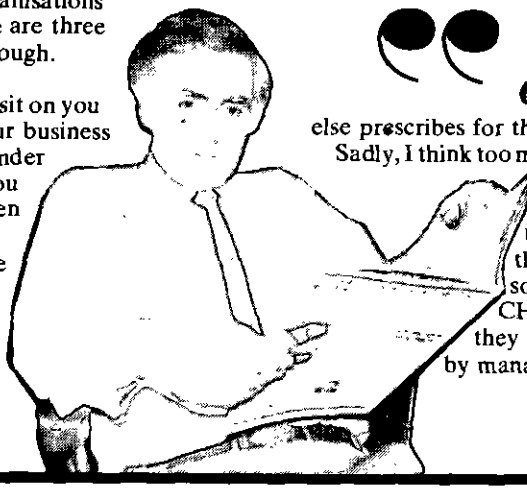
PERSONAL

In my view, the Health Service is for us all, the public. We pay for it and the people who work in it are our employees, all of them. Therefore it is the public who should be making the basic decisions on the sort of health services they require from their resources. If we CHCs fail to put ourselves over to the public, and therefore fail to represent them properly, this will largely be due to our own lack of courage rather than the inadequacy of the powers invested in us. I feel we have considerably more muscle than is often supposed, and that we could move into the heavyweight class if we became more skilful at interpreting the powers given to us by statutory regulations.

Our duty is to the public and if we can obtain improvements in our health services by co-operation with regional, area and district officers, so much the better. But we may have to make ourselves unpopular with them if we are to protect the public interest, and this should not be avoided. Wages for senior people in the public services now compare very favourably with the private sector so we should be expecting a very high standard of management — but we are not getting it.

There is a great parallel between a CHC and a trade union. To my mind, a good trade union will kick the managers' pants publicly and openly a great deal of the time because the conflict situation is the right and unavoidable one to be in. If it is to be used positively and constructively, it must also be able to earn the managers' respect and be able to make deals and compromises that give something to each side. This can be difficult and it needs resilience and confidence — but CHCs should feel confident because they have everything going for them.

With new organisations like CHCs there are three stages to go through. Firstly the system — try to sit on you and tell you your business and keep you under control. But if you can resist this then you move into stage two, where they try to suck you in to their world to neutralise you by making you a part of their decision-making process. That is OK if you are big enough, but with only two staff and a limited amount of members' time CHCs are not big enough so they should move into stage three. This is where they insist on defining their own role in their own terms and act in accordance with this identity and purpose rather than the one that someone else prescribes for them.



Are CHCs or are they

Sadly, I think too many CHCs are not yet moving out of stage one, and this is illustrated every time they accept it when someone tells them CHCs have no power, they are not hampered by managerial

SURVEYS PART ONE

In April we sent a request to CHC Secretaries for information about surveys their council has conducted or plans to do. The idea was to help CHCs working on similar problems to make contact with each other so that they could learn of any techniques, difficulties or suggestions, and so make the process of conducting surveys perhaps a little easier. In their replies, some Secretaries have pointed out that the word "survey" can be confusing. It might mean a systematic canvassing of opinion, or an investigation, or a study, or something else, depending on the approach that different CHCs choose to take.

So the lists of CHCs below indicate which councils are actively working on a particular area. They may be surveying opinion using a questionnaire, or they may be studying the area in other ways. The headings are broad, and include councils working on different specific aspects of the whole area. Some CHCs will have finished their particular project, others will be planning it or in the process of carrying it out. We hope you will find this information useful, and we are grateful to Secretaries for completing and returning the request form. Any uncompleted forms are still welcome, and we can update and add to these lists later, if this would be helpful. Part Two of the replies will appear next month.

ABORTION: City & Hackney, North Warwickshire, Rhymney Valley, Lincolnshire, North, Kings, Havering, Kensington & Chelsea and Westminster South, Hartlepool, St. Thomas's, Coventry, Dudley, King's Lynn, Lewisham, Liverpool Central & Southern, Wakefield Eastern, SW Herts, South Hammersmith.

ACCIDENT & EMERGENCY SERVICES: Rhymney Valley, Brent, Liverpool Central &Southern, Lewisham, Dudley, Wakefield Eastern.

ALCOHOLISM: Coventry, King's Lynn, South Gwent, SW Herts, Kensington & Chelsea & Westminster North West, West Dorset, Maidstone, Lewisham, Exeter.

AMBULANCE SERVICES: SW Herts, West Surrey, East Somerset, Leeds East, Dudley, King's Lynn, Lewisham, Rhymney Valley, Stockport, Wakefield Eastern.

BOUNDARY/OVERLAP PROBLEMS: Rhymney Valley, Stockport, Dudley, King's Lynn, Lewisham, Hartlepool.

THE CHC: SW Herts, Rhymney Valley, King's Lynn, Kensington & Chelsea & Westminster North West, Lewisham, Liverpool Central & Southern, Wakefield Eastern, Haringey.

CHEMISTS' SERVICES: South Tyneside, Swindon, North Birmingham, St. Thomas's, NW Herts, Dudley, Lewisham, Basildon, Liverpool Central & Southern, Halton, Maidstone.

CHILD HEALTH SERVICES: Rhymney Valley, Stockport, Ipswich, Lewisham, South Gwent, City & Hackney, Chelmsford, Dudley.

CHIROPODY: SW Herts, Rhymney Valley, Kings, Southampton, Cambridge, Leeds East, Chelmsford, Coventry, King's Lynn, Ipswich, Lewisham, Liverpool Central & Southern, Kingston Richmond & Esher, North Herts, Dudley.

CLOSURE/CHANGE OF USE: Hounslow, SW Herts, South Tyneside, Rhymney Valley, North Tees, Swindon, Aylesbury, St. Thomas's, Chelmsford, Stockport, Mid Surrey, King's Lynn, Lewisham, South Gwent, Liverpool Central & Southern.

COMMUNITY HOSPITALS: Lincolnshire North, Havering, Southampton, St. Thomas's, Northumberland, Central Derbyshire, King's Lynn, Liverpool Central & Southern, SW Herts, Aylesbury.

COMPLAINTS: SW Herts, Rhymney Valley, Stockport, Coventry, King's Lynn, Lewisham, Liverpool Central & Southern, Dudley, South Gwent, Haringey.

DENTAL SERVICES: Rhymney Valley, Chichester, North Birmingham, North Surrey, Dudley, King's Lynn, South Gwent, North Herts, Lewisham, Liverpool Central & Southern.

SERVICES FOR THE DISABLED: West Surrey, Chichester, Wirral Southern, Central Nottinghamshire, King's Lynn, Lewisham, Kensington & Chelsea & Westminster North West, Newcastle, Dudley.

DRUG DEPENDANCY: SW Herts,

VIEW

Tom Richardson (Assistant Secretary Oxfordshire CHC)

responsibilities and they can derive self-esteem from the fact that they are working for something worthwhile on behalf of the public — what more do they want?

People who work for CHCs or who are on them should see that their activities are legitimate, far-reaching and potentially very rewarding. I think the Ministers are hoping desperately that CHCs will take the

champions of the public - administrators' lackeys?

power that is there, ready for them. One way is through the processing of complaints. We can't always change what went wrong for a particular patient but we can often do so for their successors. For example in the regulations about FPC Service Committees (S.I. No. 455 1974) it is quite clear that anyone can take up a complaint with a Service Committee, not just the person who alleges the wrong. This is an open invitation for CHCs to recognise.

Also, anyone can approach the Health Service Commissioner with the sort of complaint that doesn't involve family practitioners, once the health authorities have replied to it. CHCs should make sure they understand how their opportunities for getting to work on complaints is a vital key to contact with the public.

Then, CHCs must realise that they cannot spread themselves over everything. In their districts or areas they ought to decide to concentrate on half a dozen issues only, but really make sure they do a proper job on the ones they do get in to. On planning, for instance, I don't think CHC members should give their own opinions — which may or may not have validity. They are there to give the public's opinion so that is what they should do. But they should realise that the public — the consumer of any given planning proposal — may not always be the patient alone. It may be a doctor, a technician, a nurse, an ambulance driver, another organisation. The NHS management's task is to draw up several alternative plans for spending a certain amount of money and to submit them to CHCs (and other bodies) which should of right have an influence on them. The social services generally have got to move away from doing things to people and get round to doing things for them and with them.

It is for CHCs to define their own task in the light of their understanding of what the NHS and its management is about. To judge from their minutes and annual reports, it looks as if many of them haven't realised that they are not executive bodies administering a vast budget. That is the job of the RHA and AHA, and members of these authorities are there to do this on behalf of the Secretary of State, not to represent us, the public.

For our part we ought to make the most of having observers at AHA meetings. The CHC representative has every right to speak, shout and roar — the only thing he can't do is vote. He should be sure to be well-briefed, and to have an item about the CHC at least every month in the local press and radio. We ought also to insist on far more than the single annual meeting with the AHA, and we ought to see that our right to be consulted on AHA appointments is recognised.

CHCs have all the power they need; they must accept it, enjoy it and feel strong — that is all it takes.

Kensington & Chelsea & Westminster North West, Liverpool Central & Southern.
SERVICES FOR THE ELDERLY: SW Herts, City & Hackney, Aberconwy, East Somerset, Chichester, Aylesbury, East Herts, Worthing, Leeds East, Chelmsford, King's Lynn, Lewisham, Arfon Dwyfor, SW Leicestershire, Kensington & Chelsea & Westminster North West, West Dorset, South Nottingham, North Herts, Stockport, Dudley, Liverpool Central & Southern, Kingston Richmond & Esher.
FAMILY PLANNING & CONTRACEPTION: Stockport, Coventry, Dudley, King's Lynn, Liverpool Central & Southern, Rhymney Valley, Aberconwy, Halton, Maidstone, North Herts, Central Sheffield, South Gwent.
FLUORIDATION: Winchester, Chichester, Aylesbury, Leeds East, Stockport, Dudley, South Gwent, SW Leicestershire, SW Herts, South Tyneside, North Warwickshire, Isle of Wight, Lewisham.
GENERAL PRACTITIONER CARE: North Birmingham, Kensington & Chelsea & Westminster North East, Southern Sheffield, South Gwent, SW Herts, Chichester, King's Lynn, Havering, Kensington & Chelsea & Westminster North West, Aylesbury, Dudley, Wakefield Eastern.
HEALTH CENTRES: Trafford, Northumberland, Coventry, King's Lynn, Lewisham, Basildon, Isle of Wight, South Gwent, Liverpool Central & Southern, Rhymney Valley, Chichester, Havering, North Birmingham, City & Hackney, Maidstone, Hartlepool, Leeds East, Stockport.

News from CHCs

- 3,500 people visited a two-day exhibition on "Aids to Daily Living for the Handicapped and Elderly" organised by Weston CHC. The exhibition was designed to provide a source of information for all those concerned with the welfare of the handicapped and the elderly, and for disabled people themselves. Displays on a wide range of aids and services were mounted by welfare agencies, the fuel boards and aids manufacturers. So successful was the exhibition that a number of participants have already requested that the CHC repeat the event.
- The provision of a hearing aid clinic in Filey for an experimental period of three months is the result of a request from Scarborough CHC. The CHC was concerned that people were having to pay increasingly expensive bus fares for long journeys just to change a hearing aid.
- A booklet for expectant mothers has been published by Tameside CHC and offered to the AHA for distribution to patients. Rhona White, the author, is a physiotherapist and a member of the CHC. The booklet: "In Answer to Yours" sets out to explain basic ante-natal procedures and to provide answers to the kinds of queries that mothers-to-be raise.
- A 25-minute film about their work has been commissioned by Wakefield Eastern CHC. Made by students from Leeds Polytechnic as part of a film-making course, it shows scenes of CHC meetings in progress, and portrays the CHC's role in local issues. The film is to be shown to local audiences, and the CHC intends to send a representative to answer questions at each screening.
- 17 local organisations were represented at a forum on alcoholism called by Maidstone CHC recently. The function of the meeting was to bring together people working in the field locally, to assess the extent of the problem in the area and to exchange ideas. The meeting was addressed by a local consultant who is Chairman of the Kent Council on Alcoholism.
- Mrs M. Shaw has been appointed Vice-Chairman of Hounslow CHC.
- Dr D. A. Ireland is the new Vice-Chairman of Salop CHC.
- Mrs Jean Coupe has been appointed as the new Secretary of Tunbridge Wells CHC. She has been in post since the end of April, and succeeds Nancy Greenfield who retired recently due to ill-health. Mrs Coupe was previously Vice-Chairman of Brent CHC.

PRIMARY CARE: THE CHC's ROLE

by Dr Ian Tait, Suffolk GP and Visiting Professor of General Practice at University College Hospital.

Medicine has a long history as a successful entrepreneur profession. So successful that in contemporary society its services are seen as a basic right to be ensured by political means. When this happens, the traditional relationship between the profession and society is altered in important ways.

When the British National Health Service came into being in 1948 the profession was committed to the provision of an open access comprehensive medical care service for all. During the last 25 years, it has struggled to reorganise itself to cope with this new kind of relationship. Some of these efforts have been misdirected; some I believe have been no less than heroic.

In the process, what might be called the emotional capital of the profession has been largely exhausted, amid what we now seem to be seeing is a general refusal by the profession to continue to tolerate a situation in which it has to meet ever-increasing demands with resources that seem increasingly inadequate.

This somewhat gloomy picture of contemporary medicine will be familiar to you. I would like to suggest it is not as hopeless as it may appear. The last 25 years have witnessed the loss of some high professional ideals but they have also seen the end of a great many illusions and fantasies about medicine and medical care, and about the relationship between doctors and their patients.

The hope that I see for the future is a hope that will not be frustrated by the inevitable shortage of resources, but works towards a greater degree of shared responsibility in the better use of those resources.

If such a thing is to be possible a new responsibility will be placed on those organisations such as community health councils that can represent the public in the difficult and uncomfortable task of negotiating and agreeing priorities for the use of limited resources. They will have to play their part in doing this for all aspects of the health service, but my particular concern is with their relationship with general practical or primary medical care.

It would be useful to start by looking at what might be called the mathematics of the situation. When the National Health Service offered to the people of Britain an open access medical care service for all, it did so by a very logical if somewhat ruthless method of sharing the number of general practitioners amongst the total population and more or less telling the parties concerned to sort it out for themselves.

The pattern of general practice that has emerged in Britain depends to a very large extent on certain very simple figures. They are worth looking at. If we do this in round terms we come up with these results:

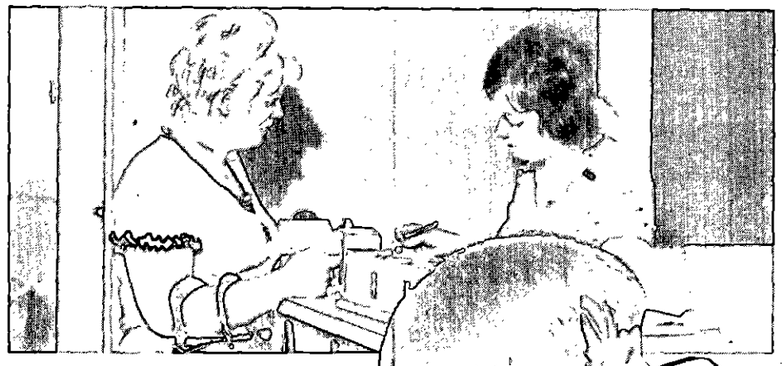
Take a total population of fifty million and divide it amongst twenty thousand general practitioners. This gives an average list of 2,500 patients for each GP. Statistics from general practice give rather variable figures for the number of times that each patient sees their general practitioner in one year, but the overall average is approximately 3.5 times.

This means that on average each GP has 8,500 consultations in each working year. If we make allowances for weekends, holidays, postgraduate study and other work outside the practice, we will be left with a figure of about 200 days in the year in which the doctor can see his list patients. This means that each GP must see at least 40 patients each and every working day.

There are of course great dangers in arguing from such average statistics. But I think they are useful in demonstrating one thing and that is that the resources of general practice, in terms of time, are stretched dangerously thin.

All of us know very well what we want out of our doctor when we are ill. We need someone in whom we can have both professional and personal trust; someone who is not too busy to listen to our fears as well as our symptoms and will be able to understand and meet our particular need for help, whether it be for simple advice or in facing the great issues of life and death.

My father, who was a country doctor, had to cope with the disruption and strains caused to his practice by the introduction of the health service. Many of his private patients became national health patients. I remember in trying to explain to them that things would have to be rather different, he used a railway analogy. Of course, he would tell them, you'll get there in the end, but you'll be travelling third class and that cannot be as comfortable.



Some of them understood, some never intended to. If there were too many people sitting in the surgery waiting room they would come round to the front of the house, ring the door bell for my mother, and ask her if she "would be a dear" and just go and fetch my father so that he could see them in his study like the old days!

I remember it made him very angry and very sad. He would have much preferred to look after a limited number of patients in the way he and they liked. Such a system was not socially equitable, not perhaps even morally justifiable, but it was professionally satisfying. What my father meant by his railway analogy was that neither he nor his patients had any choice other than to spread the resources available more widely, but necessarily also thinner.

I do not think we have recognised clearly enough the extent of the change that is implied both for doctors and patients in the new relationships and new responsibilities imposed by a comprehensive medical care system. Instead of being unconditionally committed to the needs of a limited number of patients with whom the doctor has a personal contract, the GP has now been placed in the situation in which he has to act as the executive agent of a form of rationing system. It is not a role he enjoys or perhaps does very well.

What does all this mean for the future relationship of the CHC to general practice? I believe that the general public now have to assume a much greater responsibility for how we all use limited medical resources. This takes leadership, and that leadership must come from bodies like community health councils.

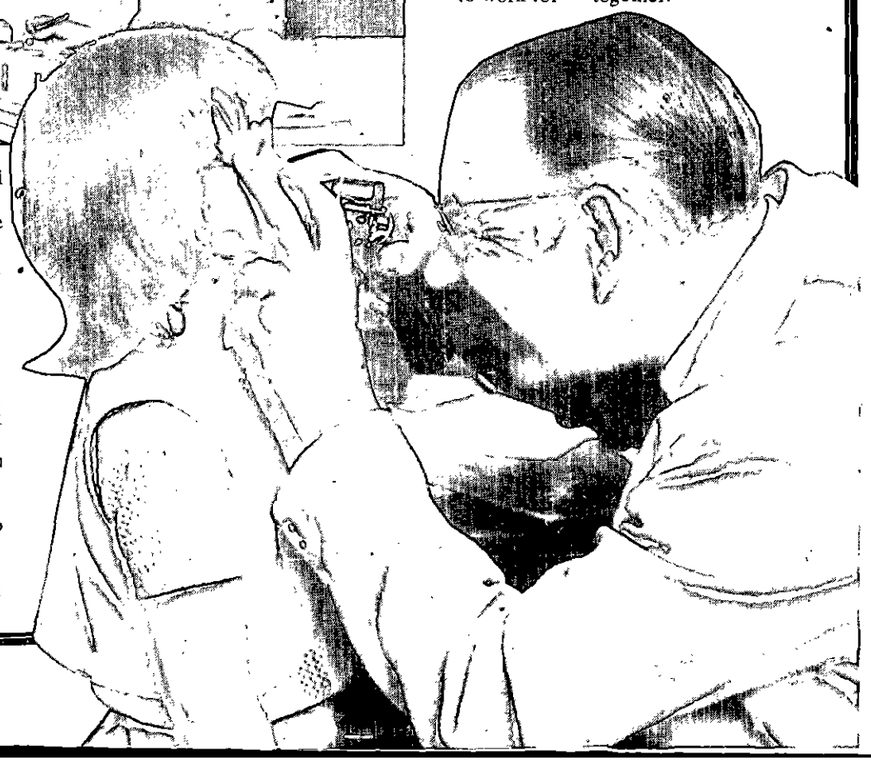
If we look at what I call the mathematics of primary care, we can in fact see that only very few of the figures are capable of significant alteration. For the next 20 years the population is certainly going to get larger and its medical needs will increase as will the proportion of the elderly. It takes ten years to train a doctor so we cannot expect any rapid increase in their number. Perhaps the only figure that can be altered is the number of times the average patient seeks medical advice.

We have to ask — are all these consultations necessary? Could some of the needs expressed in these consultations be met in other ways? To what extent could programmes of health education improve the use of our medical resources? The care of the dependent elderly throws an immense burden onto our community medical services as it does on individual families. To what extent could community self-help groups be organised to meet this most pressing of our health care needs? These are questions that cannot be answered by medicine alone.

Indeed, the message I have for the community health councils is really a challenge that they should become weight-bearing partners in the task of meeting the health care needs of communities. To do this they must convince existing medical organisations that they do more than identify defects from the safety of the sidelines.

They must demonstrate their ability to make an active working contribution to the solution of the problems that they know exist. They must do this not by making more demands for other people's money or time, but by finding ways in which we can all make better use of the unused human resources that exist in all our communities.

It begins to look as though we shall get the medical care system that we deserve. Leadership from CHCs might help us to deserve a better one. It could be as poor as we can afford or as good as we are prepared to work for — together.



EDITORIAL

This month for the first time CHC NEWS has been expanded to 12 pages in the new format. We aim to include ongoing news about the activities of community health councils in different parts of the country, plus factual information about several aspects of the health service, and some ideas or thoughts from interesting people both within and outside CHCs. We hope you will find many items to interest you, and will write in with your letters and articles, queries, suggestions and criticisms.

The other side of our work here at CHC NEWS involves helping individual members and staff of CHCs with their queries. The collection of press cuttings, statutory information and material from other sources that we are compiling has already proved to be of considerable help to several CHCs, and anyone who has not yet made use of this is very welcome to contact us.

One letter on page 2 refers to the DHSS's consultative document on health and social services priorities, which is obviously of interest to CHCs. In response to the suggestion of a CHC Secretary we have produced a draft of a short leaflet/questionnaire which CHCs could use. It explains very simply what the government's priorities are and asks people to give their opinion on the priorities that they would find acceptable. We hope this draft will help those CHCs who want to consult locally on the priorities question — in each region a Secretary has a copy.

CHC NEWS

JUNE 1976 No 8

CHC NEWS is distributed each month free of charge to members and secretaries of Community Health Councils in England and Wales. It is also available to subscribers at £2.50 per annum (or special discount rate if five or more copies of each issue are ordered). Special and overseas rates on application.

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CHC NEWS
King's Fund Centre, 24 Nutford Place, London W1H 6AN.
01-262 2641

Published by King Edward's Hospital Fund for London and printed by The Chesham Press Ltd, 16 Germain Street, Chesham, HR5 1LJ.

BOOK REVIEWS

HEALTH, MONEY AND THE NATIONAL HEALTH SERVICE

Unit for the Study of Health Policy, 1976. (Available from USHP, 8 Newcomen Street, London SE1 1YR, price 60p, including postage).

Has scientific medicine had a satisfactory impact on current mortality rates and the prevalence of disease? Could the commoner forms of disease and death actually be caused by our way of life, and therefore be preventable? Is there sufficient public discussion about the purpose of having health services or about the content of health policy?

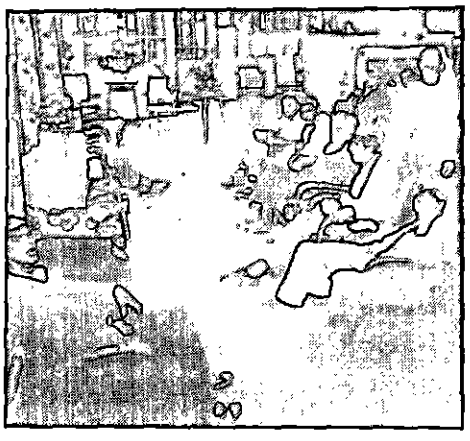
This booklet raises these and several other challenging questions. It carefully examines orthodox explanations of the state of the UK economy and suggests that there is a serious conflict between our desire for health and well-being on the one hand, and our unquestioning commitments to long-term economic growth on the other. The authors see the current goals of the health services centreing on scientific "curative" medicine — a preoccupation with high technology, discovery, intervention and repair of bodily damage. But it is widely accepted that health results from maintaining a sound balance between people and their environment. Psychiatric illness, heart disease, cancers and accidents all present challenges to this balance, where scientific medicine has been surprisingly unsuccessful, as evidenced by figures for mortality rates and the prevalence of disease.

In the author's view this demonstrates the anti-health character of much industrial and social policy, and a need to rethink the proper goals for a national health service. At the moment the NHS is a national repair service engaged in salvaging what is left of people following years of stress, bad diet, over-consumption of alcohol and cigarettes. Indeed, ". . . the pinnacle of achievement in health has come to be equated with the spectacle of men and women becoming over-stressed and under-exercised, indulging in excessive consumption of food, cigarettes and alcohol for a number of years before being rushed to an intensive care unit and submerged in expensive medical technology only when acute symptoms have prevented them from indulging infurther consumption". The authors call for a fundamental reappraisal of prevailing ideas of social progress and a more reasoned approach to ideas of what really constitutes human health and well-being.

THE POOR IN HOSPITAL

by Ann Shearer, (available from The Disability Alliance, 96 Portland Place, London, W1, price 60p inc. postage).

CHCs have an invaluable role to play in checking the administration of financial benefits to patients in long-stay hospitals, says Ann Shearer in this pamphlet. There are over 100,000 people in the country who are permanently resident in psychiatric and mental handicap hospitals. Her study reveals that many of them have no income other than "pocket money" (sometimes as little as 10p per week) allowed to them by the hospital authorities; and that the majority of those who work for the institutions in which they live are still paid well below the rate for the job — despite guidance from the DHSS that reward payments to patients should take account



of the economic value of their work.

"The Poor in Hospital" gives a synopsis of the sources and rates of income available to long-stay patients, and points out the inadequacy of the current provision and the inequalities inherent in it.

Patients who are entitled to contributory pensions and benefits, supplementary benefit, or the new non-contributory invalidity pension, receive a basic disposable income of £2.65 per week: but many elderly people in particular are excluded from these provisions, and are still dependent on amounts of "pocket money" determined by the hospital authorities. Even where there is an entitlement to benefit, the responsible medical officer has the authority to withhold or reduce a long-stay patient's personal allowance if he thinks that the full amount cannot be used for the patient's benefit. The pamphlet points out that the reduction of a patient's income is still used as a punishment in many hospitals, and that in still more institutions, patients are denied access to their own money, largely for administrative convenience.

Ann Shearer contends that all people who live in hospital "should have an absolute right to a small sum of spending money each week, and should be fairly paid for the work they do".

As well as checking the overall administration of benefits, she says CHCs should involve themselves in the provision of a service to individuals living in hospitals: with other interested bodies they should try to come up with an advocacy system fit to be put into immediate action in pilot areas.

BUT WHY CANCER, SALLY?

by Basil Stoll (available from Heinemann Health Books, 23 Bedford Square, London WC1B 3HT, price £1.35).

Written primarily for women, this book is an attempt to put the taboo subject of cancer into perspective. It describes, in a straightforward un-neurotic way what (as far as we know) makes a woman vulnerable to a particular form of cancer. It warns of the factors that may increase the dangers for those with hereditary susceptibility to the disease, and outlines ways of reducing the risks.

As a nation, we are extremely ignorant about cancer. The widespread, but erroneous belief that there is no cure makes many of us afraid to acknowledge the presence of worrying symptoms, and consequently hinders the early diagnosis that is crucial to successful treatment. Basil Stoll advocates a comprehensive cancer education programme, the selective screening of high-risk groups, and — on an individual basis — vigilant self-examination and the avoidance of habits that can foster cancer.

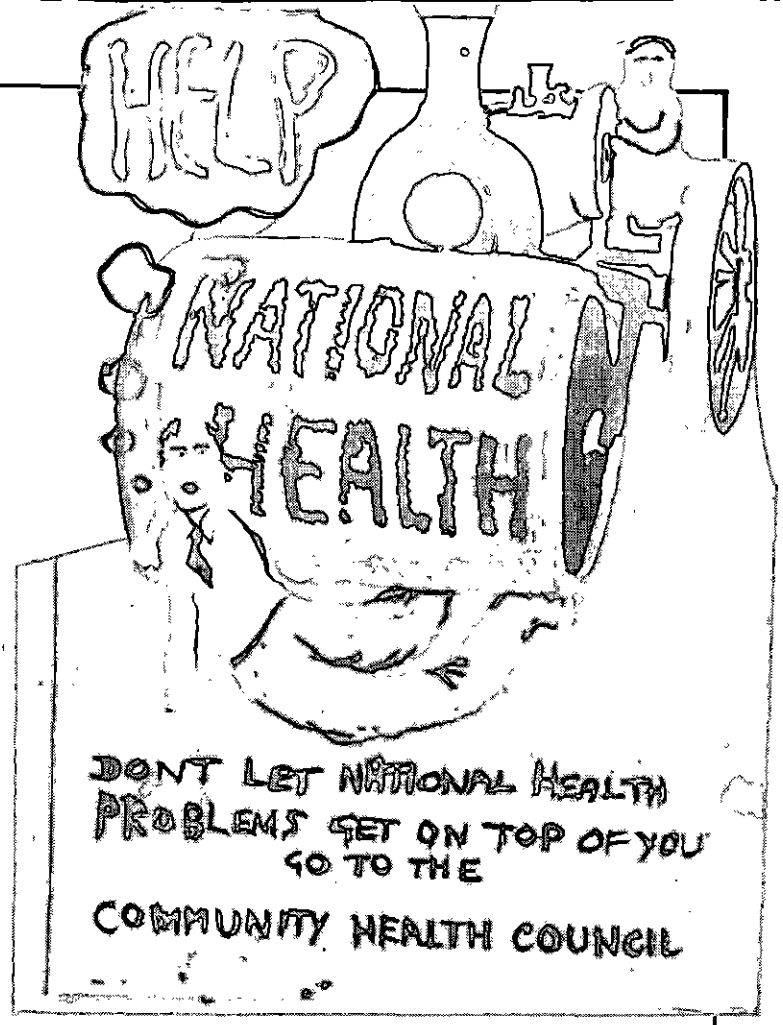
His book describes how cancers develop, who is most vulnerable to them, and what is likely to increase the risks. Almost all readers will be aware that a person's liability to lung cancer is greatly increased by cigarette smoking. Far fewer will know, for example, that early marriage and frequent sexual activity can increase a woman's likelihood of contracting cervical cancer; or that the use of an "obstructive" method of contraception can reduce the risks. On the other hand, sexual activity and childbirth both tend to diminish the likelihood of cancer of the breast, while obesity increases the dangers. Less common forms of cancer are also discussed in some detail.

As an easily understandable analysis of current cancer research, this book is a useful contribution to health education on a subject about which many women are particularly sensitive.

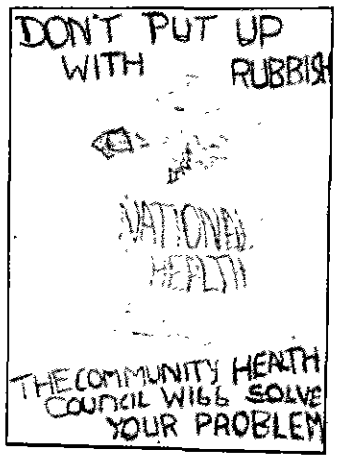
Age Concern Information Pack

Age Concern has produced an Information Pack for CHCs. It is designed to enable CHC members with a particular interest in the elderly to make informed comment on items which may arise. They hope the pack will also be of interest to those directly and indirectly concerned with the health or community care of the elderly. The Age Concern Pack includes abstracts of specialist reports, press cuttings, a quick reference table of statistical sources and a reading list on health. Copies of the Pack are available from: Age Concern England (Dept. H), Bernard Sunley House, 60 Pitcairn Road, Mitcham, Surrey CR4 3LL. Price £1 plus 15p forwarding charge. Payment should be sent with orders.

PUBLICITY THROUGH POSTERS



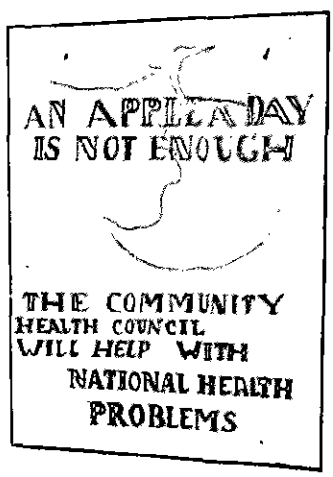
St Helens and Knowsley CHC have found an ingenious way of making themselves known to many people in the area, as well as getting some really exciting and imaginative designs for their own posters. This came about through the CHC inviting children at the local schools to take part in a competition, with prizes for the winners. The task for the children was to design a poster which would make the public want to come forward and contact the CHC.



Tony Richards, the CHC Secretary, wrote to all the Education Departments with schools in the area. He enclosed copies of an introductory letter, rules for the competition and some CHC leaflets, and asked the Directors of Education to circulate these to the head teachers. The letters went out last October and all entries had to be submitted by mid-February. Designs had to be in poster paint or water colour, size 16in. by 11½in. in black and white and two other colours, and each entry had to have the child's name, age and school on the back. The Education Departments were also asked to nominate independent teachers to be judges, and the CHC then wrote to them directly, inviting them to take part. About one week after the closing date in February the judges came to the CHC office where all the entries were displayed, and they made their selections.

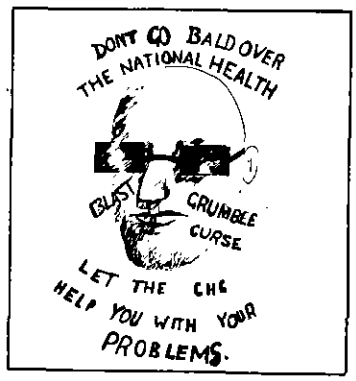
Tony Richards wrote to the winners at their schools inviting them to receive their prize from the Mayor and Mayoress at the Town Hall. In fact, as the CHC covers two district councils, one set of winners was chosen from entrants in St Helens, and another set from Knowsley, and two prize-givings were held: one in each Town Hall with the respective Mayors and Mayoresses officiating. In February all the local papers were contacted and asked to mention the competition and give the prize-giving coverage. CHC members received a note reminding them of the prize-giving dates and the Chairman and officers of the AHA and FPC Administrator were also invited.

On the day of the prize-giving, the posters were put on display in the Town Hall — on exhibition stands borrowed from the Area Health Education Officer Apart from the prize-winning children themselves, their friends and families were also invited, together with the art teachers and other school staff and the press. Refreshments were served and the guests admired the posters on display. Then the Mayor and Mayoress arrived, and the Chairman of the CHC gave a short talk about the CHC and the purpose of the competition.



The prizes were duly presented: a Polaroid Super Swinger Colour Camera for the first prize; a Kodak Instamatic Camera for the second prize, and the third prize was a pen set. The press took pictures of the children and their winning designs, and these were in the next issues of all the papers. The CHC is delighted with the outcome of the competition. Until now their only poster had been one jointly produced very early on by the Cheshire CHCs, and they were not very happy with it. Now they have, apart from the winning designs, over 75 other very good ideas which they can use in the future. But not only did the competition do this, it also made the community health council really mean something to hundreds of children, families and schools in their area. The press coverage has also helped the CHC to reach the general public, and the posters will be on a travelling display in the coming months in public libraries, parish halls and schools.

The CHC covering as it does a huge single-district area with a population of over 350,000 needs a really good publicity effort to make itself known. Tony Richards has no reservations about recommending the idea of a posters competition to other CHCs who want to improve their publicity. It costs very little (the prizes were bought at a discount store) and it has achieved what it set out to do. He would recommend that you give the schools plenty of time to organise their entries and



that you keep in touch with them to see they will be ready in time. This competition specified children should be 14-15 years old (so that the designs would be of a standard suitable for printing) so it was important not to hold it just when the children were busy with CSE and GCE exams.

The new posters are being placed in hospitals, clinics and health centres, and the winning poster has also been used in a half-page advertisement that the CHC took in the main local paper.

Health Advisory Service

At the end of April the DHSS issued circular HC(76)21, announcing changes in the future activities of the Hospital Advisory Service. The details will be summarised below, but first it may be helpful to run through the background of the HAS.

In 1969 the HAS was created as a means of assessing standards of care in long-stay hospitals. These had become a particular cause for concern because it was painfully being realised that patients and staff could be at risk wherever the quality and distribution of care was inadequate. The HAS operated independently of the health departments through four multi-disciplinary teams: two for mental handicap, one for mental illness and one for hospitals for the elderly and chronic sick.

These teams visited hospitals and units all over England and Wales, and inquired into the details of their day-to-day activities. They would spend anything from a few days to a few weeks in one place, acting not as detached experts coming to criticise, but as professionals advising professionals.

After each visit they would write a report which was sent in confidence to the hospital authorities and senior staff concerned, as well as to the Secretary of State. The authorities would then discuss the report with the DHSS and agree on responsibility for implementing the recommendations.

The DHSS advised authorities that because the success of the HAS's approach depended on the confidentiality of the reports and their restricted circulation, CHCs should not be given copies. But CHCs would find it helpful to know what the team's recommendations had been. It was left to the authorities' discretion whether they would release any more details to CHCs who requested this.

In 1972 one mental handicap team was disbanded and a second team set up for the elderly, but when the NHS reorganisation was imminent, HAS activity was reduced to just two teams — one for the elderly and one for mental illness. In July 1974 it was announced that the remit and name of the HAS would be changed so that it could cover the acute hospital sector as well, and consultations on this commenced. Nearly two years later a decision has indeed been taken to change the HAS into the new Health Advisory Service, but along rather different lines.

1. The HAS will now work through joint multi-disciplinary teams with the Social Work Service of the DHSS. These five or six-member teams will look at hospital services, community services and the links between the two.
2. There will be three of these new teams: one for the mentally ill, one for the elderly and one for children receiving long-term hospital care. (Mentally handicapped children will probably be covered by the National Development Group.)
3. Their job will be to encourage and disseminate good practice, new ideas and constructive attitudes and relationships; and to act as catalysts to stimulate local solutions to local problems.
4. Like the old HAS they will not be able to investigate individual complaints or matters of clinical judgement.
5. Before each visit the DHSS and authorities will be asked to supply information about the services to be visited. They will be invited to submit their comments as will be the CHCs and FPCs — who can say if they would like to meet the visiting team. Senior staff of the health and local authorities concerned, JCCs, staff organisations and any other local bodies may be invited to make comments.
6. The team will try to reach agreement during the visit about each issue they raise with the staff. Their full report will go to the Secretary of State and the authorities involved. A summary of the recommendations only will go to the appropriate CHCs.
7. After about six months the HAS will ask the health and local authorities about matters raised in the report which have not been resolved, and may make follow-up visits.

Statistics on the NHS in 1974

The annual Health and Personal Social Services Statistics give an overall picture of the current state of the nation's health services. The latest volume, published in April this year, shows that an increasing proportion of doctors are women, foreign, under 40, or a combination of all of these, and that as patients, it is for nervous diseases and ailments that we are most likely to receive treatment. There is a trend towards shorter stays in hospital, and in most specialities the average stay is now under ten days.

The numbers of medical and dental staff in hospitals have risen by over 40 per cent in the last 11 years. There has also been an improvement in 1974 in the levels of nursing and midwifery staff, although the number of pupil nurses fell and there was a slight drop in hospital ancillary staff. Administrative and clerical staff in hospitals increased by about 9 per cent in the year. (This is partly accounted for by the creation of new functions in the reorganised structure.) Although there was only a slight increase in general practitioners, the number of trainees did rise sharply in 1974, and there has also been some improvement in the distribution of GPs throughout the country. The number of dentists providing general services has risen slowly over the last few years, and the number of persons per dentist has dropped commensurately — although the total number of courses of treatment exceeded the previous year's total by almost one million.

(Health and Personal Social Services Statistics 1975, available from HMSO, £3.80.)

Although there was no change in the number of NHS hospitals in 1974, there was a further decrease in the number of beds available. In-patient admissions increased by 40,000, and the waiting list swelled by 8,000. The number of new out-patients decreased by 9,000, but total attendances increased by 34,000. Over 274 million prescriptions were dispensed in 1974 (almost 4 per cent more than in 1973), at a total net ingredient cost of £204.9m. Of these prescriptions, 81 per cent were for proprietary preparations, and the largest single group was for preparations acting on the nervous system.

On the community health services, the statistics show that a slightly smaller proportion of young children are being vaccinated or immunised against diptheria, whooping cough, tetanus and poliomyelitis, but that a million new patients were seen by the family planning services between April and December 1974.

The numbers of patients resident in mental illness or mental handicap hospitals has been declining steadily over the last four years. Stays are becoming shorter and the percentage of first admissions for psychiatric in-patient care is falling. One marked area of growth however is in the number of patients being admitted with alcoholic psychoses or alcoholism. The major trend in the personal social services over the year included a slight increase in local authority provision of residential accommodation for the elderly, the disabled, and the mentally ill; more children in care, increased day-care facilities for the under-fives, a 50 per cent increase in contributions towards the costs of TV licences, and an increase of almost 25 per cent in the number of people registered as substantially or permanently handicapped.

GP's TERMS OF SERVICE

A doctor's terms of service, when he is working as a general practitioner in the NHS, forms his contract with the Family Practitioner Committee. These are set out in Schedule 1 of S.I.1974 No. 160 [NHS (General Medical and Pharmaceutical Services) Regulations 1974] amended by S.I. 1975 No. 719. It may therefore be useful to summarise some of the obligations imposed on a doctor by his terms of service that are likely to affect members of the public directly. Any complaints made against a GP to the FPC have to be made in relation to the terms of service.

A doctor's duty to his patients is described as being to render "all necessary and appropriate personal medical services of the type usually provided by general medical practitioners". This does not, however, oblige him to provide contraceptive services, or (except in an emergency) maternity medical services, unless he has undertaken with the FPC to do so.

> 22. A doctor acting as a deputy may treat patients at places and at times other than those arranged by the doctor for whom he is acting.

The places and times a doctor holds his surgeries, and any appointments system have to be approved by the FPC. His patients may have to be informed of changes or special arrangements, if the FPC requires it. The GP's responsibilities include: keeping adequate records of the illnesses and treatment for his patients; issuing prescriptions for any drugs, preparations or appliances required for their treatment; and providing normal GP services personally. The doctor does not have to provide treatment personally if he has another doctor acting as his deputy or if he authorises a competent person to delegate for him where this is clinically reasonable.

Apart from medical services, the question of payments demanded by GPs from their patients is also dealt with in the terms of service. Medical services are usually not charged directly to the patient, but a GP can legitimately demand a fee for some immunisations requested in connection with the patient's intention to travel abroad. Circumcision for religious rather than medical reasons can incur a fee, as can a request to attend a patient at a police station in connection with charges the police intend to bring (although in this case the GP could not charge for any treatment administered as a result of his examination).

A charge for treatment can also sometimes be made when there is a dispute as to whether a patient is on a doctor's list or not — when, for example, the patient cannot produce his medical card, and the doctor has "reasonable grounds" for believing that he is not on his list. The terms of service cover more points than have been raised here, and explain them in greater detail. This article just draws attention to some of them, and the original regulations should be consulted for details of the requirements.

> 30. A doctor shall a) keep adequate records of the illnesses and treatment of his patients;

The people a doctor is normally obliged to treat are the patients registered with him, those of a doctor for whom he is deputising, and those whom he is legitimately requested to attend in an emergency. Furthermore, although a doctor may refuse an application for inclusion on his list (either as a permanent patient or as a temporary resident), if the applicant lives in the area and is not registered with another doctor there, he can insist on being given "any immediately necessary treatment" for one period of up to 14 days, or until his is accepted by or assigned to another doctor.

> 13. Subject to paragraph 3, a doctor shall render to his patients all necessary and appropriate medical services of the type usually provided by general medical practitioners.

In the normal course of events, a doctor can only be required to treat a patient at either his practice premises or at the place where the patient lived when he first registered with the doctor (unless the doctor has agreed to treat him elsewhere). But if the patient's condition makes it necessary, the doctor is under obligation to provide treatment elsewhere in his practice area.

Appointments to CHC

Health Circular HC(76)25

This important circular sets out new guidance on eligibility of CHC members to serve from 1 January 1977, and cancels paras. 10-17 of HRC(74)4. Prospective members should realise and be able to take on the necessary commitment of time and energy to CHC work, and they should not normally live outside the district or be over 70. NHS employees and family practitioners are now eligible. Local authorities should particularly apply this advice to their councillor appointments. RHAs should specifically include a Trades Council representative and a disabled person in their nominations. They should also bear in mind names put forward by the CHC and consider other community organisations not specifically concerned with health as eligible. An appendix deals with voluntary organisation appointments, and RHAs must consult the CHC on the procedure they use and on the list of bodies taking part.

Home from Hospital

MIND has launched a campaign to increase the number of homes and help available for psychiatric patients who are ready to leave hospital. The slogan of the campaign is "Help a healthy mind leave hospital" and a grant of £20,000 has been made to it by the DHSS.

The campaign, which will last until October, also aims to raise funds for community care and to create projects and develop resources for the accommodation, support and day care of former patients. A Granada "World in Action" film made in conjunction with MIND was shown on television on 26 April, and a copy of it is available. Further details about the campaign and supplies of leaflets and posters are available from: Kina Avebury, MIND, 22 Harley Street, London W1N 2ED.Telephone 01-637 0741.

CHC NEWS welcomes contributions to the paper — particularly from members and staff of community health councils. Please forward any articles, letters or news items that would be of interest to other readers to: The Editor, CHC NEWS, 24 Nutford Place, London W1H 6AN.

CHC gets grants for extra staff

Continued from page 1

that it should provide an element of training or opportunity for further education to the employees; and (4) that the area should have a relatively high rate of unemployment. Two further points are that the wage limit is £50 p.w. and the project must end by March 1977.

Sponsors include health authorities, local authorities, community organisations and charities, and following Worthing CHC's initiative — community health councils. 1,749 projects employing 19,794 people had been approved at a total cost of £27.9m by the end of April this year. In Worthing CHC's case they have received £3,497 to employ 7 people for 13 weeks. 3 are young graduates, 3 are redundant executives and one (the project manager) is a former bank manager. They have been interviewed from the Professional and Executive Register, and their first week at work for the CHC consisted of an intensive training programme provided by senior NHS and local authority staff to give them a basic knowledge of the way services for the elderly are provided. The second week introduced them to the technique of doing the survey and they tried a small pilot study. Now they are on the main part of the interviewing. CHC Secretary Chris Mackwood is delighted with the project because it is proving to be so worthwhile for all concerned. She warns other CHCs who are thinking of becoming sponsors under the JCP that the preliminary arrangements to set the survey up and make the application to the JCP involved a great deal of careful work, and should not be undertaken lightly.

However, CHCs will see that the JCP offers a unique opportunity to undertake some further work — it need not be a survey — and at little or no financial cost to the CHC. This must be welcome at a time when budgets are so tight and time is so short. There is a small staff for each JCP area, and they will give advice to anyone who intends to be a sponsor:

North East: 38 Market Square, Sunderland SR1 3LP. Tel: Sunderland 43316/7. **Yorkshire and Humberside:** Pennine House, Russell Street, Leeds. Tel: Leeds 41417. **Central:** Selkirk House, 166 High Holborn, London WC1V 6PF. Tel: 01-240 1706 or 01-836 1213. **South West:** St Stephens House, 9 Catherine Street, Exeter EX1 1TN. Tel: Exeter 32341. **Midlands:** George House, George Road, Fiveways, Edgbaston, Birmingham. Tel: 021-454 2995. **Merseyside:** Graeme House, Derby Square, Liverpool L2 7SU. Tel: 051-227 4111. **North West:** Elizabeth House, St Peters Square, Manchester. Tel: 061-236 9401. **Wales:** 4th Floor, Pearl Assurance House, Greyfriars Road, Cardiff CF1 3AG. Tel: Cardiff 372501/2. **Scotland West:** 450 Sauchiehall Street, Glasgow G2 3JX. Tel: 041-332 9722. **Scotland East and North:** Lauriston House, Lauriston Place, Edinburgh EH3 9EB. Tel: 031-229 2515.

Steering Committee News from J.E. Pater Secretary

By now all CHCs will have received copies of the Draft Constitution for an association and of the Explanatory Notes on the Draft Constitution, and will be considering whether they wish to prospose amendments at the Conference in November. The two papers in the form in which they have been circulated were discussed and revised by the Steering Committee at their meeting on April 27th.

Their hope is that the papers will enable CHCs to formulate clear conclusions about the formation of an association, and that any proposed amendments to the Draft Constitution will be sent to this office as soon as possible. Amendments received after July 31st will be too late for consideration, since a Working Group of the Committee will be meeting in August to draw up a complete list of amendments for circulation to CHCs in September, so that they may consider their reaction to them before the Conference on 3rd November.

Any CHC wishing to propose an amendment will need to do so at the Conference to ensure that another CHC will then be prepared to second it, and to send the amendment to this office by 31st July. It is hoped that the Conference will be able to transact its business between 11.00 a.m. and 4.30 p.m. These hours have been fixed to meet the convenience so far as possible of CHC representatives travelling from the North or West. The aim is to devote the first hour and a quarter to a speech and questions and answers from the Secretary of State (Mr David Ennals), and the remaining three hours and a quarter of business to discussion of and voting on the formation on an association. The Secretariat will be glad to receive any comments or queries from CHCs at any time.

Parliamentary Questions

Laurie Pavitt, MP, asked the Secretary of State to take steps to add officers from local authority social services departments as full members of district management teams. Dr Owen refused, but he did add that he was concerned to strengthen the collaborative approach and to encourage DMTs to invite local authority officers to their meetings when matters of joint interest were to be discussed.
(Hansard Vol. 908, Col. 284).

In response to a question from Barney Heyhoe, MP, Dr David Owen said that a resolution of Hounslow CHC about the discharge of handicapped and mentally ill patients into the community without proper facilities had been brought to the attention of the Secretary of State. he went on to say that hospital discharge policies must be realistic and take account of the local availability of supporting social services; and that good practice requires that consultants should satisfy themselves that adequate support facilities exist before discharging a patient.
(Hansard, Vol 908, Col 284).

Directory of CHCs

A directory of the names, addresses and telephone numbers of all the community health councils in England and Wales is now available, priced 60p.
Corrections are published monthly in CHC NEWS. Please notify the Editor of any changes.

Cheques and postal orders should be made payable to "King Edward's Hospital Fund for London" and sent with orders to: CHC NEWS, 24 Nutford Place, London W1H 6AN.

Please note the following changes:

Page 7: Calderdale CHC

Address: 3 Harrison Road
Halifax
West Yorkshire
HX1 2AF
Telephone: Halifax 56181

Page 23 Tunbridge Wells CHC
Secretary: Mrs Jean Coupe
Page 23 Bexley CHC
Telephone: Crayford 529851
Page 23: Bromley CHC
Chairman: Mrs. J. L. Finlay
Page 25 North West Surrey CHC
Address:
Adjacent Maternity Unit Car Park
St Peter's Hospital
Guildford Road
Chertsey
Surrey
Telephone: Ottershaw 3635
Page 38 Sandwell CHC
Address: 2nd Floor
12 Lombard Street
West Bromwich
West Midlands B70 8RN
Page 40 Central Southern Liverpool CHC
Secretary: Jane Leighton
Page 61 Index
Insert: Brighton, 21
Page 62 Index
Insert: Hounslow, 16