# CHC NEWS

For Community Health Councils

September 1976 No 11


# Patients' Committees one year on

*by Dr Alistair Wilson MA MRCGP*

One year ago, CHC NEWS (September 1975 No 3) contained an article written by me describing the activities of the Aberdare Health Centre Patients' Committee. Since then there has been considerable interest in the scheme from CHCs, AHAs, some doctors, 2 medical schools, the British and Wales TUCs, the Cooperative Movement, the medical and lay press and the radio.

During the last year the Aberdare Patients' Committee has met about 20 times. It has, in addition to looking at the services provided by the health centre staff, discussed the AHA plan for local hospitals, cooperated in the setting up of a social club for the mentally ill, won the support of the local council for subsidised transport for hospital visitors, held a public meeting (with the CHC) to gather evidence for the Royal Commission on the NHS, set up a Towns Committee to develop a scheme of street wardens to look after the aged and infirm, and held 26 public lectures and debates on health subjects. There have also been 2 social gatherings. The medical students who come to work at the centre get enthused with the new kind of primary care that we, patients and health teams, are creating together.

During this past year, a number of other people have become interested in the idea of setting up patients' committees, and as a result, several are being formed in different parts of the country. The main impetus is coming from community health councils, although here and there, a few doctors have become convinced of the need for patients' participation in primary care units, for example at Glyncorrwyg (South Wales) where the committee was elected in October 1975, and at the Warwick Medical Centre at Taunton. The South Clwyd CHC are negotiating with the doctors and the FPC to set up a patients' committee at Buckley Health Centre, which already has a staff committee. South Wirral CHC will be holding a public meeting this month at West Kirby at the opening of a new health centre, and they hope to get the nucleus of a patients' committee then, as the local doctors have already expressed some measure of support.

Other CHCs which are looking into the possibility of setting these committees up are South Birmingham, Bromsgrove and Redditch, Cardiff, Vale of Glamorgan, Darlington and Salop. An attempt to set up a patients' committee at Croydon Health Centre failed, but last September, the British Medical Journal published an article about a 'community health participation scheme' in operation at Berensford Health Centre, near Oxford. There are also believed to be patients' committees of various kinds at practices in Bristol and the Isle of Wight. Interest is definitely mushrooming, and I have little doubt that in a few years' time, as the benefits to patients and health staff alike are realised, patients' committees of different kinds will be created in health centres all over Britain. More CHCs and dedicated doctors will, I feel, become convinced of their value in bringing more and more people into democratic participation in running the NHS; in developing positive and preventive health education including the teaching of the early signs and symptoms of disease, and in ensuring that primary medical care in Britain is raised to a much higher level.

# Complaints enquiry

CHCs have recently received a letter inviting them to submit evidence on the need for an independent review, when a complainant remains dissatisfied with the way his complaint has been handled. At present he can ask the Health Service Commissioner to investigate or he can pursue the matter in the courts. But the Health Service Commissioner cannot investigate complaints involving clinical judgement or where there is a legal remedy, and many of these are the most serious cases. The Davies Committee recommended that regional investigating panels be created to deal with such complaints but this solution proved unacceptable in some quarters.

So this year, the Secretary of State referred the matter to the Select Committee on the Parliamentary Commissioner for Administration.

Their work is quite separate from the recent draft code of practice on handling complaints. They are seeking evidence from CHCs and other bodies on: (a) whether an independent review is required in principle; (b) if so, what criteria should it meet; (c) what would be the best form for it to take, and (d) any other points relevant to this issue.

The Select Committee is not seeking a consensus of CHCs' views. Although a second letter has gone out asking for regional submissions, we have been assured by Pat Gordon (Secretary of City and Hackney CHC and a Specialist Advisor to the Select Committee) that this will not always be appropriate. The Select Committee is anxious that individual CHCs should be free to submit their evidence without delay, and before mid-October.





# YOUR LETTERS

## REGIONAL COOPERATION

*from Philip Topham, Secretary Blackburn CHC*

How effectively are RHA policies and decisions being monitored in your region? The original statutory instrument provides that CHCs can establish joint committees to perform some of their functions, and CHCs in every region have now spontaneously formed regional associations in one form or another. It would be appropriate for these to take on the vital job of monitoring the RHA, but this depends on the degree of responsibility CHCs are prepared to vest in their regional bodies, and what recognition of this status would then be given by other NHS bodies.

One of the realities which must be faced if CHCs are to collaborate is that they must themselves agree on priorities between their respective districts. Either they do this and present a strong united front to the health authorities, or go their own way, having correspondingly less influence. The narrow, local viewpoint represents a real failure to understand that it is only by changing regional and national policies that CHCs will achieve improvements for their own district and enhance the principle of public participation.

## CHIROPODY SERVICE

*from John Pottinger, Chairman Bradford CHC*

The item "Chiropody Service" in CHC NEWS 10 reminds me of a wealth of correspondence indulged in by the Bradford CHC last autumn. At that time, the Council resolved to support the Council of the Society of Chiropodists in its proposals to amend the Professions Supplementary to Medicine Act 1960 to enable a roll of "chiropodial aides" to be set up.

We wrote to this effert to the (then) Secretary of State and to our local MPs. It is sad that the writer in your journal nearly 12 months later should record a similar state of affairs.

May we hope that a National Council of CHCs could press more successfully for amending legislation which (it appears to the laymen) would be short and uncomplicated? The Bradford CHC is constantly aware of dereriorating services (by nature of the waiting lists) in community chiropody.

## PROFESSIONAL v PUBLIC INTEREST

*from B. Maunder, Secretary Swansea/Liw Valley CHC*

It cannot be doubted that, at present, family practitioner committees lack real and effective accountability, as do those in contract with the committees. One example concerns difficulties with the deputising system provided by local GPs. After receiving many complaints the CHC wrote to West Glamorgan FPC suggesting that (a) the number of potential patients for whom an on-call doctor could accept responsibility should be limited, and (b) that a single telephone number be provided to enable the public to contact the on-call doctor directly instead of having to deal with answering machines or operator interceptor systems.

The FPC first claimed that these suggestions were ruled out by the regulations, but when challenged by the CHC agreed that no such prohibition existed. The CHC then requested a meeting, and **six months later** the FPC refused to have a meeting after having consulted with the local medical committee. The CHC has now taken this matter up with the Secretary of State at the Welsh Office, and has the support of the Association of Welsh CHCs. Apparently the self-interest of professional staff is allowed to militate against the public interest, but hopefully, with the assistance of other CHCs, this situation can be improved. I would be glad to receive the comments of CHCs on this.

## PLAYING THE GAME?

*from R. L. Payne, Secretary Rotherham CHC*

Tom Richardson (CHC NEWS 8) seemed to imply, reading between the lines, that CHCs should be prepared if necessary to adopt an aggressive attitude in their dealings with those who manage. But experience shows that an aggressive approach tends to place the other side on the defensive. Conversely, a cool, determined, professional attitude may bring about a situation more helpful for discussion and consultation.

I think we should all face the fact that knowledgeable professional administrators will never willingly permit CHCs to exercise every bit of power they might, because it would not be in their interests to allow this. But that is not to say that CHC secretaries, to be successful should have an NHS management background. All I wish to emphasise is that the CHC secretary must be able to negotiate on equal terms with those to whom he must take the wishes of the Council and the community it serves. The rules of the game are not yet fully understood by CHCs, and in this top management league, ignorance of the rules is not treated with sympathy, but exploited. Therefore, unless we develop a high standard of professional knowledge, CHCs will not have the impact expected of them.

## HEALTH ADVISORY SERVICE

*from H. S. F. Jennings, Member Wakefield CHC*

I am not happy about the procedure outlined in the article on page 10 of CHC NEWS for June.

We are constantly being reminded that we represent the 'Consumer' (in the broadest sense) and yet the DHSS sees fit to allow CHCs to see only a summary of HAS reports. The disturbing events reported at various hospitals in recent years point to the need for vigilance by visiting CHCs; yet where is our public credibility when we are not given in full the HAS recommendations?

Withholding of information arouses suspicions, however unfounded, that there is something to hide and wrong conclusions are drawn from rumour and speculation. The DHSS should make full disclosures of HAS reports to CHCs mandatory on AHAs not discretionary.

## SALE OF PAINKILLERS

*from Pauline Phillips, Secretary East Herts CHC*

Referring back to your feature and editorial in the May issue of CHC NEWS, are other CHCs getting apprehensive too about the impact of the proposed legislation on rural communities? In East Herts we are already worried about the effect on rural areas of centralising services. If, in addition, people can't go to the corner shop for simple remedies — especially during the 'flu season — this will only make matters worse.

As you point out, CHCs were not invited to comment on the proposals, but is it too late to do anything at all?

## A NEGLECTED GROUP?

*from Eugenie Summerfield, Assistant Secretary South Tees CHC*

A growing interest aroused by the media in hormone replacement therapy for women in the menopause led us to look deeper into how their needs are being met. Quite apart from HRT, our sample survey of women in the 40-60 age group revealed that many were not having their health care needs met. Some women did not know about all the normal physiological changes which were likely to occur. A great number of the women were reluctant to discuss their problems with their doctors or their families, yet felt they would like an opportunity to 'talk through' their worries.

From this we feel that the scope of health education should be extended to prepare people more fully for the changes of middle life, and that some form of counselling or self help service with professional back-up should be started, perhaps through one of the women's voluntary services. We would like to hear from other CHCs who have also come across these issues and who may already have such a counselling service in their area.

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*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.*

# Advice centres and the law

*by John Hobson Community Lawyer at Southwark Law Project*

Various Community Health Councils are now setting up information and advice services. This article considers whether there are circumstances in which people who give negligent advice and information to others might be held liable to compensate them.

Although neither is likely to apply in the case of Community Health Councils, it perhaps needs to be mentioned that there are two clear cases where such liability will always arise. The first is where advice or information is given recklessly or with the intention that the person who receives the information should act upon it. This is known in law as the tort of deceit and the party deceived can recover damages for any loss that results. Secondly, if the advice is paid for, then there is a contract supported by consideration upon which a court action can be based. If, for instance, a person employs a solicitor to advise him then the solicitor must be careful to give correct advice or be sued for breach of the contract between him and his client.

Neither of these situations is likely to occur in a Community Health Council advice and information centre. Information is likely to be given free, so it is unlikely that there will ever be an enforceable contract between adviser and client. Furthermore it can generally be assumed that advisers act in good faith and do not purposely give misleading information. Yet people will occasionally be given advice which is wrong and misleading and there may be circumstances when honest (and unpaid) advisers may find themselves liable.

**HOW THE LIABILITY CAN ARISE**

Before 1964 it was doubted whether liability for negligently given advice could ever arise. Then, in that year, in the case of Hedley Byrne & Co. Ltd. —v— Heller & Partners Ltd (1964 A.C. 465) the House of Lords indicated that the duty to be careful in giving advice did exist and that the consequences of carelessness could be an award of damages against the negligent adviser.

In order for this duty to take care in giving advice to arise, the following situation must be shown to exist. First it must be understood by the parties that the person who receives the advice intends to rely upon it and it is reasonable that he should do so. Thus casual advice given in the course of a social meeting is not likely to face the same duty. Also the person who gives the advice must be someone who holds himself out as being skilled and competent to give advice on the subject-matter of the inquiry. Thus (to quote from one of the judgements in the above case) a duty to take reasonable care arises when a person "takes it upon himself to give information or advice to, or allows his information or advice to be passed on to another person who, as he knows or should know, will place reliance on it".

This situation will clearly therefore exist at CHC information and advice services and it makes no difference to the duty that the assistance is given free. There is therefore an obligation to make sure that the information supplied to clients is accurate and up to date. A client who receives information that is not and acts upon it to his detriment may therefore be able to look to his negligent advisers to compensate him for loss that results.

**IN WHAT WAY CAN AN ADVISER BE PROTECTED AGAINST LIABILITY?**

Protection can be achieved in two ways: by disclaimer and by insurance. It is possible to disclaim liability for negligent advice and in the case of Hedley Byrne itself liability was avoided. because the information had been provided "without responsibility". This makes it clear to the person who receives the advice that it is entirely up to them and at their own risk whether or not they act upon it. Any words used in an endeavour to exclude liability must be clear and unambiguous. They must be brought to the attention of the client before or at the time the advice is given. Thus if an advice or information centre wishes to exclude liability by a disclaimer they must display a prominent notice or give each client a piece of paper stating such words as: "we accept no responsibility for the accuracy of any advice given".

This of course is unlikely to do much to increase the confidence of the clients or the reputation of the service. It is more customary to face the consequences and to insure against them. Insurance cover in respect of claims for negligence is usually known as professional indemnity insurance. In order to help the rapidly increasing number of legal advice centres the Legal Action Group has been able to negotiate a standard policy which each local centre can obtain. Perhaps community health councils can collectively arrange something similar.

# ABORTION

The First Report of the Select Committee on Abortion for this session of Parliament was published on 28th July containing recommendations for legislation.

**Background**

In 1967 Parliament passed the Abortion Act which principally extended the grounds on which an abortion could legally be obtained. Subsequently, the Lane Committee was set up to examine the workings of the Act, and its report was published in 1974 (see CHC NEWS 7). In November 1974 James White MP introduced his Abortion (Amendment) Bill into Parliament and, after its Second Reading, it was referred to a Select Committee (see CHC NEWS 2). The Select Committee made 4 reports during that session of Parliament, and its proposals for closing some of the loopholes in the Act were accepted by the DHSS for immediate action.

The Select Committee was re-established in 1976 with the same membership as before but the 6 members who supported the 1967 Act resigned from the Committee because they did not believe it would improve the conditions for the availability of abortions. The remaining members continued their work, and intend to publish further reports.

**The Report**

The main recommendations concern those agencies providing advisory, referral and pregnancy testing services, which charge fees. The report says these agencies should have to be licensed by the Secretary of State, and that they should be separated from clinics providing abortions. At present, nursing homes where abortions are done have to be licensed annually by the DHSS. The Department is shortly expected to publish a list of approved referral agencies, and the position would then be that licensed nursing homes would be asked to accept referrals only from those agencies listed by the DHSS.

The Select Committee has also recommended that referral agencies should have no financial links with the nursing homes to which they send women. This proposal is strongly criticised by such agencies as the Pregnancy Advisory Service and Brook Advisory Centres. They argue that they have been able to bring down the cost of abortions to women by running linked referral and abortion facilities. The Committee felt that existing links enabled some agencies to make unacceptable profits from their services. However the PAS and Brook organisers have stated that this proposal would not only increase their running costs and hence the cost of abortions, but that it would push more women without the means to pay into the hands of the unscrupulous organisations.

Another recommendation of the Committee is that the upper limit for abortion should be reduced from 28 to 20 weeks (except in certain special cases). Also, anyone performing an abortion should have to notify the woman's GP, provided that the woman has given her signed consent to this.

# Essential facts for Psychiatric Patients and the Disabled

## PSYCHIATRIC HOSPITAL ADMISSION LEAFLETS

*Mrs Clare Ellis, Edgware/Hendon CHC*

The Mental Health Committee of our CHC recently decided to look at the quality of the literature given to patients on admission to the mental hospital serving this district. We were concerned to find that at present no such information is provided. We feel that it is essential that patients and their relatives should be given as much help as possible in what can be a very confusing situation. We resolved not only to urge the hospital to make such information available, but also to suggest what items ought to be included. So we obtained admission leaflets from twelve psychiatric hospitals throughout the country and, from these, compiled a suggested list of topics. We hope it may assist other CHCs who find a similar lack of provision in their own area.

### Model admission leaflet

*Introduction:* History and organisation of hospital (sectorisation), modern methods of psychiatric treatment, aim to treat patients in the community.

*Location:* Map of area showing road numbers. Transport facilities — both public transport and hospital service. Plan of hospital layout, car parking facilities. (Separate card giving this information for relatives).

*Admission Procedure:* Time of arrival, where to go.

*What to Bring:* Clothes required, laundry facilities, valuables, money, medicines, food — advice to visitors, smoking regulations.

*Hospital Life:* Staff — categories, uniforms. Treatment, occupational therapy, industrial therapy, etc. Social worker. Amenities — post (incoming and outgoing), telephones, papers, periodicals, canteen and shop including opening times, trolley rounds, entertainments (cinemas, dances,etc.), sports facilities, library, hairdresser, television and radio, churches (details of services and availability of spiritual advisors — written by the Chaplain), voluntary help organiser, League of Friends, gifts to the hospital (warning against gifts to staff).

*Information:* Visiting times, social security benefits, social insurance, enquiries, complaints, Mental Health Review Tribunal, Community Health Council.

*Going Home:* Leave — visits home, discharge, follow up — outpatients clinics.

## FACILITIES FOR THE DISABLED & CHRONIC SICK

*Mr RWJ Wood, Harrogate CHC*

A study group of this CHC has made a special investigation of the facilities available to chronically sick and disabled people who live at home. The information was collected by talking with staff, patients and visitors at hospitals and treatment centres, and from experts in the social services and voluntary agencies.

The details have been printed as a short leaflet and cover local social services and NHS facilities, other statutory and voluntary provision and special facilities (eg. transport), and a list of local organisations. The leaflet is distributed widely to the public, and has been paid for by the CHC since it is a part of our publicity effort.

# National Development Group for the Mentally Handicapped

*by Professor Peter Mittler, Chairman*

The National Development Group (NDG) has now been in operation for nearly 18 months. During that time, much of the Group's work has had to be behind the scenes. They have had to come to grips with DHSS policies and with the problems of planning at national level. In their second year, the NDG are anxious to come very much more into contact with those who can have a direct impact on service provision: and they count CHCs particularly highly in this respect.

CHC members will know that in the consultative document *Priorities for Health and Personal Social Services in England*, DHSS Ministers have suggested that mental handicap should have priority second only to services for the elderly. They have proposed that the targets set out in the White Paper *Better Services for the Mentally Handicapped* (Cmnd 4683) should be fully maintained on the local authority side with further improvements being maintained at a significant rate in the hospitals. In concrete terms this means that local authorities would have to provide nationally a further 1,000 residential places and 2,400 adult training centre places each year. These are substantial figures and provision of that order will have a significant implication for hospital services. It will also be necessary to consider just how the planned increase in financial allocation to the NHS sector can be used to bring about the maximum improvement there. A hospital capital programme of about £9m annually, is suggested and that revenue expenditure should increase by about 1.6% annually.

The fate of these proposals depends on the result of consultation and on decisions to be taken locally. The NDG hope that CHCs will work to ensure that the priority suggested for mental handicap becomes a reality.

The NDG have now issued two short bulletins which summarise the work they have been undertaking, and copies should have been received by all CHCs. They have also issued a pamphlet: *Mental Handicap: Planning Together*. Copies of this have also been sent to CHCs. The pamphlet covers a very wide range. It sets out to provide ideas which will enable those responsible for service planning and provision to obtain the maximum benefit possible from the proposals which DHSS have made for more effective joint planning between NHS and local authorities and for a system of joint financing. The pamphlet is by no means the final word on mental handicap planning. The NDG have issued it in the hope that it will provide a beginning and a basis for discussion. They have tried to set out what they see of planning priorities nationally and to give some brief indication of how the planning task might be tackled. But it has not been written to cover particular local situations. How local needs can best be met can only be judged by those with an intimate knowledge of the particular area.

The NDG do however hope that CHCs will find the pamphlet of practical value.

CHCs may like to know that the NDG is also preparing discussion pamphlets on the following aspects of mental handicap service: services for children; day services for adults — especially adult training centres; provision for handicapped school leavers; the role and function of the mental handicap hospital; short term residential care.

The pamphlet which has already been published lists useful sources of further advice and gives some information about available literature.

Members of the NDG or of its associated Development Team are available to address any CHC that wishes to invite them. Because their numbers are small however it may be a little time before the Group could respond to any particular request. They are however always ready to provide general advice and information as far as they can, and the NDG hope that CHCs will not hesitate to contact them.

# PERSONAL VIEW

*BY CLIVE JORDAN*
*Member of*
*Lewisham CHC*

**"The Government's objective is to develop a structure for the National Health Service which will allow real devolution to those operating the service locally without detailed intervention from Whitehall or from the regions. This is only acceptable if there is a strong democratic element in the local administration."** *Democracy in the National Health Service, HMSO, 1974.*

As CHC members, we are beginning to learn that a "strong democratic element" is not something that can be achieved merely by demanding it in a government publication: it is something that needs to be worked for at the grass roots. It seems to me that as CHC members we have no more right to influence the development of the health services locally than the professionals in the district management team — unless we are properly accountable to the public and patients whose interests we represent. How can we ensure that accountability actually takes place, not only within the CHC as an institution, but in the NHS as a whole?

Would, for instance, directly elected CHC members make the CHC into a stronger "democratic element"? I believe that they would not, for two reasons: firstly, because at present we have no direct power over the local administration of the health service, and direct elections would therefore be a sham. But secondly — and more importantly — because we already know that the ballot box does not in practice give the average member of the public any real control over those public services for which he pays. The principal job of a CHC is not merely to recreate the kind of local authority democracy which has increasingly been found wanting, but to pioneer participatory structures in which the patient and the potential patient can feel that he has a real influence on the development of the health service in his locality. One of the most exciting things in the health service today is the extent to which a handful of CHCs are beginning to press for the extension of the work developed by Alistair Wilson in Aberdare. Patients' Committees are just one way of developing a stronger democratic element; there are many other ways in which the professional doctor, dentist and administrator can share the decisions they make about the way the service is run.

If the job of CHCs is to introduce a strong democratic element in the local administration, we have to think not only of making the local health services accountable to the 30 or so members that happen to make up our Council, but also of making them accountable to the people we represent.

It would, however, be wrong to suggest that this will be easy to bring about. For one

thing, it goes against years of health care development in which those with medical expertise are second only to the clergy in having a divine knowledge and judgement. For another, the majority of health service users tend to have only a passing interest in its provision: when they contract a disease, break a bone, or have a baby . . . But it is precisely this lack of participation and accountability which has led, among other things, to the disastrous growth of acute services and specialised surgery to the detriment of primary health care, and other less glamorous services.

And the problem is compounded by the fact that the decision-makers in the NHS do not even have the minimal accountability to the consumer which is made possible by the management of other public services by elected representatives. If members of a local authority do not provide, for example, the social services which we need, we do not re-elect them. If a health authority is not responsive to our needs, we are powerless to change it, unless we make a more concerted effort to demonstrate the need for, and the viability of, more democratic structures.

The plain fact about the health service is that the vast majority of its users are politically weak: the old, the handicapped, the sick — those who are temporarily or permanently defenceless. The principal job of community health councils must be to give these people a political voice, not only by the techniques of traditional representative democracy, but also, and much more importantly, by developing methods by which they themselves can participate in the decisions which affect them, in a meaningfully democratic way.

In many ways, CHCs were created in response to the adage "health is too important to be left to the doctors". If that is true, then it is equally true that politics is too important to be left to the politicians.

# News from CHCs

- A new CHC is to be set up in Milton Keynes in 1978. At present the new town is served by Aylesbury CHC which has a working group on that area's health needs, and which will establish a branch office there until the new CHC comes into being. The decision that Milton Keynes should have its own Council came after Aylesbury CHC had written to the AHA outlining the differences between the new town's community and needs, and those of the rest of the district.
- Dr James Fairley replaces Cllr Mrs Tuck as Chairman of West Essex CHC.
- New Chairman at City and Hackney CHC is Mr Dennis Timms. This year's Vice-Chairman is Mr Sam Springer.
- NW Leicestershire CHC has written to all housing authorities in the district asking them to consider setting aside a small number of houses for use as group homes for people recovering from mental illness, when new council housing developments are being planned.
- Miss Lucinda Pickersgill has been appointed as Assistant to the Secretary of Salisbury CHC. She took up her duties on July 26th.
- Wandsworth and East Merton CHC has invested in £700 worth of video-tape recording equipment to be used as part of the process of keeping the public informed about health service issues and the work of the CHC.
- A number of CHCs have been upset by the DHSS directive to RHAs (in circular HC (76)25 on appointments to CHCs) to include a Trades Council representative in the membership. Jack Humphries, Chairman of East Somerset CHC is strongly opposed to the principle that organisation should automatically have the right to sit on a Council. Members of Cornwall CHC feel that the directive could introduce and element of political bias, and "cut down the public's freedom of choice".
- Discussions between the Leeds Eastern CHC, community health staff and the Area Chiropodist have resulted in the provision of a mobile chiropody service for fifteen local villages. The well-equipped unit calls at each village at least once a fortnight, and is towed by a landrover which also provides a pickup service for patients with transport difficulties.
- Secretary of South Hammershith CHC, Ivana Cooke, has become health correspondent of the London Free Press, a newspaper which covers community activities in the London area.

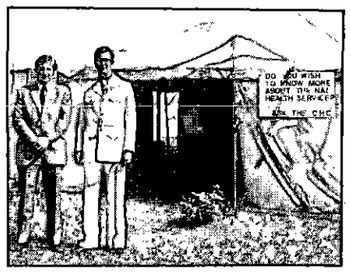
# News from CHCs

*Continued from page 5*

- In the light of current concern about the possible hazards to health from asbestos, South East Cumbria CHC has asked their AHA to provide them with information on the extent to which asbestolux in particular is used in local hospitals. They have also asked what steps are being taken to establish whether it is in a safe condition, and what on-going checks are to be made. The CHC are urging that the material only be used in future, subject to the most careful precautions.

- In its submission to the Royal Commission on the NHS, Bradford CHC is to suggest that the structure of community health councils should be changed so that fewer local authority representatives and more nominees from voluntary organisations can be appointed.

- The North and South Lincolnshire CHCs joined forces for a 'meet the people' exercise at this year's Lincolnshire Agricultural Show. In the middle of the summer's heat-wave,




Secretaries Geoffrey Callaghan and Geoffrey Briggs hit on the idea of stimulating people's interest with a free supply of cold drinks.

- Mrs Mair Thomas, a member of Bromley CHC, has been awarded an MBE for her services to the community. Mrs Thomas has been a divisional director of the local Red Cross for 13 years. She is also a member of the Bromley Association for the Handicapped, vice-chairman of the Council for Voluntary Service, and a member of the Social Services Committee.

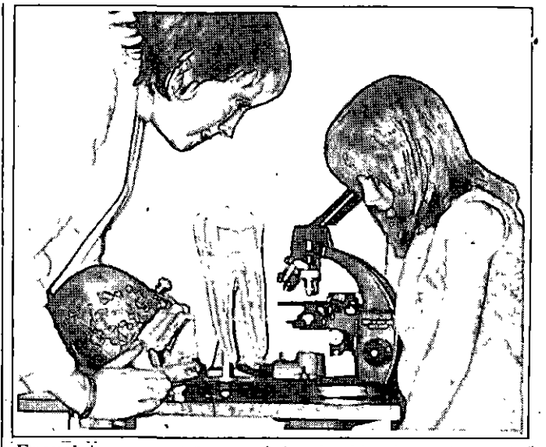
- Telephone calls and visitors to the South District Kensington, Chelsea and Westminster CHC have trebled since the distribution of a special newspaper. The CHC produced the 4-page tabloid-style paper at a cost of approximately £800. It contains information on the CHC's role and on patients' rights. Anyone who would like to see a copy should contact the Secretary, Christine Hogg.

# DENTAL DISEASE CAN AND MUST BE PREVENTED

*by Diane Plamping, Lecturer at King's College Dental School, and dentist at the Lakeside Health Centre in Thamesmead*

This is a difficult time to talk of changes in health care as that almost certainly leads to talk of money; a very unpleasant prospect these days! It is still more difficult to beg on behalf of the ugly duckling service, dentistry. However, it is a service that every member of the community has recourse to at some time or other, and furthermore, we are not asking for more and more dentistry, quite the reverse. We want a change in direction with possibly less dental treatment but more prevention of dental disease.

For the past 20 years the dental NHS has been a repair service. Increasingly intricate and sophisticated methods have been devised to repair the damage done by decay to teeth and by periodontal disease to gums. But the increasing numbers of dentists and their combined expertise has not stemmed the flow. Dental disease still has the dubious honour of being the most common disease in the country. National surveys show that one third of the population aged over 16 years have no natural teeth. Half of eight year olds have had teeth extracted under general anaesthesia with all the attendant unpleasantness and risks. Even in those parts of the country with a favourable dentist/population ratio, the pattern of tooth loss is very similar, although more fillings may be done before the teeth are taken out. The nub of the problem is that more increasingly expensive treatment will not significantly alter the life of a tooth.



Enough is enough. The disease can and must be prevented.

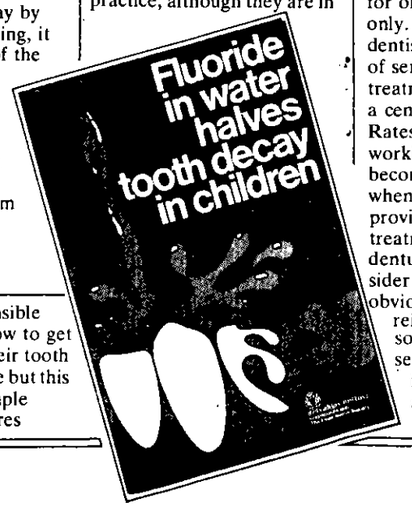
## PREVENTION

The two dental diseases can be prevented. The modification of diet to reduce the number of sweetened snacks and drinks we have, can reduce the number of holes formed, and the addition of 1 p.p.m. fluoride to public water supplies can reduce the number of holes by half. However, more teeth are lost through gum disease than through tooth decay. This is caused by the presence of a bacterial film on the teeth called plaque. If it is not removed once per day by effective tooth brushing, it will cause bleeding of the gums: This is a sign of a disease which causes the gums to recede. Eventually the teeth loosen having no gums to support them and have to be extracted.

## WORKFORCE

Teaching people sensible eating habits and how to get the best use from their tooth brushes will take time but this and many of the simple mechanical procedures involved in placing fillings in teeth need not be done by expensively trained dentists. It is now accepted as commonsense for a doctor to delegate work to appropriately trained ancillary workers without lowering quality of service. The most effective use could be made of available trained personnel by training more ancillary workers to enable a dental team to provide therapeutic and preventive care.

Several types of dental worker exist but the hygienists are perhaps most well known and play an active role in providing preventive dental care in general practice, although they are in very short supply. An even rarer breed of dental worker is the dental auxiliary. They are trained to prepare simple cavities in teeth and fill them but only 300 are on the register. The expansion of training programmes for these and other types of dental worker could be achieved with little extra cost, with a great increase in the number of people with expertise in the practice of preventive dentistry.



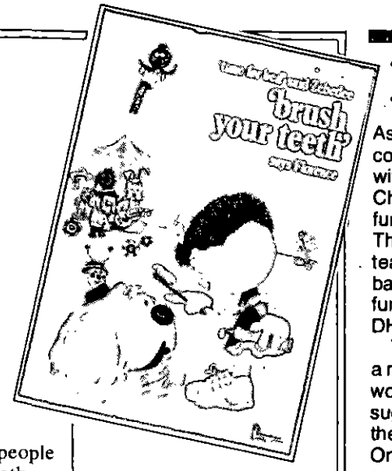

## PAYING THE DENTIST

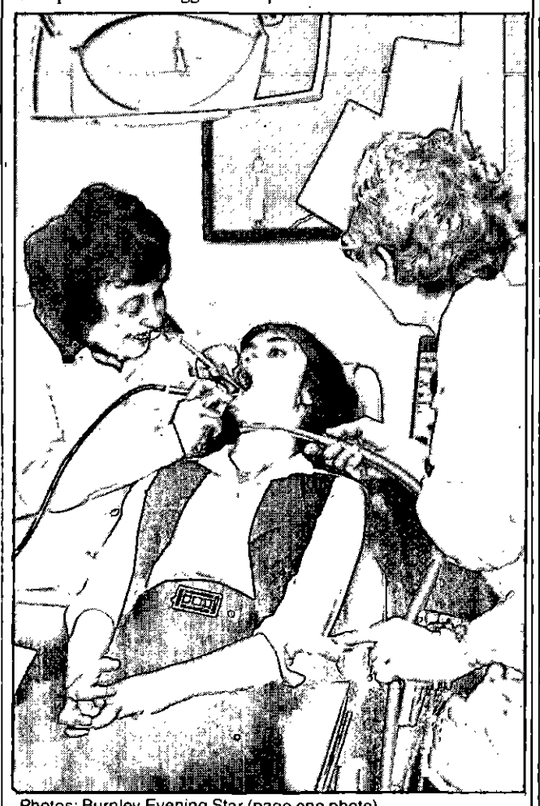
The final plea relates to the organisation of dental services. They are still disintegrated with the vast majority of practitioners working in the General Dental Service (GDS) under contract to the Family Practitioner Committee. This separation from the community dental service (CDS) and the peculiar nature of the GDS contract makes planning dental services very difficult. Unlike the medical practitioner, a dentist can practise in any part of the country without restriction. In fact, maldistribution of dentists has grown worse since the inception of the NHS. A dentist can choose whether to accept a patient or not for NHS treatment and even if the patient is accepted, it is for one course of treatment only. Within the course the dentist is paid a fee per item of service. Each type of treatment has a fee set out by a central body (the Dental Rates Study Group). The working of this system may become apparent to patients when dentists refuse to provide certain items of treatment on the NHS, e.g. dentures, because they consider the fee inadequate. It is obviously very difficult to reimburse dentists for something that cannot be seen such as oral hygiene instruction and diet advice. Such things bring small if any payments, and are therefore rarely practised.

Only one in eight people claim to have had tooth brushing instruction from their dentists. If preventive dentistry is to be made more widely available, it may be necessary to consider changing this system of payment and bring the dentists' contracts more into line with other professional groups practising in the health service, or giving priority to salaried dental services.

So the picture is not as bleak as it may at first appear. The problems are great but solutions are within our reach and pocket. We suggest that CHC members press for the following measures to be introduced:

1. Reduced need for dental treatment through the introduction of preventive measures.
2. Provision of care by a dental team with each member's skills used appropriately, to provide a high quality of service cost effectively.
3. A system of payment which allows dentists to practise preventively.



Photos: Burnley Evening Star (page one photo), Basildon Evening Echo.

# EDITORIAL

As part of the drive to reduce management costs and bring about greater devolution within the NHS, David Owen invited the Chairmen of RHAs to investigate the functions of the DHSS as they saw them. The 100 page report from their enquiry team was issued recently on a restricted basis*, and it contains some very fundamental criticisms of the way the DHSS works.

The enquiry team could not recommend a major reorganisation of the Department's work at this stage, although they do suggest some radical alterations in the way the existing machine can be made to work. One idea (which Dr Owen strongly supported in a recent speech) is that there should be some interchange between DHSS and health authority administrative staff, so that relevant working experience can be gained on both sides.

Another recommendation is that the DHSS should delegate far more of the detailed work that it does to the Regions. This might include giving RHAs the responsibility for closure decisions, and making them gather the information for answers to certain types of Parliamentary Questions. There are many other important ideas in this report; and the fact that such an enquiry could be conducted is a most encouraging sign. The DHSS will have to back up their venture into "open government" with a willingness to distribute the report much more widely, and to make sure that future reports on the "interface" between tiers in the NHS is frankly and honestly debated.

** Regional Chairman's Enquiry into the working of the DHSS in relation to Regional Health Authorities, DHSS, May 1976.*

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# BOOK REVIEWS

**MEDICINES: A GUIDE FOR EVERYBODY**

*by Peter Parish, Penguin, 1976, £1.50.*

This useful book presents the facts about drugs in clear and sensible terms. It is divided into three parts: the first explains how the drugs work on the body and produce desired and undesired effects. The second part discusses those drugs commonly used to treat disorders, and explains the difference between various types and brands. The last part is an alphabetical reference list of individual drugs giving details of contents and action, and referring the reader to relevant passages earlier in the text. The book is written to help the layman understand the whole business of drug treatment so that it makes more sense to him, and he can participate more in any programme concerning his own health.

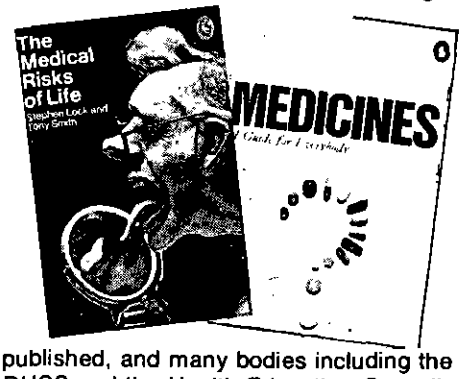
The NHS spends a significant portion of its annual budget on medicines prescribed by doctors, and individual people readily buy medicines over the counter at the chemist's shop. Yet the degree of understanding that doctors and consumers have about the way their chosen drugs work is unsatisfactory. The appropriate use of drugs requires two things: knowledge about the way the body works in health and disease, plus knowledge about the way the chemicals contained in drugs have their effects on the body.

There is no reason why ordinary people should not have access to this information as well as the doctors and pharmacists whose job it is to know. The author states in the introduction: "The pharmaceutical industry is continually striving to increase the benefits and decrese the risks of their products. But they cannot be responsible if these are not prescribed and used properly. The appropriate use of drugs, based upon knowledge of their benefits and risks, will not only benefit the consumer but should be in the best interest of doctors, pharmacists, pharmaceutical industry and governments."

**THE MEDICAL RISKS OF LIFE**

*by Stephen Lock and Tony Smith, Penguin, 1976, £0.95.*

The subject of promoting health and preventing disease is a familiar one to CHCs. Plenty of epidemiological evidence about the incidence of disease is being




published, and many bodies including the DHSS and the Health Education Council are trying to encourage people to take note of it. The centre pages article in the last issue of CHC NEWS suggested that maintaining personal health also depends on favourable social and economic conditions. This book, *The Medical Risks of Life*, looks at some examples of our social and economic environment in terms of the way they can effect our health. It is written by the Editor and Assistant Editor of the British Medical Journal but unlike many of the articles published there, this book is in easy and enjoyable language. It is filled with facts and figures about such subjects as diet, food poisoning, pollution, work, exercise and sport, pets, detergents and several others, and in each case the risks to health are discussed. For most readers with an interest in this subject, the book provides a good overview and will whet their appetite to follow up some of the points in more detail. The final chapter gives a useful review of the causes of death and puts the concept of 'risk' into perspective.

**REPORT ON CHIROPODY SERVICES**

*Age Concern, 1976, 30p*

Although the elderly are one of the priority groups for NHS chiropody treatment, many old people are waiting from 3 months to 3 years for an appointment. This booklet explains how the situation has developed and shows where the difficulties arise in trying to arrange an effective chiropody service. It concludes with a set of recommendations covering such points as the training, pay and career prospects in the profession, the use of mobile clinics and private chiropodists, and a greater emphasis on preventive measures.

**OUTSET REPORT**

*(Available from Outset, 30 Craven Street, London WC2 5BR, £1 + 26p p&p.)*

This short report describes a survey of people living in the City of London which was done to identify handicapped people, their needs, and the extent to which they were being met.

The handicaps cover a wide range although sight and hearing problems occurred most frequently. The most common needs were for home chiropody, home help, help with bathing and bath aids. The report says that the survey method used can act as an ongoing way of updating information, and it can be used by local authorities seeking to implement Section 1 of the Chronically Sick and Disabled Persons Act.

# Health Service Commissioner's Annual Report HMSO, 1976 75p

This Annual Report covers the work of the Health Service Commissioner for the year ending on 31st March 1976, and copies have been sent to CHCs. Of the 610 complaints handled, 360 (59%) were rejected as outside the Commissioner's jurisdiction. He is allowed to investigate complaints from members of the public that they have suffered injustice or hardship as a result of (a) failure in a service or (b) failure to provide a service on the part of RHAs, AHAs, FPCs, special health authorities and the Public Health Laboratory Service; or (c) maladministration which has affected any other action taken by or on behalf of these authorities. Results reports were issued for 128 (21%) cases, 3% of the remaining cases were discontinued after partial investigation and withdrawal, and the rest were carried forward to this year. Of the 128 completed cases, just over half the complaints were upheld by the Commissioner. The bulk of the report consists of summaries of 52 of the investigations, and they make most interesting and informative reading, giving an idea of the range of the subjects and the nature of the investigations carried out.

In relation to maternity units, the Commissioner points out that waits of up to 3½ hours were not uncommon in an antenatal clinic, and the administration of pethidine and rupturing of membranes were not uncommon in certain units. In some mental illness and mental handicap hospitals and units, the lack of a sound procedure for investigating and recording complaints, detaining voluntary patients in hospital, and administration of ECT against a patient's wishes were some of the points mentioned.

For elderly patients, there can often be a great change in them when leaving the personal attention of their family at home for the care of the hospital staff. The Commissioner feels that close relatives should be warned of this possibility and the change it produces in the elderly person, before admission. Another point commented on is the shallowness of investigations conducted by some health authorities, and the inadequate replies given to some complainants.

One of the matters dealt with by the Commissioner which did not involve patient care concerned the procedure used by an RHA to obtain nominations from voluntary organisations for CHC membership. The report ends with a statement by Sir Idwal Pugh (who is also Parliamentary Commissioner for Administration, like his predecessor, Sir Alan Marre) that he intends to see what further steps might be taken to improve public awareness of his existence and his work.

# RIGHT TO FUEL

*by Jane Griffiths, Haringey Fuel Action Group*

Last winter Mrs Linda Basset died of cold. "She had plenty of electric fires in the house" said a neighbour, "but she was frightened to put them on because of the bills from the electricity board." Thankfully, deaths from hypothermia are comparatively rare, but when they happen they tend to hit the headlines. What we hear less about is the nagging worry and constant hardship which has become a way of life for hundreds of thousands of elderly and sick people during the winter, and now increasingly for low income families too.


Equally, little is said about the less dramatic effects of inadequate heating on the health of these vulnerable groups. Warmth has a vital part to play in keeping chronic infections like bronchitis and arthritis at bay. Children's chest complaints are far more likely to persist if their surroundings are cold and damp, and they are more succeptible to infections.

Hard evidence of the relationship between bad heating and ill health is beginning to accumulate. A study carried out in Spring 1975 by Mary Brennan and Bryan Stoten of the Dept. of Social Medicine at the University of Birmingham showed that children with unemployed fathers are twice as likely to be admitted to hospital as those whose fathers are in work. They point out that, "When there is unemployment, food, fuel and clothing, basic to good health, are the goods most likely to be edged out of the family budget when income falls."

In a similar vein, the National Consumer Council, currently undertaking an enquiry into the effects of fuel price increases on the poor, have said, "Because necessities comprise such a high proportion of the budgets of low income households, a rise in the relative cost of fuel might mean cuts in the consumption of fuel or some other staple, usually food."

With fuel price increases of 50% for electricity, 55% for coal and 34% for gas last year, it is hardly surprising that many of the most vulnerable members of society have to struggle to keep warm, and that some of them have failed. But what can be done to change the situation? One fact we must face is that certain groups of people with very low incomes — pensioners, the unemployed, the disabled, the sick, one parent families — simply cannot afford the fuel they need to keep warm. Many are claimants of state benefits which are patently inadequate to meet fuel needs. The Supplementary Benefits Commission see £2.50 a week as the "amount a reasonable claimant could be expected to spend on fuel out of the basic scale rates", and of this £2.20 is expected to cover heating and hot water. But with electric bar fires, used by large numbers of the poor as they are cheap to buy, £2.20 will not even keep one average-sized room in London at 70°F for 16 hours a day (this is the Department of the Environment and DHSS recommended level for the elderly and babies).

Extra discretionary heating additions of between 55p and £1.65 a week can be made if a claimant is chronically sick, bedridden or has rooms which are particularly hard to heat, but these do little to cover the shortfall, even for those who actually manage to claim them. So one major improvement would be an increase in the level of state benefits, at least in line with the rise in fuel costs. This would be much more satisfactory than the recently announced ad hoc payments to electricity consumers who claim Supplementary Benefit and Family Income Supplement. It is not only claimants who cannot afford the fuel they need. Low wage earners, particularly those with large families, suffer too, and cannot even turn to the DHSS for help. Their problem could be reduced if fuel costs were cut down by better insulation and more efficient means of heating. But this means capital outlay which the poor cannot afford, so grants for such improvements need to be brought in. Local authorities can help too, by improving insulation standards in council properties and installing heating systems with reasonable running costs.

Apart from those who just haven't got the money, there are many thousands struggling to pay their vastly increased fuel bills. Many of these could manage if they could choose a payment method that suited their budget, rather than facing huge quarterly bills. Recommendations on different payment methods are contained in the Oakes' Report: *Review of Payment and Collection Methods for Gas and Electricity Bills,* commissioned by the Government. Copies are free from Library, Dept. of Energy, Thames House South, Millbank, London SW1P 4QJ. The Government has responded with a call for a code of practice to be worked out with the industries.


Photos: Blackfriar's Settlement.

One reason why fuel boards have been less than energetic about developing alternatives is that at present they can rely on the ultimate sanction of disconnection to 'solve' the problem of fuel debts — for them if not for the consumers. The Right to Fuel Campaign and many others including the Oakes' Report, say this sanction should be withdrawn. After all, those who don't pay their rates can still send their children to school and have their dustbins emptied, while the money is recovered through the courts. Cutting off fuel supplies is a drastic step causing severe hardship. It solves nothing and merely passes on the problem to other agencies like social services and the NHS. Fuel is vital to health and a reasonable standard of living today. We must recognise that people have a right to fuel — and ensure they are able to pay for it.

## WHAT CHCs CAN DO TO HELP

- Get your CHC to support the policies of the Right to Fuel Campaign and to press for the speedy implementation of the Oakes report.
- Cooperate with local groups campaigning on fuel issues. You can get addresses for your area from: BAS Right to Fuel Campaign, 7 Exton Street, London SE1, 01-261 1919.
- Join the Right to Fuel Campaign. Already over 140 local neighbourhood associations and 12 national organisations have affiliated.

# THE MEDICAL PRACTICES COMMITTEE

*by L. F. Hallyar, Secretary*

## *–its membership and how it works*

The Medical Practices Committee (MPC) is constituted under Section 34 of the National Health Service Act 1946. There are 9 members of the Committee who are all appointed, usually for a 3-year term which may be renewed by the Secretary of State for Social Services. Various bodies, including other Government departments and professional organisations are consulted before appointments are made or renewed. The Chairman and 6 other members (5 of the 6 must be in active practice) are all family doctors; one of the remaining 2 members is a barrister and the other is an Administrator of a large Family Practitioner Committee. Two of the members practise or practised in London and the others work and/or reside in various parts of England and Wales.

The principal function of the MPC is to control the distribution of family doctors within the NHS throughout England and Wales. This is achieved by reviewing the need to fill medical practice vacancies as these occur, and the consideration of all applications by doctors for inclusion in the Medical Lists maintained by FPCs. Such an application may be 'refused' by the MPC only if the number of family doctors practising in the area or part of the area is already adequate. The MPC also select doctors for appointment to medical practice vacancies advertised by FPCs. Established partnerships are allowed to nominate their own replacements, subject to the MPC's prior agreement that the vacancy may be filled.

This system of control may be described as one under which the MPC have no power to direct a family doctor to work in any particular area, but by controlling the replacement or admission of additional doctors in areas that are more generously doctored and by making it known that applications in such areas may be refused, doctors are encouraged to apply for appointments in areas that are less adequately served. Meetings of the MPC are normally held on Wednesday afternoon and Thursday morning of each week in order to obviate as far as possible delay in dealing with cases. Each case is considered on the advice of the local FPC who are required to consult the Local Medical Committee before making a recommendation on the action to be taken.

In order to determine which localities have sufficient doctors or need more doctors, the administrative area of each FPC is divided into practice areas, and each such area is classified in one of four ways according to its needs. Practice areas generally consist of suitable divisions of health or local government districts — groups of parishes or wards are also acceptable. The MPC have found by experience that in the larger cities, areas with about 100,000 residents are best suited for identifying and controlling the distribution of family doctors. In rural areas and the less densely populated urban districts the size and delineation of practice areas will depend on local circumstances. Although the MPC reserves the right to determine the boundaries of practice areas, its policy is to agree proposals as far as possible with FPCs and LMCs.

Delineations and classifications are based on periodical returns by FPCs showing the local grouping of family doctors and their lists of patients; these reports are updated each time individual cases are submitted to the MPC, so that a classification may be automatically reviewed each time a doctor enters or leaves an area. Although a special procedure is used for classifying areas as designated, all classifications are in effect normally based on the size of the average number of patients registered with the family doctors who practise mainly in each practice area, after taking account of pending resignations and admissions plus the addition of one more doctor, as follows:

| Average-list size | Classification |
|---|---|
| 2500 and above | Designated |
| 2201-2499 | Open |
| 1801-2200 | Intermediate |
| 1800 and below | Restricted |

The sole purpose of the designated classification is to attract more doctors to an area by making initial practice allowances available to newcomers, and for the purpose of paying allowances to established family doctors in areas that have been continuously designated for at least 1-3 years, depending on the amount of the allowance. In assessing average-lists, adjustments are made inter alia to exclude the practices of certain part-time and elderly doctors. Otherwise the foregoing numerical guidelines are usually adhered to, although the MPC sometimes exercises discretion in the light of special local circumstances: e.g. demolition areas or, at the other extreme, areas in which there is substantial new housing construction.

In designated and open areas the average-list of the local doctors will, other considerations apart, demonstrate that local family doctors collectively have at least reasonably full practices. Requests to fill vacancies and applications to start a new practice are therefore usually granted without question. Proposals relating to intermediate or restricted areas are not however automatically rejected and often agreed. Each such proposal is carefully considered with the assistance of detailed advice from the FPC, which is required to provide all local information which might be relevant to the issue. This information will always include details of the ages and, should this be a factor, the health of the incumbent and nearby doctors (if any) together with the time they work in hospital and other appointments outside general practice. A short analysis of the lists of patients registered with these doctors will also be provided — special account is taken of the numbers of temporary residents treated, and the extent to which rural doctors are credited (for remuneration purposes) with rural practice units for patients living some distance from the doctor's surgery. Account is also taken of above-average percentage of elderly patients on a doctor's list and the number of patients (if any) for which each doctor dispenses prescriptions. Should there be some other special factors such as new housing construction or traffic congested roads which make it difficult for doctors to reach a particular locality, the practice or applicant concerned and the FPC will be expected to provide details. In short, every effort is made by the MPC to ensure that all cases arising in intermediate and restricted areas receive a detailed and just consideration on the fullest possible information.

Applications from doctors wishing to start a new single-handed practice in these areas are usually unsuccessful — unless the FPC can demonstrate that the locally established family doctors are much harder pressed than their average-list of patients would suggest. Readers will have noted the absence of direct consultation between the Medical Practices Committee and Community Health Councils. This is because of the procedure prescribed in Regulations made by the Secretary of State whereunder Councils advise Family Practitioner Committees in matters relating to the operation of the health service within a health district. FPCs in turn advise the MPC of any representations received from Councils.

In conclusion, it is important that the operation of the MPC's main powers should not be applied so harshly so as to arouse widespread opposition from the public and profession alike. At the same time the MPC has the clear duty of balancing the undoubted needs of the high average-list designated areas (these may well have problems other than an unfavourable doctor/patient ratio) which do not readily attract doctors, against the needs of low average-list areas like Central London which do readily attract doctors but which may have special problems. The MPC must however rely on FPCs to provide clear evidence of these problems, and this is a field in which CHCs can give valuable assistance in advising FPCs on any need for more family doctors in given health districts.

# Organisation of the in-patients day

In 1971 a committee of the Central Health Services Council was appointed under the chairmanship of Sir John Hanbury, to advise on the principles which should govern the organisation of the in-patient's day in hospital.

The committee's report was circulated to health authorities in July this year. It stresses the importance of preserving the dignity, individuality and independence of each patient. Hospitals are not machines; patients are not units on a production line: they are people and must be treated with respect. These sentiments inform the report, and underlie many of its recommendations.

The committee feel strongly that hospitals should aim to give patients as *normal an environment as possible, with* privacy, comfort, and every encouragement for self-help. *Comfortable day rooms and* adequate recreational facilities are *considered to be essential. Privacy is* regarded as important: the report *recommends that as well as ensuring that* adequate provision of baths, showers and sanitary appliances be remedied, hospitals should also make private interview rooms available to patients.

Despite recommendations from earlier *bodies, the committee found that both* unnecessarily early waking and routine *sanitary rounds are still common practice. It* says that both should be discontinued. *There is a concern that patients should be* encouraged to maintain their dignity and *independence, and the report recommends* that, when at all possible, patients should be *allowed to wear their own clothes, that* storage and laundry facilities should be *available to them; that patients should have* a say on the control of lighting, *temperature, ventilation, waking times, and* the times at which lights have to be put out; and that there should be convenient telephone facilities in wards and day rooms.

*The committee have also made several* recommendations about visiting times, and *state that visiting arrangements should be* reviewed by senior management staff to *establish a policy of flexible visiting where* this does not already exist. The introduction *of new visiting arrangements should be* accompanied by training of staff and *information for patients and visitors, to* ensure that they understand the system and are ready to co-operate.

On the staff side, the need for adequate *liaison between hospital and community* health services is stressed, and there is a *firm recommendation that a* communication centre should be *established in each health district to* co-ordinate communications about the *patient's stay in hospital, and his needs* following discharge. In more general terms, *the report emphasises the value of good* communication with the patients and his *relatives, and suggests that, particularly in* the case of children and the elderly, *relatives have a substantial part to play in* their care.

*The committee visited 32 hospitals* before producing the report, and found that *there are widespread problems of* communication between patients and *hospital staff, which were often the real* cause of complaints against hospitals. They say, "We believe that patients need to have far better opportunities for close communication with those who are most concerned with their care and treatment. Within certain constraints, we think they should have information about themselves as a right."

# Medical certificates changed

From October 4th, medical evidence given by family doctors to patients claiming sickness benefit and other social security incapacity benefits is to be provided in a new form.*

The present medical certificate will be replaced by a doctor's statement. A doctor will no longer be required to certify the patient's incapacity for work. Instead he will state the advice he gives to his patient about refraining from work, and will in most cases be required to specify the diagnosis on which he bases this advice.

As long as the period covered does not exceed two weeks from the date of the statement, the doctor may specify the date on which he considers that the patient will be fit to resume work. Where a patient is likely to be ill for a longer time, the doctor's statement can cover any period up to a maximum, initially, of 6 months. When the patient has been away from work continuously for 6 months on medical advice, the doctor may then issue a statement covering any appropriate period.

** See circular HC(FP)(76)2 Medical Evidence for Social Security Purposes, and Statutory Instrument 1976 No 615: The Social Security (Medical Evidence) Regulations 1976.*

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.

# Parliamentary Questions

### CHCs AND AHAs

Two questions asked recently by Laurie *Pavitt MP concerned the relationships* between CHCs and AHAs. In response to *the first of these, Dr David Owen said* that no formal arrangements existed to give *a CHC the right of appeal when its* representations have been rejected by the *AHA. He pointed out, however, that the* CHC can make representations at regional *and Ministerial level if necessary.*

In his second question, Mr Pavitt asked if *the Secretary of State would extend the* powers of CHC observers at AHA meetings *to permit them to receive all the discussion* papers, and to enable them to cover all *matters in their reports back to their* councils. Dr Owen replied that CHC observers should receive all except confidential documents, and that the circumstances in which a matter is regarded as confidential should be exceptional. He added that CHCs are free to discuss all matters reported back to them by their observers.

### DENTAL TREATMENT COSTS

*The Secretary of State has no power to shift* the onus from the patient to the dentist to *establish the fact that the treatment is given* privately and not on the NHS said Dr Owen *in reply to another question from Laurie* Pavitt MP. He added that the British Dental Association does advise its members to ensure that patients clearly understand the basis of any contract they make before any treatment commences.

### *LENGTH OF HOSPITAL STAY*

More than £50 million could be saved by *reducing the average length of stay of* hospital patients by one day, said Dr David *Owen replying to a question from Walter* Clegg MP. He stressed, however, that such *a saving could only be made if there were a* reduction in the number of beds: otherwise *expenditure would increase with increased* turnover.

*In answer to a later question on a similar* subject he said that the attention of health authorities had been drawn to the desirability of planned admission and discharge of patients, and to the usefulness of clear and simple statistical information to assist consultants and others concerned in the use of hospital beds.

### *GP BLEEPS*

Four health authorities are operating paging schemes for general practitioners to help them keep in touch with accident, hospital and emergency services. In some other areas paging devices are being *organised by groups of GPs themselves.* And the Post Office is also hoping to *introduce a similar service in the Greater* London area later this year.

*Replying to questions from Frank Allaun* MP and Lewis Carter-Jones MP, Dr Owen *said that the DHSS itself has no plans for* subsidising paging schemes, or for *providing GPs with bleeps.*

# Health Councils in Scotland

*by T. S. McGregor, Chairman of Edinburgh Local Health Council*

For health service purposes Scotland is divided into fifteen areas each served by a Health Board whose members are appointed by the Secretary of State for Scotland. These Boards are responsible for the provision and administration of health services in their area, and their policies are effected through an area executive group at area level and, if necessary, district executive groups at district level. The system does not have a regional tier as in England.

Local Health Councils (LHCs) have been set up in Scotland as CHCs were a year earlier in England and Wales, to represent the interests of the public. Health Boards have a duty to provide to each LHC information about the planning and operation of the health service in its district and are required, as far as possible, to consult the LHCs about any proposals they may have for the development or alteration of the service. There are 48 LHCs with memberships ranging from 12 to 30. One third of the members are appointed by local authorities and the remaining two thirds are appointed by Health Boards following nominations by voluntary bodies (6-14 members) and trade unions (2 or 3 members). A national publicity campaign initiated by the Scottish Home and Health Department seems to have misfired and made little impact. Many LHCs have received good coverage in the local press but even there the public is still largely ignorant of their existence and function. In view of their need for publicity it is surprising to find that several LHCs still meet in private, refusing admission to press and public alike.

Frequently LHCs serving the same Health Board area have met together to discuss common problems, and some have made joint approaches to their Board. Others, believing that they are responsible first and foremost to the public in their own districts have been reluctant to cooperate with adjacent Councils whose claims compete with their own. Initiatives are being taken to establish a National Association of Local Health Councils and cautious progress is being made in this direction.

I am convinced that an improvement in the health of our community will not be achieved by modern medicine alone, nor by administrative reorganisation of which health councils are a part, but by all of us who are members of the public taking responsibility for our own health and for the health of our community. If LHCs can help to promote widespread and informed discussion on the nature of health and a greater determination to achieve it, they will have succeeded in introducing a new dimension of public participation in health care which is an essential ingredient of a healthy society.

# National dried milk withdrawn

After announcing restrictions in February on the use of National Dried Milk for babies under 6 months, the DHSS have now decided that NDM is to be discontinued completely in 1977 (the exact date is not yet known). Proprietary brands of suitable modified baby milks are available already, and the Government will not be producing its own brand.

The price of NDM and vitamins, which are supplied at health clinics, will go up from 15th November this year. But more people will be brought within the income limits for eligibility for free milk and vitamins on that date.

## Change of address

Please note that our address now is CHC NEWS, 126 Albert Street, London NW1 7NF. Telephone: 01-267 6111

## 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.

The kit is easy to assemble and dismantle, and when assembled, the stand's overall dimensions are 2.3 metres high x 3.0 metres wide (7ft 8in x 10ft).

CHCs wishing to borrow the stands should contact CHC NEWS to make a booking.

## 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, 126 Albert Street, London NW1 7NF.

Please note the following changes:

**Page 5: Beverley CHC**
Chairman: Mrs Elizabeth Frith

**Page 6: Scarborough CHC**
Chairman: E McKie

**Page 9: NW Leicestershire CHC**
Chairman: G H Sharpe

**Page 14: East Hertfordshire CHC**
Chairman: T K Pearson

**Page 18: Basildon and Thurrock CHC**
Address: 13 Clarence Road
Grays, Essex RM17 6QA
Telephone: Grays Thurrock 70004
Chairman: Mrs L I Greenfield

**Page 18: West Essex CHC**
Chairman: Dr James Fairley

**Page 20: City and Hackney CHC**
Chairman: Dennis Timms

**Page 20: Enfield CHC**
Chairman: Rev R S Gurr

**Page 24: King's CHC**
Address: 75 Denmark Hill
London SE5 8RS

**Page 26: Chichester CHC**
Chairman: D N Hoult

**Page 27: Roehampton CHC**
Address: 222 Upper Richmond Road West,
London SW14 8AH
Telephone: 01-878 0265

**Page 28: Portsmouth and SE Hants CHC**
Chairman: A P Ridley

**Page 30: East Berkshire CHC**
Telephone: Slough 20357

**Page 30: Aylesbury CHC**
Telephone: Aylesbury 5000 Ext 518/7

**Page 39: Wolverhampton CHC**
Secretary: M W Domoney

**Page 40: Halton CHC**
Address: 75 High Street, Runcorn,
Cheshire WA7 1BR
Telephone: Runcorn 60926

**Page 44: North Manchester CHC**
Chairman: Rev Dr T A Chadwick

**Page 46: Wigan CHC**
Address: Bryan House,
61/69 Standishgate,
Wigan WN1 1UP
Telephone: Wigan 39631/2
Chairman: Mrs M A Ward
Secretary: Mrs B A Goldthorpe

**Page 46: Ynys Mon-Anglesey CHC**
Address: 7 Church Street,
Llangefni, Anglesey
Telephone: Llangefni 723283

**Page 46: Arfon-Dwyfor CHC**
Chairman: Miss Mary Richards
Telephone: Caernarvon 4961

**Page 49: Swansea/Liw Valley CHC**
Address: delete '3rd Floor'
Chairman: T E Jones

**Page 50: Vale of Glamorgan CHC**
Address: Sully Hospital
Sully, South Glamorgan
Telephone: Sully 530046

**Page 54: South Western Region**
Enquiries to:
Gloucester CHC, Roebuck House, 37a Brunswick Road, Gloucester GL1 1LU
Chairman: D A V Harper
Secretary: Miss J Melling
Telephone: Bellegate 3044