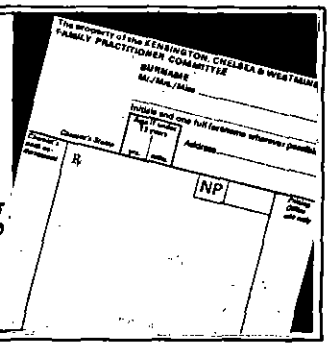
CHC NEWS

For Community Health Councils

July 1976 No. 9



Films spread the news

There is no doubt that public interest in CHCs is growing. The press are covering CHC activities in greater depth than before and in a few weeks time the BBC will be showing a 40-minute film entirely devoted to the work and interests of CHCs. This will be one of 13 programmes called "Inside Medicine" that commenced on 21st June. They go out on Monday evenings at 9.50 pm on BBC2 and the date of the CHC film should be announced shortly.

For many people this film will be their first introduction to community health councils, but another film about CHCs is already being made for dental students as part of the community dentistry course at the University of London. Aubrey Sheiham and Diane Plampling, lecturers at two of the schools of dentistry, saw that subjects like fluoridation or the system for paying dentists could be presented with far more impact as films instead of ordinary lectures. Their films have already had considerable success and the next in the series will look at CHCs, particularly in relation to issues of concern to community dentists.

Of course, the success of film compared with written material is its simplicity — the directness of its message and the ease with which it can communicate to different audiences.

Howard Knight, Secretary of Central Sheffield CHC, is a firm believer in this — in fact, part of his CHC's Annual Report will be presented as a video film. It covers aspects of the Council's work including a survey of the use of incontinence aids and the problems for elderly orthopaedic patients discharged from hospital. The script has been worked out by the CHC and the film is being made by people at Centre 45 (who are on 90-day training orders instead of prison sentences). Work on the film gives them the chance to get involved in lively issues of public concern. It will be shown using a video cassette recorder borrowed from the RHA, so the cost of the whole scheme to the CHC is negligible. Apart from having a more effective influence on AHA members, the film will also be used by the CHC for its talks to local groups.

The three CHCs in Manchester have also realised that visual presentations have a tremendous value and they are having a film made jointly to boost their publicity drive. It is being made by a professional company who have spent time learning about the CHC. The result will be a 15-20 minute sequence of slides accompanied by a specially written sound commentary which Fred Trueman has been asked to record for them.

A further illustration of film's versatility is given by St Thomas's CHC in presenting their alternative suggestions to a proposed hospital closure. Instead of only submitting written evidence, they have backed their case for changing the hospital partly into a community hospital by showing a film. This arose because members of the CHC had visited the first community hospital to be opened — at Wallingford — and had been impressed with its achievements. So a member, Bernie Spain, arranged for a video film to be made about the hospital and this has been shown to the AHA, to the public at CHC meetings and to several other audiences with an interest in the proposals.

Although the CHC may not manage to persuade the health authorities, they already know that the film has helped considerably to inform people about a very complex subject. Their example, and the others, do show how film can really help CHCs to get themselves and their views across in new and exciting ways.

● *See* **"MEETING THE CHALLENGE"** *on page 2.*

Cameras capture the action Photos: Radio Times/BBC

YOUR LETTERS

MEETING THE CHALLENGE

from Gordon Tollefson, Secretary Wakefield (Eastern) CHC

One of the major challenges facing CHCs this year, next year and for many years to come must be that of publicity — to publicise to the community that they can influence their health service through the local community health councils and at the same time gain help themselves in a variety of ways.

Posters, leaflets, newspapers and talks all have their place but in our modern society it is the "visual aid" which has the greatest impact. The Council, here in Pontefract, followed this theory and have produced a 16mm 20 minutes colour sound film entitled — "Who Cares?" The premiere took place only a few weeks ago and as a result of excellent press coverage, bookings for the film are already pouring in from local organisations and parish councils. The film illustrates the problems of communication both inside and outside the health service. It closes with an emergency ambulance dash to hospital in which a major breakdown of communication is demonstrated.

We were fortunate in being able to obtain the services of a local polytechnic for the making of the film but the interest and enthusiasm aroused so far assures us that we are making a major breakthrough in our publicity challenge. Perhaps this is a project worth consideration by others.

CHCs' SAVINGS

from John Logan, Chairman Eastbourne CHC

At the last meeting of my Council's Executive, fears were expressed about CHCs "Spending their Savings" on health service equipment (CHC NEWS 7). No doubt all this equipment was needed by the bodies that received it. Nevertheless, the fact that CHCs have this sort of money to play with could bring CHCs into disrepute in the eyes of the very people they are setting out to help. We feel that if there is a surplus it should have been returned to Region for them to spend.

CHCs' EFFECTIVENESS IMPROVED

from Derek Watson, Member South Tees CHC

CHCs must take conscious steps if they are to be able to exercise sensible judgements when called upon to do so. One way is to listen to people who are immersed in the health service — its problems, needs, successes, and so on. Apart from having constructive links with the DMT, my Council is setting up a series of informal meetings where we can hear from the people who are really in the thick of things — doctors, nurses, technicians, ambulancemen, social workers, etc. The meetings will be largely unstructured to encourage frank and constructive discussion, although it may help to provide a theme on which to focus our attention.

STAFF MEMBERS OF AHAs and RHAs

from P. Seers, Secretary North Hammersmith CHC

CHC Secretaries, together with administrators, treasurers and other chief officers of RHAs and AHAs are ineligible to stand for election to health authorities as staff members, according to the Consultative Document "Election of Staff Members".

It is clearly misleading, in that officers directly responsible to AHAs and RHAs may be called upon to attend meetings of those authorities, to give an account of their work, and answer questions on particular aspects of health service provisions, maintenance of buildings, etc., and these are NOT part of the CHC secretary's duties. Indeed, the original circular on CHCs (HRC(74)4) clearly states that secretaries "*are to be employed* by the RHA or AHA" (para 19) but "would be *accountable* to the CHC" (para 22). Any suggestion to the contrary would inevitably prejudice the role of the CHC as an independent body.

Since CHC secretaries are not directly responsible to the AHA or RHA, their opportunity to stand for election to the relevant authority should not be denied. This is surely an issue that a National Body of CHCs could have pursued — as it is we hope that individual CHCs will support our stand.

PATIENTS' MEDICAL RECORDS

from J. D. Emerson, Secretary Bath CHC

A member of the public has queried the situation whereby in law a patient's personal medical record is the property of the State. The suggestion is put forward that personal medical reports kept by a GP on his patients form a sort of contract between the patient and the doctor, normally protected by medical ethical standards regarding confidentiality. There is increasing fear that this confidentiality tends to be breached because information from GPs records may be obtained by the DHSS and other official bodies for statistical purposes. If a breach of this nature can occur, the way is open to other leakages, unintentional though they may be.

It is also suggested that a patient should be entitled to require that certain information should be passed on by a GP to another person, e.g. on transfer from one GP's list to another. It is understood that GPs have discretionary powers in situations of this sort but that there are no rights accredited to the patient.

If the argument is accepted that GP medical records on a patient form a sort of contract between the two parties, should there then not be some acknowledgement of patients' rights?

NATIONAL CONFERENCE OF CHCs

from Lady Marre, Chairman, Steering Committee

I am afraid that Mr Hutton (CHC NEWS June) has misunderstood both the objectives of the Steering Committee and the purpose of the November Conference. The Committee would certainly not pretend to "know better than individual CHCs what is good for them"; nor does the Committee see the "sole purpose" of the Conference as being "to agree a constitution".

The Committee quite simply takes the view that CHCs cannot rationally decide whether they want an Association unless they know what sort of body the Association is likely to be. Hence the need for a draft constitution, and for discussion of the draft, as a preliminary to deciding whether to have an Association. This is what the November Conference is all about, and it will end with a vote on the formation of an Association.

COMPLAINTS INFORMATION

from Michael Mannall, Secretary Hounslow CHC

In this area an official complaints procedure was set up a year ago providing members of the Authority and the Community Health Council with a quarterly statistical return of complaints. My Council has grown very dissatisfied with these statistical returns and have been feeling for other forms of information with regard to complaints. I understand that in some districts much fuller information is given about complaints to the CHC. I would be grateful for any information your readers can give me in regard to this subject.

NEW SOCIETY: INITIATIVES

from Paul Barker, Editor.

We intend to launch a regular series of articles in New Society shortly about new initiatives and innovations in the social services.

A time of financial stringency is a time when ideas are even more at a premium than at other, more lavish periods. We would like to seek these out.

We don't want to rely on the usual chain of contacts and information. We would like to feel that nothing fresh was being missed.

There is an invitation to let us know of any developments that fall under your responsibility which are reasonably new but which are actually in operation.

If there are any joint developments or other initiatives you know about and would like to draw our attention to, please contact us immediately.

A selection of these initiatives will appear in the magazine, usually written up by our specialist staff-writers, who would make contact direct about paying you a visit.

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.

WHY SHOULD THE PUBLIC CARE?

by Ann Gallagher, Lecturer in Community Work at Goldsmiths' College, University of London

Faced on the one hand with a responsibility for representing the public's views on the health service, and on the other with what often appears to be a somewhat apathetic response from the public itself, CHCs can find themselves asking: "Do the public care about health issues — and if they do, how can we capitalise on that? In short, how can we involve the public?"

To begin to find answers to these questions, I intend in this article to look at some of the circumstances in which people are more willing to become actively involved in issues of public importance, and at some of the ways in which that involvement can be stimulated. There are two major preconditions for public involvement on any issue: people must feel concerned about the matter; and they must believe that they can have an influence on it. These points may seem obvious, but the second of them needs to be stressed. Too often, concerned people stop caring because they feel powerless to affect a situation. Then they appear (and are accused of being) apathetic. Genuine concern may therefore become repressed or be left unvoiced unless the possibility of change becomes meaningful.

Firstly then, how can latent concern on matters of general importance be fostered?

Perhaps the fundamental point to make here is that the subject under consideration must have a reality for those we seek to involve. In order to be concerned, people may need to see an issue in relation to themselves or to those they are close to. "Your child could suffer severe pain for hours if she needs dental treatment at the weekend" means more to most people than "This area has inadequate provision for emergency dental treatment." The most difficult issues to involve people in are those which affect everyone, but in a general and seemingly remote way. Take the case of a health authority developing a long term plan for hospital provision in a district: how do people respond to it? The man-in-the-street's first reaction is likely to be a vague one. And vagueness is not a spur to activity. Any CHC hoping to develop public participation in relation to general issues and abstract programmes will need first to translate these ideas into everyday possibilities. It will need to express the implications of various plans in specific terms: e.g. "This plan will provide more resources in the district, but will create a gap in that particular service . . .".

The second point that I wish to make is that people need to know about an issue before they can be expected to want to influence its outcome. Often, it is up to those already interested in achieving a change to tell people about it in the first place. How public awareness on any subject is to be aroused will vary greatly with the nature of the issue. A number of factors will have a bearing on the best approach to use.

The first question to be considered is how do we define the group of people who are actually affected by this issue? Communication about something affecting a relatively small geographically defined population will take quite a different form from that needed on a matter that concerns a particular age group in the population, for example.

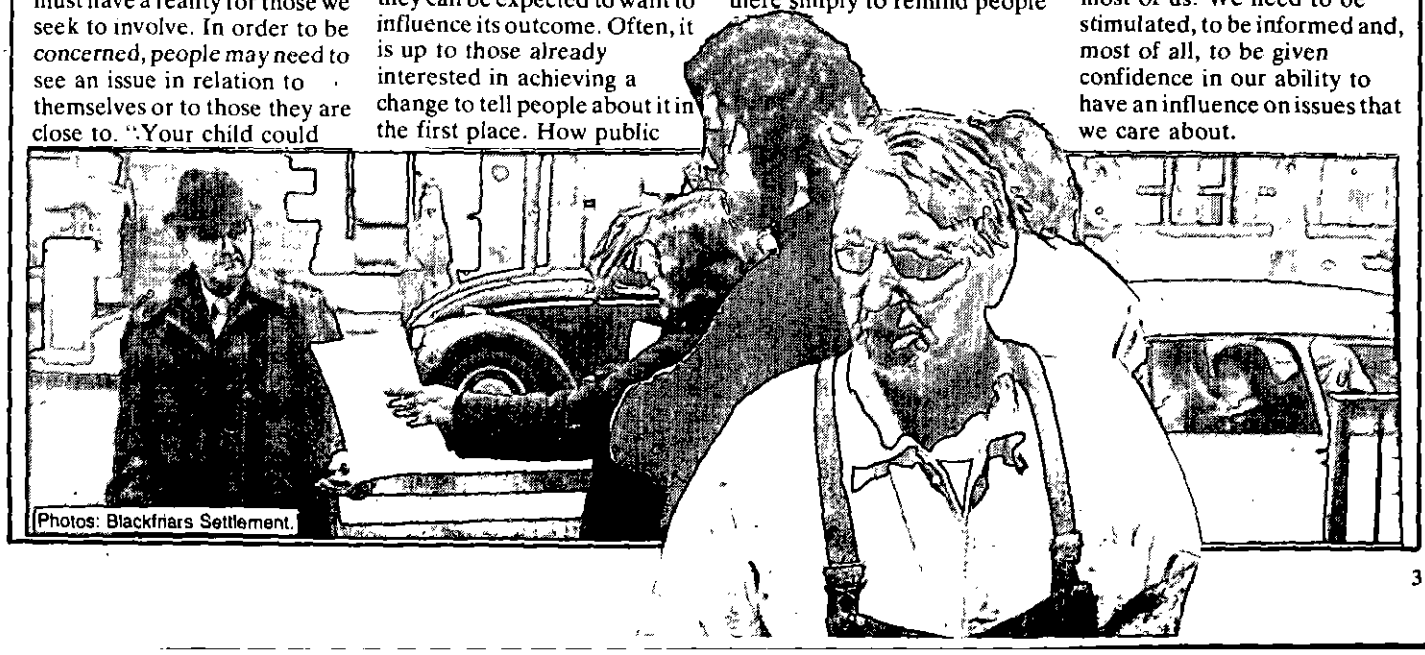
On a housing estate which has no chemists' services it will be possible to use the most successful method of reaching and engaging people — direct contact. Those people who want to get opinion on this subject organised can actually go from door to door in this defined area and talk to people on a one-to-one basis. Their direct contact with the residents can be supplemented by posters, leaflets and other forms of communication. In this case these do not need to be detailed, because they are there simply to remind people of what has already been discussed rather than to inform them about it for the first time.

As I have mentioned, there are other topics where the people in question can be identified, not geographically, but because they share a common concern or experience — such as inadequate chiropody provision for the elderly, or a shortage of facilities for having hearing aids repaired.

In these cases it may be more difficult to locate and contact those most affected. The organisers will have to rely much more heavily on the media, leaflets, posters, mailings, and (if they are lucky enough to have access to them) on theatre or video, to draw attention to the issue and to contact their target people in the community. With this kind of indirect communication, it is important to remember that it is a one-way process so messages must be clear. You can't ask a poster what it is trying to say.

Whatever the target group is, formal and informal networks that already exist should be taken into account and employed. It may be helpful to note that while the more structured organisations can easily be identified (councils of voluntary service, federations of tenants' and residents' associations and other local groups), the informal links are less obvious, but just as effective. Community workers and people who are active in the locality will know where people come together and who are the key figures to whom everyone talks.

Public involvement, then, is rarely something that just happens. It is not a habit with most of us. We need to be stimulated, to be informed and, most of all, to be given confidence in our ability to have an influence on issues that we care about.



Photos: Blackfriars Settlement.

News from CHCs

- The Chairman of North Warwickshire CHC from April this year is Cllr W. H. Knight. He replaces Cllr A. H. Walker.
- Newham CHC has elected Cllr J. C. Taylor as Vice-Chairman for the current year.
- The Secretary of Weston CHC, Mr Edgar Evans, has been appointed a member of the local Disablement Advisory Committee.
- Cllr Jim Tatchell of North Tees CHC has been elected as this year's Mayor of Stockton by the borough council.
- Mr Graham Wagstaff has been appointed as the new Secretary of South Nottingham CHC to replace Mr A. J. Jarvis who left on June 31st. Mr Wagstaff previously worked for Task Force in Chesterfield.
- Mrs P. M. Hill has replaced Mr W. H. Lewis as Chairman of Rugby CHC.
- The Chairman of the Isle of Wight CHC, Mr D. H. Gordon, has been elected as this year's Mayor of Medina.
- Oxfordshire CHC have recently opened part time information centres in Banbury and central Oxford, in addition to their main offices in Headington. Because the CHC covers a large single-district area, the two branch offices have been set up in order to make the CHC more easily accessible to its constituent communities.
  The Banbury office opens on Market Day to cater for people from the surrounding villages, and the information centre in Oxford (which is staffed by a retired hospital manager, Mr R. L. Wallace) is open for information and advice on three days each week.
- In conjunction with a local college of education, Leeds Western CHC are organising a five-week course of evening classes entitled "Know Your Health Service". The course will start in the autumn, and the weekly classes will cover the structure of the reorganised NHS, the elderly, mental health and family practitioner services. The final session will be a forum on the future, and a panel of CHC members will attend to join in the discussion.
- The monthly newsletter produced by Hillingdon CHC was the major source of publicity for a well-attended public meeting on fluoridation. The meeting was addressed by a dentist and a representative of the National Pure Water Association The CHC's recommendation (which was decided by the Chairman's casting vote, in favour of fluoridation) was preceded by a two-hour discussion.
- Hexham MP, Mr Geoffrey Rippon, is one of several northern MPs who have been persuaded by Northumberland CHC to ask questions in the House of Commons about transport to health service facilities.
- A one-day seminar on the theme of the MIND "Home from Hospital" campaign is being held for CHCs in North Derbyshire, South Yorkshire and North Nottinghamshire. It will be held on Wednesday 7th July and Southern Sheffield CHC are responsible for the arrangements.
- Plymouth CHC has successfully waged a campaign for wider services and support for the mentally handicapped in the district. They have now received written confirmation from the Minister of State that provision has been made in the 1976/77 regional programme for a mental handicap consultant to serve the whole district.
- People in City and Hackney district were given an opportunity recently to find out more about the concept of nucleus hospitals. The CHC organised a public meeting on the subject when the RHA announced that funds had been allocated to build a small new hospital in the district. Members of the DHSS liaison team for the region explained the facts about nucleus hospitals and the pilot project already underway in Newham.
- The design of villas to be built for mentally handicapped people at two hospitals has been improved, following suggestions from Wandsworth and East Merton CHC. The Council's suggestions were designed to produce a more home-like environment for the residents, including reducing the number of bedrooms in each villa, and providing kitchen facilities and domestic washing machines.
- Rochdale CHC have won the right to equal representation with the RHA and AHA on a working party set up to consider hospital services in the area. The working party is the result of the CHC's concern about the level of service to patients, low staff morale and consistently adverse publicity about local hospital services. Communication at area level had been poor and the CHC's access to information limited. The CHC voiced its concern to the RHA, and the working party was established.
  The Rochdale working party has a wide brief and is taking evidence from patients, members of hospital staff and other interested parties. They expect to complete their investigations by the end of this month, and will be publishing a full public report on their findings.

There is a vital last chance for CHCs to influence the progress that may be made later this year towards establishing a National Association. Since our inception, CHCs have been involved in a massive learning and assessment exercise; mastering the intricacies of the reorganised NHS structure, establishing our role and uncovering in some detail the problems of our own districts.

We have been encouraged principally to deal with DMTs and our impact at Area level has been limited. We have been fighting local battles and there has been no proper forum for discussion of wider problems. Differences of view between local management and CHCs have been a reflection of those wider problems and of constraints imposed by central government. Key decision making is taking place at the Department and at Region without a coordinated community view being presented.

For example, CHCs find themselves opposing closures of small successful units which management claim leads to greater efficiency and provides savings to achieve a financial balance. The policy motivation for such activity however arises not so much in districts as from the dictates of Regions and the DHSS. The voice of the community

HEALTH CLINICS: Swindon, Chichester, Rhymney Valley, Hounslow, Manchester Central, Rotherham, Edgware/Hendon, Lewisham, Dudley, Trafford.

HEALTH EDUCATION: Rotherham, Central Sheffield, SW Leicestershire, Mid Surrey, Coventry, Chelmsford, Kensington & Chelsea & Westminster NW, West Surrey, SW Herts.

HEARING PROBLEMS: Stockport, Dudley, Leeds East, West Surrey, Chichester.

HOSPITAL ADMISSION PROCEDURES: South Tyneside, Rhymney Valley, Ipswich, Dudley, Hartlepool, Kensington & Chelsea & Westminster South.

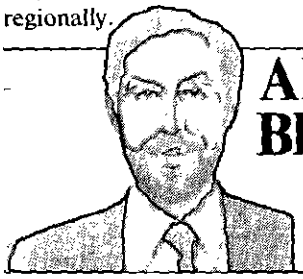
HOSPITAL DISCHARGE PROCEDURES: Manchester Central, Dudley, Central Sheffield, Leeds East, Stockport, North Herts, Salop, South Tyneside, Kensington & Chelsea & Westminster South, Hartlepool, Rhymney Valley.

HOSPITAL "HOTEL" SERVICES: South Tyneside, Stockport, Rotherham, Lewisham, Hartlepool, Central Nottinghamshire, Hounslow.

HOSPITAL OUTPATIENT WAITING TIME: South Gwent, South Lincolnshire, Ipswich, King's Lynn, Stockport, Dudley, Coventry, East Somerset, North Birmingham, Havering, Leeds East, Hartlepool, Rhymney Valley, Southampton.

HOSPITAL VISITING TIMES: North Warwickshire, Swindon, Havering, Lewisham, Ipswich, Kensington & Chelsea & Westminster NW + South, Dudley, King's Lynn, Rhymney Valley, Hartlepool.

PERSONAL VIEW



Alternative National Blueprint for CHCs

by Paul Gottlieb, Chairman of Brent CHC

would be much more powerful if CHCs as a body could enter into proper dialogue and direct consultations either nationally or regionally.

In London the problem is especially intense as it is split into four NHS Regions with added territory spread from Sussex to Essex and from Kent to Bedfordshire. Happily, London CHCs have seized the opportunity offered by the Royal Commission on the NHS to bring together all CHCs in Greater London to present joint evidence to the Commission on a range of health care problems particularly relevant to London as a whole. It has been very encouraging to see the overwhelming support this action has had among nearly all London CHCs — a clear indication of the widespread concern at the mismatching of NHS territorial arrangements with real health needs and problems.

The National Conference in November is to be presented with a national structure for CHCs based upon NHS administrative boundaries and not therefore necessarily geared or weighted to reflect the true needs of CHCs. There could be alternative blueprints for combining CHC efforts and a fundamental debate is required at the National Conference about the direction in which we should be moving, rather than brief discussions on a series of minor amendments to the Steering Committee's draft.

In local government, consultation and discussion among local authorities and between local authorities and central government is mediated via separate associations of metropolitan and non-metropolitan authorities. Equally within the NHS, urban and rural areas do face fundamentally different sets of problems and this provides a real, rather than an administrative, basis for groupings of CHCs in major urban centres and for other regional groupings for rural districts. The suggestion of such regional groupings as a firm base for a national voice for CHCs has not yet been fully explored throughout the national membership of CHCs.

If CHC members support the ideas I have outlined here, I hope they will write to me (c/o Brent CHC) so that an alternative blueprint can be properly formulated well before the National Conference is upon us.

SURVEYS

PART TWO

This month we complete the list of information recently returned from CHCs about the surveys, studies and investigations they are, or have been, involved with. In the future, further information will be issued, as more replies are received. Where only one CHC has indicated activity on a particular subject they are not listed; so please contact the Editor for further specific information.

HOSPITAL WAITING TIME FOR ADMISSION: South Gwent, Dudley, Rotherham, Coventry, East Somerset, North Birmingham, King's Lynn, Hartlepool, Ipswich, Rhymney Valley.

MATERNITY SERVICES: City & Hackney, Crewe, Rhymney Valley, Salop, Chichester, Newcastle, North Herts, Cambridge, Leeds East, Northumberland, Chelmsford, Stockport, Coventry, Dudley, King's Lynn, Ipswich, Lewisham, South Gwent, Medway, Liverpool Central & Southern, Rotherham, Kidderminster.

MENTAL HANDICAP SERVICES: Manchester Central, Rotherham, Kidderminster, Exeter, Liverpool Central & Southern, Medway, South Gwent, Arfon Dwyfor, Lewisham, King's Lynn, Dudley, Chelmsford, East Roding, Northumberland, St Thomas's, Leeds East, Wirral Southern, Worthing, Southampton, North Herts, Havering, East Somerset, West Surrey, SW Herts.

MENTAL ILLNESS SERVICES: West Surrey, Kensington & Chelsea & Westminster NW, East Somerset, Chichester, Swindon, Havering, Aylesbury, Leeds East, St Thomas's, Chelmsford, Stockport, Dudley, King's Lynn, Lewisham, Arfon Dwyfor, South Gwent, Kidderminster, Liverpool Central & Southern.

NUCLEUS HOSPITALS: Stockport, Chelmsford, Aylesbury, Havering, City & Hackney.

OPHTHALMIC SERVICES: Halton, Aylesbury, South Gwent, Dudley, Rotherham.

PAY BEDS/PRIVATE PRACTICE: Rhymney Valley, East Somerset, East Roding.

SCHOOL HEALTH SERVICES: SW Herts, Crewe, South Gwent, Lewisham, Exeter, West Surrey, North Birmingham.

SMOKING: Basildon.

SOCIAL SECURITY BENEFITS: Kidderminster, Liverpool Central & Southern, Lewisham.

SOCIAL SERVICES PROVISION: Liverpool Central & Southern, Lewisham, Kidderminster, King's Lynn, Kensington & Chelsea & Westminster NW.

STERILISATION: North Camden, North Warwickshire, Havering, Leeds East, Hull, Central Derbyshire, Rugby, Lewisham, Haringey, Weston, Rotherham.

STROKES: Kidderminster, Rugby, SW Leicestershire.

RURAL PROBLEMS: Rhymney Valley, East Somerset, Swindon, Aylesbury, North Herts, East Herts, East Dorset, Northumberland, Northallerton.

ASPECTS OF TRANSPORT SERVICES: SW Herts, Lewisham, South Tyneside, Aylesbury, Northumberland, Chelmsford, North Surrey, Basildon, Northallerton, Southampton, Dewsbury, Southend.

GPs' PRACTICE ORGANISATION: South Tyneside, Rhymney Valley, Coventry, Kensington & Chelsea & Westminster NE, Central + Southern Sheffield, Lewisham.

SERVICES FOR SOCIALLY DEPRIVED: Southampton, Central Sheffield, Liverpool Central & Southern, Swindon.

COMMUNITY SERVICES IN GENERAL: Central Birmingham, Kensington & Chelsea & Westminster NE, SW Herts, Aylesbury.

GENERAL ATTITUDE SURVEYS: South Tyneside, Kidderminster, East Dorset, Trafford, Wakefield Eastern, Weston.

This article on the care of old people in the community is by J. A. Muir Gray (Community Physician) and J. Graves (Area Information Officer) Oxfordshire AHA. • Reproduced with permission of the Editor, WORLD MEDICINE

What hope for the elderly in 1984?

Almost half a million more people will be over the age of 75 by 1984, and by 1994 there will be an increase of 25 per cent of this age group compared with today. Considering these figures, what should be our overall objectives in developing services? Elderly people are not different from young people. They want to do what they want — to live in a comfortable dwelling, with sufficient income to give reasonable freedom to choose food, drink, holidays and leisure, with their tastes the main deciding factors, not the costs and prices. The drop in income which most people experience on retirement alters this situation. Their "autobiography" finishes and the State starts to dictate their "biography".

The two objectives I suggest we should have are (1) to support people at home as long as possible, instead of solving their problems by putting them in an institution; and (2) to make them independent of paid agents of the State. The first is important because it is what people want. Costs are impossible to compare. The cost of services is not a function of the site of their provision — i.e. in the home or in an institution. It is a function of the standard of care and can be as low or as high as we wish to make. It is probably equally cheap to "warehouse" people in homes or hospitals and provide no services as to leave them at home without any services. However, keeping people at home has a number of advantages: (1) The activity and decision-making of life at home provide a physiotherapy and occupational therapy which it is almost impossible to recreate. (2) No debt charges are incurred when domiciliary services are started as they are when a hospital or institution is built. (3) People at home are nearer their neighbours, friends, and family who can and do give tremendous help and support.

Various measures of this objective are possible. As a base line, the number of people who have been in institutions, hospitals or old people's homes for more than six months can be found and expressed as a rate for each five year age group in the review area. This allows for different areas to be compared. It should be as difficult to get into long term care as into Parliament (which is itself an institution with a high proportion of long-stay residents). Every admission must be carefully monitored and when long term stay is regarded as "inevitable" the causes should be reviewed as carefully as the review of the death of an infant.

In many cases admission is necessitated by inadequate community resources. Because institutions are built, staff are required — because staff are required, costs are incurred — because costs are incurred, there is less money to spend on preventive services — because there is less money to spend on preventive services, people are institutionalised, increasing the pressure on residential care services.

The second objective is proposed not because of the expense of domiciliary services. A belief that people prefer to be independent, or with only the help of their family in the personal acts of dressing, undressing, personal hygiene and toilet, warmth and food is the reason for this objective, although the economic factors are of course important.

Many of these activities are done by home helps, district nurses and auxiliaries and facilitated by occupational therapists, physiotherapists, social workers and health visitors but could be carried out by the persons themselves in the right environment. Central heating or a well-designed gas fire obviates the need for carrying coal, lighting and cleaning fires. (People should have coal fires if they want, but too often it is the problem of lighting a coal fire which necessitates admission to an old people's home or prevents discharge.)

The social benefits from the visits of domiciliary workers are very much a part of their therapy. Relationships develop and, in some cases, dependency develops. The substitution of a visit by an environmental modification e.g. installing a special shower room with a seat instead of being bathed by a nurse who calls once a week, will have disadvantages and increase isolation. But when there is such demand for the skills of domiciliary workers, other ways of providing the social benefits of their visits must be sought and found. The development of a Cooking Club, at which housebound people learn to overcome their disabilities and cook again, meet one another, have lunch and cook their next day's meal might be an alternative to meals on wheels. Most people with physical disability can be supported in a well designed or adapted house in a community which promotes social interaction and with the use, when required, of the skills of domiciliary services and of hospitals or homes where intensive rehabilitation can be given in admissions of short duration.

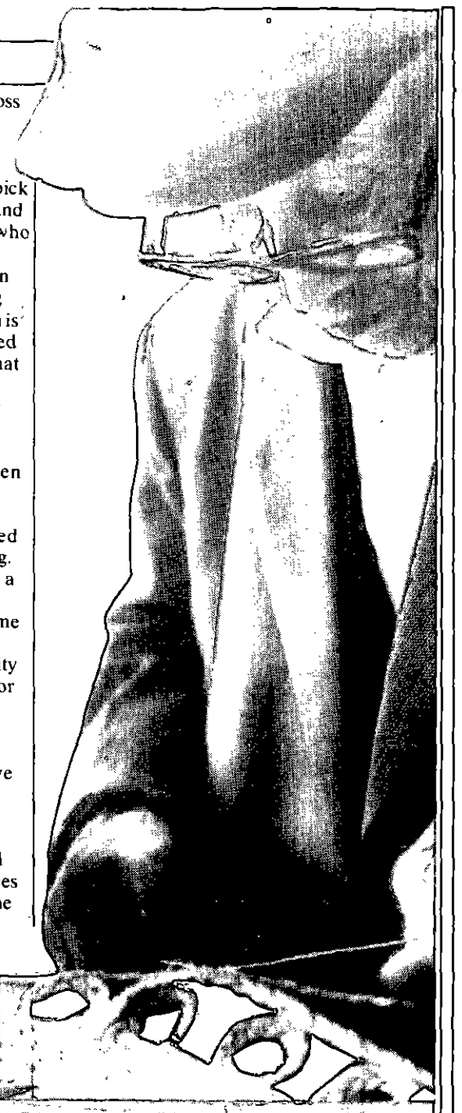
The disability which will be more frequently insoluble in the community in 1984 will be that of mental disability. The aspect of confusion which causes most problems is often what I shall call the state of being socially objectionable — a cumbersome phrase but I can think of no better, or no worse. The "nice" confused person will be helped by family and neighbours and will have a loyal home help. Someone with objectionable habits, for example shouting abuse at neighbours, accusing people of theft, poor personal hygiene, will be rejected by family and neighbours and may make the job very difficult for home helps and other domiciliary workers.

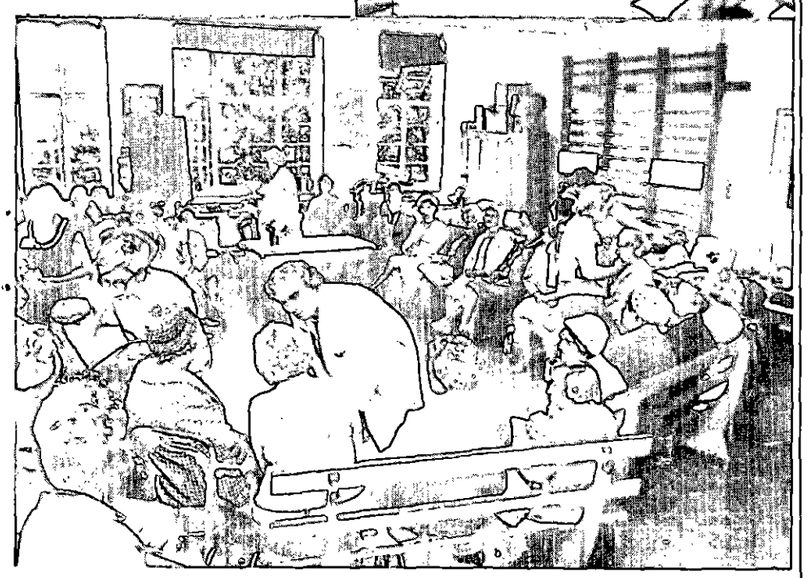
The same holds true in old people's homes. It is not disorientation, memory loss or functional mental illness that causes problems and referral to a psychiatrist, but the person who sits and chatters incessantly to the man who is trying to pick a horse or who has bad table manners and picks food off other people's plates, or who shouts at night.

Not all the symptoms are due to brain pathology. Some are preventable, being caused by social isolation. Social isolation is a form of brainwashing and must be treated urgently and enthusiastically, ensuring that newspapers and calendars reach housebound people, checking that their radios work, visiting them, stimulating clubs, churches and pubs to seek out housebound people whether they had been "regulars" or not, and bring them into normal life.

Above all the public must be persuaded that the State cannot provide everything. They all have the necessary skills to do a great deal of good work. This applies specially to retired people who can become community activists. They can work on campaigns to improve diets and the ability to keep warm in a time of inflation, both for themselves and for housebound people. Cuts in rural bus services will provide another struggle for them to take up.

For too long we hoped we would solve these problems by service growth when things had settled down after the NHS reorganisation. We are at the limits of growth and beyond the stable state, and must face these problems with the resources we have and with the participation of the community.





Photos: Nursing Times and Help the Aged.

EDITORIAL

It is often overlooked that the quality of services for patients depends very largely on the quality of training given to professional staff. For this reason, the NHS (Vocational Training) Bill, published on May 26th, will be of interest to CHCs. When this Bill becomes law, new doctors will have to undertake a further 3 years' training to become principals in general practice.

At the moment, many new doctors interested in general practice do take a vocational training programme voluntarily. It covers two years, approved hospital work, and one year in a general practice approved for training. These programmes are organised on a regional basis by the Regional Adviser in General Practice, from whom more details could be obtained.

The Bill does not specify the statutory contents of future vocational training schemes. These will probably be worked out at the Bill's committee stage (expected later in the summer) on the basis of existing programmes and in the light of comments submitted by the Royal Colleges and other interested bodies. CHCs may well want to ensure that the Bill encourages future programmes to include those matters which they see as central to good general practice.

Surely if vocational training is going to improve the quality of GPs — and hence primary care — new doctors need to learn how to deal with people and organisations as much as they require good clinical knowledge. They need to know how health services are planned and managed locally, and they need to know how their contribution to health care fits into the whole.

GPs must also keep up to date with developments in knowledge and practices throughout their working years.

CHC NEWS

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BOOK REVIEWS

GUIDE TO THE SOCIAL SERVICES 1976
Published for the Family Welfare Association by Macdonald and Evans, 1976. Available from bookshops, £1.75.

This is a concise paperback reference book which many CHCs may already have in their offices. But it is mentioned here for those CHC members and secretaries who are looking for a simple and reliable source covering the range of social services on which they may need some information.

There is a section on the NHS (which mentions community health councils) that will probably not tell them anything new. Later pages, however, set out details of services for the elderly, the blind, the deaf, the physically disabled and the mentally ill. These sections, although brief, contain basic facts about the law and statutory and voluntary provision relating to each of these groups, including social security, housing and employment rights. There are names and addresses and telephone numbers of most of the bodies listed, so further details can easily be checked.

Another section deals with social work services provided by local authorities and voluntary agencies and other services which are the responsibility of local authorities. Then there are details of central government departments, the legal system, and provision for legal aid and advice (and a list of centres giving legal aid and advice). The section on social security benefits is very clear considering the tangled maze of payments and eligibilities that exist.

Perhaps of more general "consumer" interest, there are sections dealing with employment and industry, taxation and savings, housing, marriage, separation and divorce, forces welfare, nationality and citizenship, and charities. The book is revised annually so the facts are probably as up-to-date as any work of this kind can be, and for £1.75 it is good value for money.

KEEPING ACCOUNTS: A HANDBOOK FOR VOLUNTARY ORGANISATIONS
by Derek Hayes, NCSS, 1974. (Available from Research Publications Services Ltd., Victoria Hall, London, SE10 0RF, 40p plus postage.)

"Keeping Accounts" was designed by the NCSS as a handbook for voluntary organisations. It will, however, prove an invaluable asset to anyone who fulfils one or more of these functions: treasurer, book-keeper, or financial planner in any organisation. It is written by Derek Hayes, principal lecturer in the Department of Management at Slough College of Technology, and provides clearly explained advice on many of the financial issues and procedures which tend to baffle the layman.

As well as explaining the importance of accurate record keeping, the 32-page booklet outlines ways in which the honorary treasurer can act as a financial planner, a management information service and a financial analyst for his committee.

It describes in detail how to use and maintain the cash book, the petty cash book, and the receipt and payments account, as well as outlining the particular functions of each in the accounting system and the relationship between them.

There is also a chapter on the procedures involved in a more detailed accounts system, which explains how to prepare both a trial balance and an income and expenditure account if this is required. In addition, "Keeping Accounts" contains useful hints on the information that can be obtained from a balance sheet, how to make use of cash-flow predictions, and how to prepare a budget.

The Human Touch

PEOPLE'S POWER
by Dr E. F. Schumacher, NCSS, 1975, 20p.

Dr E. F. Schumacher is author of the well-known book "Small is Beautiful: a study of economics as if people mattered". His views have generated a lot of interest, and in 1974 he was invited to address the annual meeting of the National Council of Social Service on the subject of people's power.

His talk was geared towards those concerned with the social services, but the questions it raised are relevant to the NHS today. Specifically, is a large scale organisation like the NHS necessarily bureaucratic, "inhuman" and unresponsive? Or can CHCs bring back the human touch? Dr Schumacher's main thesis in *People's Power* is that in public services, as elsewhere, remoteness from and unresponsiveness to the needs of individuals are inevitable consequences of the bureaucracy that large-scale organisations generate. He argues that "organisations may well grow to such a size that they wholly lose their nature or are altogether spoiled. There may be demands that the "incompetent bosses" of the organisation should be replaced by better men. But few people seem to realise that bureaucracy is a necessary and unavoidable concomitant of excessive size; that bureaucrats cannot help being bureaucrats; and that the apparent incompetence of the bosses has nothing to do with their personal competence. A large organisation, to be able to funtion at all, requires an elaborate administrative structure. . . . The administrator of a large organisation cannot deal concretely with real life problems and situations: he has to deal with them abstractly. . . . His extraordinarily difficult task is to anticipate in his mind all possible cases and to frame a minimum number of rules to fit them all." He continues: "Let us organise units of such a size that their administrative requirements become minimal. In other words, let us have them on a *human* scale, so that the need for rules and regulations is minimised and all difficult cases can be resolved, as it were, on the spot, face to face."

Throughout his talk Dr

Photo: Godfrey Argent.

Schumacher emphasises the need to reintroduce the human touch into public service — and that means involving real people in real situations: giving them a real rather than illusory influence in decisions that affect their lives. "The idea that 'government' can solve all the problems, that 'government' can look after the people, is a poverty-stricken idea — the effectiveness of a government is precisely determined by the degree to which it helps or hinders people to look after themselves."

He concludes that although "government" is an appropriate mechanism for collecting monies, "the spending of money is something that requires "the human touch", the very thing that bureaucracy cannot have, no matter how diligent and compassionate the bureaucrats, as individuals, are wishing to be." It follows that we must attempt to devise channels of communication through which people can effectively determine how their resources are used, but Schumacher warns, "Whether in government or non-governmental organisations, the human touch and mobilisation of people's power remain wishful thinking unless the organisation is of the right size, both geographically and numerically. "Right size" is a difficult concept: the touchstone is the reaction of people — can they still give or receive individual attention? My own guess is that we should accustom ourselves to thinking in terms of much smaller units."

MENTAL HANDICAP READING LIST

Ann Shearer of Campaign for the Mentally Handicapped has compiled these suggestions for reading about the subject of mental handicap. The small number after each book refers to footnotes at the end, on where to obtain the publications.

WHO

OUR LIFE *CMH, 1972.* **LISTEN** *CMH, 1973.* **WORKING OUT** *CMH 1976.*[1]
All three are reports of weekend conferences where mentally handicapped people talk about the way they live and work and their perceptions of the services they receive, both in hospital and in the community.

TOUNGE-TIED
J. J. Deacon, NSMHC, 1974.[2]
The author has lived for 50 years in a mental handicap hospital and can communicate only with the help of three friends.

WHAT

MENTAL RETARDATION
B. H. Kirman, Pergamon, 1968.[3]
A useful short (39pp) introduction to the causes of mental retardation which highlights areas where further research is needed.

BORN TO FAIL?
P. Wedge & H. Prosser, Arrow Books, 1973.[3]
A short summary of the National Child Development Study findings when the children involved had reached 11, which shows how "mild mental retardation" is inextricable from "social deprivation" and so throws the first classification into question.

MENTAL HANDICAP *OHE, 1973.*[4]
A very useful short introduction to mental handicap and services (43pp).

THE SITUATION: AT HOME

PARENTS AND MENTALLY HANDICAPPED CHILDREN
C. Hannam, Pelican Books, 1975.[3]
Most mentally handicapped children live at home. A short account, through interviews, of what life can be like for the family, plus suggestions about the sort of help needed.

MENTAL HANDICAP AND COMMUNITY CARE
M. Bayley, Routledge & Kegan Paul, 1973.[3]
About 40 per cent of severely handicapped adults live at home. A detailed study of families in Sheffield which examines why some people are admitted to hospital and others are not, together with extensive interviews with families and important conclusions on the need to enable them and their friends and neighbours to care more effectively through a comprehensive locally-based network of services.

THE FINANCIAL NEEDS OF DISABLED CHILDREN
J. Bradshaw, The Disability Alliance, 1975 (Reviewed in CHC NEWS 4.)[5]
A short account of the Family Fund, the inadequacy of financial aid to families and suggestions for reform.

EMPLOYMENT OF MENTALLY HANDICAPPED PEOPLE
King's Fund Centre, KFC Reprint 971, 1975.[6]
Over 8,000 people now attending Adult Training Centres could be working if Government and employers took their right to work seriously. A useful report of a workshop, with examples of how mentally handicapped people have found work, and recommendations for future policy.

THE SITUATION: IN HOSPITAL

PUT AWAY
P. Morris, Routledge & Kegan Paul, 1969.[3]
The standard study of conditions in mental handicap hospitals. Although long and based on material collected 10 years ago, still essential reading for anyone who wants to understand the hospital legacy of today.

REPORT OF THE COMMITTEE OF ENQUIRY INTO ALLEGATIONS OF ILL-TREATMENT OF PATIENTS AND OTHER IRREGULARITIES AT THE ELY HOSPITAL, CARDIFF
Cmnd. 3975, HMSO, 1969.[7]

REPORT OF THE FARLEIGH HOSPITAL COMMITTEE OF ENQUIRY *Cmnd. 4557, HMSO, 1971.*[7]

REPORT OF THE COMMITTEE OF INQUIRY INTO SOUTH OCKENDEN HOSPITAL
House of Commons Paper, HMSO, 1974.[7]
Three official reports into disturbing conditions in individual hospitals. "It could happen anywhere" is the usual comment. Essential, if sad, reading.

ASYLUMS
E. Goffman, Pelican Books, 1971.[3]
A sociologist's view of "total institutions" and the dehumanisation of their inmates, which helps to explain why things are often as they are.

THE POOR IN HOSPITAL
A. Shearer, The Disability Alliance, 1976. (Reviewed in CHC NEWS 8.)[5]
A short account of the way people in long stay hospital care work without being paid and the random way they have been paid "pocket-money" in the past, together with suggestions for much-needed reforms.

CHILDREN IN HOSPITAL

WHOSE CHILDREN? *CMH, 1975* **NO CHILDREN**
Council for Children's Welfare, 1975[8].
Two short accounts of the appalling deprivation suffered by the 8,000 or so children living in mental handicap hospitals, comparing their situation with that of other children living away from home. The first outlines a strategy for ensuring that *no* child lives in hospital in the future. The second calls for an official enquiry into this situation.

THE EMPTY HOURS
M. Oswin, Penguin Books, 1973.[3]
Moving account of the way children in long-stay hospital care spend their weekends. "Will I have to spend all my life in this hospital?" asks one.

PLANS AND RESPONSES

BETTER SERVICES FOR THE MENTALLY HANDICAPPED
Cmnd. 4683, HMSO, 1971.[7]
The Government plan for the development of services for mentally handicapped people over the next 20 years, including estimated numbers using each service. Essential reading. Emphasises the right of the mentally handicapped person to lead as normal a life as possible, with services in his or her own area, together with the need for co-operation between health and social service authorities to achieve this, but leaves exact patterns open to local interpretation.

WESSEX
A. Kushlick, Research Report No 115, Health Care Evaluation Research Team, Wessex RHA, 1975.[9]
Summary of extensive "research" project which pre-dates the White Paper by 10 years and shows how the hospital service can make a creative contribution to locally-based care by providing homes to serve small population areas instead of concentrating all these places on one site to create a mental handicap hospital. Essential reading for anyone interested in putting new philosophies into action.

OPENING THE DOOR
K. Jones, Routledge & Kegan Paul, 1975.[3]
Report on one health region and local authority's response to the White Paper, only one year after its publication. Shows how far we have to go, especially in developing coherent joint health and social services plans.

LIVING IN HOSPITAL
J. Elliott, King's Fund, 1975 (Reviewed in CHC NEWS 4).[6]
Down-to-earth guide on making hospitals more like a real home for the people who live in them, with 100 useful questions as a basis for action. Applies as much to the most handicapped residents as to the more able.

NO PLACE LIKE HOME?
A. Shearer, CMH, 1975 (Reviewed in CHC NEWS 6.)[1]
Through the experience of people living in residential homes, questions whether these automatically provide a better "home" than the hospitals and emphasises the paramount importance of caring relationships between staff and residents in *any* residential setting.

NEW PHILOSOPHIES

NORMALISATION *B. Nirje in* **CHANGING PATTERNS IN RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED,**
President's Committee on Mental Retardation, Washington, 1976.
The best introduction to the simple philosophy which has been behind the development of good services in Scandinavia and the United States. "Enable the individual mentally handicapped person to share as far as he or she possibly can in the normal patterns and expectations of the local society" is the basis of it and as a guide to action it has worked better than any other we have. (Available in Britain towards the end of 1976.)

EVEN BETTER SERVICES FOR THE MENTALLY HANDICAPPED *CMH, 1972.*[1]
Using the Government's own figures, shows how a completely locally-based pattern of care for all mentally handicapped people *can* be achieved — and so the mental handicap hospitals completely phased out — over a period of 20 or so years. Essential reading alongside the White Paper.

A HUMAN CONDITION
L. Gostin, MIND, 1975.[10]
A study of the Mental Health Act from its introduction in 1959 to 1976, with proposals for much needed reform if the rights of mentally handicapped people and those with a mental illness are to be truly protected in future. The first time the thorough-going American legal and civil rights approach has been outlined for this country. Very salutary.

AVAILABILITY

1 Campaign for the Mentally Handicapped, Publications, 11 Henleaze Avenue, Bristol.
2 National Society for Mentally Handicapped Children, 17 Pembridge Square, London W2.
3 Order from any bookshop.
4 Office of Health Economics, 130 Regent Street, London W1.
5 The Disability Alliance, 96 Portland Place, London W1.
6 King's Fund Centre, 24 Nutford Place, London W1.
7 Government bookshops, or as 3.
8 Council for Children's Welfare, 183 Finchley Road, London NW3.
9 Wessex RHA, Highcroft, Romsey Road, Winchester, Hants SO22 5DH.
10 MIND Bookshop, 155 Woodhouse Lane, Leeds.

PRESCRIPTION PRICING AUTHORITY

by E. E. Stabler FPS, Secretary

The Prescription Pricing Authority was constituted by Statutory Instrument 1974 No. 9, made under Sections 5(6) and 6(3) of the National Health Service Reorganisation Act 1973 and came into being on 1st March 1974, and is the successor of the former Joint Pricing Committee for England, which was set up in July 1948 under the National Health Service Act 1946.

The Authority is a Special Health Authority, established to perform the functions relating to the examining, checking and pricing of prescriptions for drugs, medicines and listed appliances on behalf of Family Practitioner Committees in England and such other functions as the Secretary of State might direct.

The Authority has twelve members, eight of whom are appointed by FPCs and the remaining four by the Secretary of State, three being registered pharmacists and one a general medical practitioner. The membership for the current year 1976/77 is: Mr E. Brennan FPS, Mr D. Cammidge DPA FHA, Mr L. T. Gadge, Mr A. Jones JP, Mr G. S. Knowles FPS JP, Mr T. Reid FPS FHWC, Mr J. A. Stewart MBE BSc BL FPS, Mr W. H. Tooes MBE (all appointed by FPCs); Mr L. Priest MSc BPharm FPS, Mr B. Silverman MPS, Mr H. Steinman OBE FPS, Dr M. Latner (all appointed by the Secretary of State). The Authority appointed Mr Stewart Chairman and Dr Latner Vice-Chairman. The headquarters of the PPA are in Newcastle upon Tyne, where some 850 staff are employed; about 1,000 staff are employed in seven other processing divisions in Durham, Wakefield, Preston, Liverpool, Sheffield, Manchester and West Bromwich. A new division is in the process of being opened in Bolton where some 200-250 staff will eventually be employed.

Prescriptions dispensed by some 9500 chemists and appliance contractors in contract with the 90 FPCs of the Area Health Authorities are submitted each month to a specified processing division, where they are priced in accordance with prices and agreements reached between the Department of Health and Social Security and the Pharmaceutical Services Negotiating Committee. Calculations of the payments due to chemists for their dispensing services are notified each month to and subsequently paid by the FPCs. During 1975 281,722,104 prescriptions were dispensed by chemists and appliance contractors in England at a total cost of £359,532,596. There are in addition some 2120 doctors who dispense prescriptions for their patients and submit them to the PPA's headquarters office in Newcastle monthly and/or quarterly, where they are priced according to the terms agreed between the DHSS and the British Medical Association. Due payments are certified to and made to the doctors by the appropriate FPCs. During 1975 14,020,428 such prescriptions were dispensed by doctors in England at a total cost of £18,126,876. Prescribing doctors may also claim for certain drugs which they may require to personally administer — a yearly average of such claims amounts to approximately 740,552 at a total cost of about £1,568,280.

In the field of investigation of doctors' prescribing, statistics relating to each doctor on every Family Practitioner's Medical List are prepared regularly and forwarded to the FPCs. From these reports each doctor is made aware of his prescribing costs compared with the area as a whole. More detailed reports are prepared for selected doctors concerning their actual prescribing on F.P.10 forms and rendered on request to the DHSS. In a 12 month period some 17½ million prescriptions are referred to the Investigation Section in Newcastle and reports prepared for almost 15,000 doctors. Detailed reports are prepared for about 1,200 doctors from 1½ million prescriptions.

Other investigation work includes examination of selected drugs for which clinical control is necessary. The Authority's central prescription analysis department codes sample prescriptions each month and the coded information plus appropriate costings are forwarded to the DHSS, to assist the Department to measure the pattern of prescribing and distribution of prescriptions over therapeutic categories and classes of drugs, and to appraise the level of prescribing of individual preparations.

The Secretary of State has decided it would be useful at this stage in its evolution to take a fundamental look at the Prescription Pricing Authority which has grown out of the old National Health Insurance Committees formed before the first world war. He has invited Mr R. I. Tricker, Director of the Oxford Centre for Management Studies, to hold an independent enquiry into "the functions, constitution and organisation of the Prescription Pricing Authority". Mr Tricker, who has already started his enquiry, will be assisted by two assessors appointed by the Pharmaceutical Services Negotiating Committee and the British Medical Association.

PROGRESS FOR RECEPTIONISTS

by John Ryan, Secretary, Halton CHC

Since the formation of Halton CHC, by far the greatest number of complaints against the service have been about the attitudes of receptionists, particularly those working in the primary care sector. It was decided that a joint meeting between the Council and all the receptionists working in the district might help to achieve a better understanding of patients' anxieties and at the same time highlight to members of the CHC the problems which the receptionist encounter in their daily work.

The Chairman sounded out the idea informally with the DMC before the Secretary wrote to all the receptionists, emphasising that the CHC wanted the opportunity to meet them in order to better understand their work. At the meeting, the first period was spent explaining the role of the CHC. Out of a total of 18 practices, 21 receptionists attended and it was obvious from the start that these ladies were very concerned about the service they provided and the image which the general public had of them.

The discussions were forthright and highlighted many problems — not least of which is that of poor training. Very few receptionists have received any formal training for one of the most important jobs in the primary care sector, and it was soon apparent that many had developed their ideas of the job in terms of protecting the doctor from the patient and any implied criticism of the doctor brought a swift and touching defence. Very few of the receptionists had ever been included in multi-disciplinary meetings to discuss the development of the practice policy, and only a handful ever had regular sight of DHSS, AHA and FPC information circulars. It was very significant that those attending were meeting their professional colleagues for the first time and only two of them had ever seen the administrative organisation of a practice other than their own.

The receptionists based in one particular health centre now intend to follow up the CHC initiative and arrange further meetings with the aim of organising a regular forum at which they can discuss their role and contribution to the health care enterprise. They also hope that this will lead to the formation of an association to advance their professional standing and to develop good administrative practices and skills.

Private Practice and the NHS

The Health Services Bill now before Parliament proposes legislation to separate private practice from the NHS. The issue that has caused most controversy since the publication of a consultative document on this subject last August has been the Government's intention to withdraw pay beds from NHS hospitals.

Because prominence has been given to the strength of feeling on each side of the dispute, the facts of the case and the relatively minor scale of the resources involved have tended to be obscured. In fact there are only 4,444 pay beds in England, Scotland and Wales combined — 1 per cent of the total number of beds in NHS hospitals. Of these, 724 are concentrated in London, and a further 267 in Birmingham and Manchester. These figures do not however, represent the number of pay beds being utilised at any one time as the average rate of occupancy of acute beds in the private sector is considerably less than that of equivalent beds in the NHS (55 per cent as against 77 per cent). The Health Services Bill, based on the principle expressed by Barabara Castle that "access to treatment should be on the basis of medical priority alone and not on ability to pay", is now in its committee stage and is expected to receive its third reading shortly.

The intention is that within 6 months of the Bill becoming law, the present number of pay beds in NHS hospitals will be reduced by 1000. To this end a schedule was prepared in February this year, detailing the proposed locations of the first 1000 beds to be released for NHS use. The Schedule was devised on the assumption that the beds to be withdrawn would be in areas where it was considered that there were already reasonable private sector beds and facilities available for those who wished to use them.

This schedule was then circulated at area level with a request for comments from the Area Medical and Dental Advisory Committees, from organisations representing other staff and from the area health authorities. This consultation process on the first stage of the phasing-out operation continues through the Bill's committee stage, and has now been extended to include consultations at district level with local professional advisory committees and other staff bodies, and of course with CHCs.

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.

The phasing out of the remaining 3,444 pay beds is to be decided by an independent Health Services Board. The Board will have a legally qualified chairman, two members appointed after consultation with the medical and dental professions and two further members to be appointed after consultation with the NHS trades unions and representatives of patients' interests. The Board will have Scottish and Welsh Committees. It will put forward proposals at 6-monthly intervals for further reducing the number of pay beds. In making these proposals it will take into account the demand for private medicine in each area, the use that is currently made of existing pay beds, what alternative private facilities are reasonably available, and what steps have been taken to provide them.

There has been considerable discussion about the cost of the phasing-out operation. In his speech on the Bill on April 27th, David Ennals estimated it at "a very low level: £3m or £4m in the first full year." There will of course be a loss of income from private patients to the health authorities as the private beds are released for use by the NHS. The Government has, however, repeatedly made it clear that this loss of income will not result in reductions in individual authorities' revenue resources.

What has not received such widespread publicity is the level of subsidy made to private patients each year. The income from in-patients for private accommodation and treatment in NHS hospitals in England in 1974/5 is provisionally put at £15m.

The revenue cost of providing these services in the same period is estimated at £17m. This implies a subsidy from public funds of £2m in that year alone. To put it another way, the charges made to private patients for pay beds in 1974/5 were about 15 per cent below the average estimated costs (excluding consultants' salaries) per in-patient week for all beds in NHS hospitals.

As well as the phased release of pay beds for use by NHS patients, the Health Services Bill also proposes to give the new Health Services Board the task of ensuring that developments in the private sector do not endanger the service that the NHS gives to its patients: the Board will be responsible for granting or withholding authorisations for proposals to open private acute hospitals with over 75 beds. In addition the Board will give consideration to the phased withdrawal of NHS facilities used by private out-patients, and will make recommendations for common waiting lists for NHS and private patients.

General practitioners practising from health centres will continue to have the right to see private patients there, if they so wish.

Fuel

In the last two years charges for gas and electricity have risen sharply. This has meant that an increasing number of old people and poor families have had to choose between fuel and food. Last winter, over 135,000 households had their fuel supplies disconnected because they could not afford to pay their bills. Families with babies and young children were left without heating or cooking facilities; and — especially among the old — hypotnermia claimed many victims.

In response to pressure from the *Right to Fuel Campaign* (a national campaign co-ordinated by the British Association of Settlements), the Government agrred to look into ways of mitigating the growing hardships. Four separate bodies were asked to report on the subject. An inter-departmental committee of officials under the auspices of the Department of the Environment reported in February this year, but seemed to conclude that nothing much could be done.

Last month, however, the National Consumer Council, a sub-committee of the Select Committee on the Nationalised Industries, and an official government enquiry chaired by Gordon Oakes, published their reports. These bodies have recommended that urgent action be taken by the Government to end the hardship caused by high fuel prices to low-income families. They specifically recommend that the way people pay their fuel bills should be fundamentally restructured, and that the practice of demanding deposits should be severely curtailed. All agree that the disconnection powers of the fuel boards should be withdrawn, and that fuel debts should be collected through due process of law like any other debt.

The national *Right to Fuel Campaign* has welcomed these recommendations, and is now urging the Government to implement them immediately, in order to avoid further hardship next winter.

Terms of office for CHC members

A Statutory Instrument has been issued concerning the term of office for CHC members. The National Health Service (Community Health Councils) Amendment Regulations 1976 No. 791 add two extra paragraphs on to regulation 5 of the original Statutory Instrument No. 2217 1973.

They state that those members who were appointed until 30 June 1976 will continue in office until the end of December 1976, and that those appointed from 1st January 1977 shall hold office until 30 June 1980.

Welsh CHCs

A majority of CHCs in Wales have backed the government's proposals on devolution contained in the White Paper "Our Changing Democracy". The White Paper envisages for Wales an elected executive assembly which would be responsible for health matters. It was also revealed at the last meeting of the Association of Welsh CHCs that almost two thirds of Councils in Wales favoured the present arrangements for the distribution of oral contraceptives. Three Councils favoured arrangements being extended to cover nurses and midwives, but there was no support for the Pill to be distributed on a wider basis, such as over-the-counter sales.

These are two of the issues which the Welsh Office has consulted CHCs about. At the same time Welsh CHCs have been concerned about the way in which the government has consulted them — via the Association rather than individually. Several Councils have felt that this could erode their powers and often the time-scale allowed for consultation has not been sufficient for the representatives on the Association to go back to members.

The Association is seeking a meeting with the Secretary of State for Wales to discuss relationships and contacts between CHCs and Family Practitioner Committees. The Association believes that CHCs should be allowed to send observers to meetings of FPCs and there have also been moves to persuade the government to prescribe certain functions on which AHAs could issue directives to FPCs.

The Association also wants the Welsh Office to press the DHSS to take steps to get reciprocal arrangements between the US and the UK on the question of medical insurance cover. This follows a recent case of a South Wales man who, while on a visit to America, was taken into hospital for an operation, the full cost of which was not covered by insurance he had taken out. He was later presented with a bill for several thousand pounds.

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 10: South Nottingham CHC
Secretary: Mr Graham Wagstaff

Page 30: East Berkshire CHC
Address: c/o Slough Community Centre
Farnham Road
Slough
Berks SL1 4UX
Telephone: Slough 21256 Ext. 7

Page 33: Isles of Scilly CHC
Address: Dolphins
Old Town
St. Mary's
Isles of Scilly
TR21 0LW
Telephone: Scillonia 588
Chairman: Mrs Betty Pickup
Secretary: Mrs L. Langley-Williams

Page 36: North Warwickshire CHC
Chairman: Cllr W. H. Knight

Page 36: Rugby CHC
Chairman: Mrs P. M. Hill

Page 43 Central Manchester CHC
Address: Pearl Assurance Building
St. Ann's Churchyard
St. Ann's Street
Manchester M2 7LN
Telephone: 061-832 8183/4/5

Page 44: North Manchester CHC
Address and telephone: as for Central Manchester CHC

Page 44: South Manchester CHC
Address and telephone: as for Central Manchester CHC

Page 48: Pembrokeshire CHC
Secretary: Mr D. Ernsting

Page 63: Index
Insert: Roehampton, 27

Page 64: Index
Insert: Worthing, 26

Suggestions & complaints

The DHSS has issued a document with circular HC(76)107 setting out a proposed code of practice for handling suggestions and complaints concerning the hospital and community health services (other than those concerning family practitioners). This is the result of a recommendation made by the Davies Committee which reported in 1973, and CHCs will want to read the code closely. In next month's CHC NEWS we will discuss the document in more detail, particularly in relation to the role that CHCs could play in the future. The DHSS wants comments on the draft to be submitted by 1st September, and they ask CHCs to submit their views on a regional basis wherever this is possible.

Exhibition stands

A set of exhibition stands is now available on free loan to CHCs from the CHC NEWS office.

The set has 10 poster-sized panels and can be used as part of a stall at a local show, to illustrate a talk about the CHC, as a display stand at an exhibition or wherever there is an opportunity to publicise the CHC.

When assembled, the stand's overall dimensions are 2.3 metres high x 3.0 metres wide (7ft 8in x 10ft). The kit is easy to assemble and dismantle, and can be transported in a small car.

CHCs wishing to borrow the stands should contact CHC NEWS to make a booking (the address and phone number are given on p.7). The King's Fund, which has paid for the exhibition stands, had also offered to pay for the production of a general poster to be used on the stands in conjunction with CHCs' own publicity material (see CHC NEWS 6 p.7). However, a number of potential designs have been submitted to CHC people around the country for comment and unfortunately it has not been possible to reach sufficient agreement about them to proceed at this stage.

Study day on Surveys

Would you be interested in attending a study day to discuss practical methods of carrying out surveys and small investigations? The King's Fund is prepared to organise this in the autumn, if CHCs show sufficient interest in the idea. Topics for study could include: selecting a sample, questionnaire design, postal surveys, face-to-face interviews, statistical analysis, presenting the report, academic and commercial support, methods for small investigations. Please write to the Editor of CHC NEWS indicating whether you would attend such a study day and which topics you would want to see discussed, together with any other suggestions, by the end of July.

Conference

We have been asked to remind all CHCs that if they have amendments or resolutions to propose at the Conference on 3rd November they must send them in writing to the Steering Committee not later than 31st July.

If they have a question they wish to put to the Secretary of State at the morning session, this also should be sent in writing to the Steering Committee, not later than 30th September.