CHC NEWS

For Community Health Councils — December 1976 No. 14

The Association of Your Choice

Last month a national conference of CHCs decided in favour of forming an Association without delay. Of the 203 CHCs present, 112 voted in favour of an Association and 91 voted against. 26 of the 229 CHCs in England and Wales chose not to exercise their right to vote either by not attending or not voting. A small number of representatives at the conference felt that the way in which this decision was taken was procedurally incorrect and they subsequently withdrew from the meeting.

The conference went on to discuss amendments to the Steering Committee's draft constitution. Although a small number of amendments remain outstanding, the basic structure and functions of the Association have been decided. The present draft constitution lays down that the Association of Community Health Councils in England and Wales (as it is to be called) will have as its main objectives to provide a forum for CHCs, to act as their national voice, to provide information and advisory services and to encourage, promote and protect the independence of individual CHCs. In addition, the constitution should in no way reduce the independence of individual CHCs or in any way undermine their right to make direct representations on health service matters to any persons or organisations. The Secretary of State is to be asked to meet the cost of providing the information services. All other expenses of the Association will be covered by members' subscriptions. The conference decided that all CHCs who were not members of the Association would be required to pay for any information supplied.

The Association's governing body will be the Annual General Meeting to which members can send two representatives. A Standing Committee will conduct the business of the Association between AGMs and will consist of one representative from each region with up to eight CHCs in membership, two representatives from each region with eight or more CHCs in membership; North Wales and South Wales will be regarded as separate regions for this purpose. Eight CHC secretaries will serve on the committee as non-voting observers. The Chairman of the Association will be elected by the AGM, and the Standing Committee will appoint the staff. Dissolution of the Association will be considered if the membership is less than 55% (126 CHCs).

The Secretary of State has been asked to make the necessary regulations to establish the Association in accordance with the draft constitution. Meanwhile, a Provisional Standing Committee is being constituted to

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INSIDE ...

Ennals' speech to CHCs

"I haven't got a pocket of gold in the DHSS. The cash limits must stand — we must live within our budget," said David Ennals at the CHC conference on November 3rd. In his speech, the Secretary of State stressed the gravity of the economic situation, and emphasised that the health service had to play its part in the restraint on public expenditure.

To CHCs he said, "You must be realistic in the demands you make on your health authorities. It is no good asking for the moon." But he thought the discipline of economic restraint could lead to a new spirit of cooperation. The performance of CHCs could not, in his opinion, be measured in terms of success or failure on a particular issue, but only "on whether ultimately the public is better satisfied with the service it gets."

Mr Ennals welcomed CHCs' involvement with planning teams, and he recognised that some CHCs felt they had had not been consulted early enough or in sufficient detail on plans for closures or changes in the use of existing facilities. But he reiterated that he wanted CHCs to make a vigorous contribution to the planning system. On the "Priorities" consultative document, the Secretary of State indicated that a large number of comments on it had been received, and that revised planning guidelines would be published next March.

YOUR LETTERS

NATIONAL ASSOCIATION OF CHCs

Jean Coupe, Secretary Tunbridge Wells CHC

The long awaited National Conference was a curious affair in many ways, not least as nobody can yet be certain that there can be an Association if the Secretary of State acts in accordance with the closing resolution that the Association "be established in accordance with this amended draft", and those CHCs who voted against establishing an Association decide not to seek membership.

The Draft Constitution, Clause 12, states that the Secretary of State should be consulted with regard to the future of the Association if the membership falls below 55 per cent of the number of CHCs eligible for membership. Only 49 per cent of eligible CHCs voted yes for an Association. If the membership at the outset is below 55 per cent the Secretary of State must presumably consider the future of the Association at the same time as he is considering the request to establish an Association. Will he be acting unconstitutionally if he goes ahead and establishes an Association?

Another curiosity was the decision to add at the end of Clause 4(b) "All CHCs which are not members shall pay for any information supplied". The conference had earlier decided that the cost of information and advisory services be met by the Secretary of State, not from members' subscriptions. By what right can members of this Association lay exclusive claim to central funds meant for the benefit of all CHCs? If an Association is formed, and my Council decides not to seek membership, I will forward any bills received for information and advisory services to the Secretary of State.

WASTE OF MONEY

Howard Knight, Secretary, Central Sheffield CHC

Recently, the DHSS published a "Memorandum on Lassa Fever" (HMSO 45p). At a conservative estimate the distribution of this document has cost £25,000 for it has been sent to every GP — and in Sheffield more than 150 have been sent to the hospitals. Yet, only two cases have been reported in the U.K., and to quote from the Foreword: "Lassa Fever does not on present knowledge seem likely to constitute a large public health problem here. No spread has been reported from the few cases known to have occurred in this country . . .". This document is surplus to the present and future needs of 99 per cent of the people who received it. Undoubtedly it has found its way into most recipient's waste paper baskets; when all that was required was to send a copy of the document to each A.M.O., who in turn could inform each GP that Lassa Fever, with symptoms X, Y and Z etc. was now a notifiable disease.

DR OWEN ON SECRETARIES

GB Gillespie, Secretary SW Glasgow Local Health Council

Dr David Owen's interest in CHCs, and I assume LHCs, as expressed in *CHC NEWS* for November is rather enlightening. Should it be that a five-year appointment will help protect CHCs from "burnt-out" secretaries then the reason as to why secretaries have become "burnt-out" must be obtained. Also, why not make the five year rule, if it has genuine foundations, apply to every senior officer in the NHS? In most cases secretaries do try to please by efficiently following a given policy in seeking information required by Councils. By threatening them with terms of appointment unacceptable to other groups it is not likely that efficiency or motivation will be enhanced. The big question is where will secretaries better than those currently in office be obtained?

CONSUMER ADVICE

John Silverthorne, Secretary, North Staffordshire CHC

We recently received a complaint concerning the provision of private frames and lenses by an optician in this district. The point of the complaint was that the spectacles proved unsatisfactory, and when modified to the customer's requirements a further charge of £6.95 was made in addition to the £20 originally charged.

The local Family Practitioner Committee stated that they were unable to assist as the transaction had not taken place within the National Health Service. We then put the complainant in touch with the Staffordshire County Council Trading Standards Department, who negotiated with the optician and obtained a refund of the additional charge.

I felt that this account might be of interest in revealing an avenue for the resolution of complaints which are related to payment made or demanded for services, and might also be useful for certain dental complaints.

DENTISTS' PRESCRIPTIONS

Frank Brean FPS, Member of Lambeth Lewisham & Southwark AHA(T)

With reference to my pharmaceutical colleague Fred Reynold's letter in your November issue concerning dentists' prescriptions, I feel that a word of clarification is required. About 66 outmoded drugs and formulations have been omitted from the Dental Practitioners' Formulary in the British National Formulary 1976/77. Twelve of this list comprised a range of barbiturates (now rarely used) and a whole lot of products rarely prescribed. Useful additions have been made comprising modern antibiotics. The current range of allowable drugs numbers 78 items all of which are in use and make sense in modern medicine. In my view the dentist has a powerful armoury for the requirements necessary.

MORE NURSES NEEDED

Dr. J. A. Muir Gray, Oxfordshire AHA(T)

The most serious threat to our health services is not a deficiency of doctors but a shortage of nurses. Doctors are politically powerful; nurses are weak. It is important to have a medical manpower policy and this has now been achieved. The medical profession should now turn towards the development of a nursing personnel policy. The person-power of nursing is probably a more valuable resource than medical manpower, because one can envisage gearing up nurses to do doctors' work, but never gearing down doctors to do nursing.

No-one would deny that there are problems in nursing. Some are, like some doctors, overtrained for the jobs needing to be done, and others have been removed from accountable positions after Salmon (although Salmon had some good effects). However, this should not inhibit or delay action on our part to support nursing. The future of nursing is a vital area for medical concern.

COURSES FOR CHC SECRETARIES

P. J. Torrie (London) + J. Hallas (Leeds)

Two short induction courses are announced for newly appointed CHC Secretaries or for those who did not have a previous opportunity to attend a similar course.

1. Tuesday 15th February 1977 (10.30am) to Thursday 17th February 1977 (3.30pm) at King's Fund College, 2 Palace Court, London, W2 4HS. Telephone 01-229 9361. (16 places).
2. Monday 14th March 1977 (10.30am) to Wednesday 16th March 1977 (3.30pm) at The Nuffield Centre for Health Services Studies, The University, Leeds, LS2 9PL. Telephone 0532 459034. (12 places).

Both courses are residential and the locations have been chosen to reduce travelling costs to the minimum. Tuition and accommodation fees will be met from central finance but CHCs will be responsible for travelling and incidental expenses. Applications should be submitted to the appropriate Centre (from whom further information may be obtained) by January 8th 1977.

CHC SEMINARS

Stephen Cang, Brunel University, Uxbridge, Middlesex.

Your readers may wish to know that the Health Services Organisation Research Unit at Brunel has been conducting research in the field at the request of CHCs and have arranged a series of seminars at which the emerging results will be presented for discussion and analysis by members.

At least two main models of the role of the CHC are emerging. In brief, these are first

the CHC as pressure group, whose job is to help public feeling to emerge and reach the NHS — and secondly CHC as intermediary between the public and the NHS, reviewing plans, giving out information, and acting generally as the public relations wing of the service. We have planned the seminars as follows: 16th December 1976 + 14th January 1977, only for those CHC members who are not also employed or working in the NHS. 27th January 1977, for CHC secretaries only. 24th February + 3rd March 1977, for CHC members, secretaries, NHS and DHSS members.

ARTIFICIAL LIMB SERVICE

GJ Hoult, Secretary Leeds Eastern CHC

I read with interest the letter from Barrie Taylor, Secretary SW Herts CHC concerning the quality of service offered at Roehampton Limb Fitting Centre. It would seem quite reasonable that this Centre is in itself providing a sympathetic and useful service.

I should point out however that this is not the whole basis for assessing the effectiveness of the artificial limb service. The article in the April edition of *CHC NEWS* by Mr LC Softley highlights many of the problems being encountered by amputees. This Council is now involved in the broad assessment of this service and has found many problems of delay and dissatisfaction. Obviously these are not indicative of every case handled by the service, but my Council would welcome any information from other CHCs who are looking at this field.

INVALID TRICYCLE

D Baker, Secretary Northampton CHC

A public meeting was held by my CHC to discuss the proposed phasing out of the invalid tricycle. Those present overwhelmingly objected to this proposal and a resolution to that effect was forwarded to the Secretary of State. CHCs may be interested to note the reply we received from the DHSS. It states: Tricycles now in service will not be withdrawn from those who wish to keep them; the tricycle fleet is expected to be maintained for at least 5 years; present orders for new trikes now and in 1977 will be fulfilled—mostly as replacements for existing users whose trikes wear out; maintenance arrangements will be improved; alternative vehicles and electrically powered wheel chairs available when the trike fleet is ending its life will be investigated; the rate of the mobility allowance will be reviewed in November 1977 to restore and possibly improve its real value; registered disabled people who no longer have a trike may be able to recieve financial aid from the Employment Service Agency; and people who had a trike or private car allowance for getting to work will not lose their rights if they lose their job.

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

THE PRICE OF DEAFNESS

by Irene Loach, The Disability Alliance

Deafness has been described as the most desperate of human calamities. Yet the absence of hearing is the most difficult of all handicaps to imagine without having experienced it. Most people can appreciate — though crudely — the consequences of blindness or of confinement to a wheelchair or a bed for life. But the loss of sound and all its widespread effects is something to which few hearing people give much thought. The problems facing deaf people thus derive to a large extent from public ignorance of their plight, and indifference or embarrassment of their disability. Without hearing, social life is restricted, personal relationships are radically altered, and self confidence is almost unalterably damaged. A deaf person finds obstacles not only in communicating — in group situations, on the telephone, in public places — but in the much more fundamental needs of acquiring an education and finding a job commensurate with his talents. Consequently he often faces the dual handicap of a severe disability made harder by low income and low job satisfaction. What is needed is an informed public opinion which is altered to their problems and encouraged to become more imaginative in the ways in which it responds to their needs.

The Disability Alliance is therefore publishing a series of pamphlets on various disabilities and on the common financial problems of different age groups, in an attempt to raise the level of public understanding of disability. **The Price of Deafness*** is the fifth of these, and illustrates the many ways in which a loss of hearing unnecessarily relegates its victims to the status of second class citizen. Few people are aware of the extra costs incurred by all disabled people as a result of their particular impairment. In countless cases their expenditure on basic services and provisions is higher than that of the able bodied, yet is financed from smaller incomes. Recent legislation has introduced a number of fragmented allowances for different categories of disabled people, but none of them have benefited those with a hearing loss. At present the only allowance for which they are eligible is Industrial Injury Benefit, as occupational deafness was finally recognised as a prescribed industrial disease in 1975. For those who are deaf from birth, or who lose their hearing through accident ouside work, illness or old age, there are no special allowances, despite the identical consequences of a hearing loss. This anomalous situation — in which two people with an identical disability are liable to drastically different treatment — crops up repeatedly because existing allowances depend upon how and where the disability happened, rather than upon its functional effects. The Disability Alliance is therefore pressing for the introduction of a comprehensive income scheme for all disabled people, in which the only criterion for entitlement would be severity of disability. But financial support is only one

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The Association of Your Choice

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make preparations for the inauguration of the Association. Each region has been asked to nominate one member to this committee, and secretaries in England and Wales have also been asked to nominate their representatives. The committee will make arrangements for the enrolment of members and the first AGM — which will have to adopt the constitution and consider the remaining amendments. The Provisional Standing Committee will also work out the necessary subscription charge and will look for premises and advertise for staff. The first meeting of the committee will probably be early next year, and the date of the first AGM will be determined by the time the committee needs to complete its work. Each CHC will have received a brief summary of the decisions of the conference and a copy of the draft constitution as amended by the conference. A number of important questions still remain to be considered now that the decision to form an Association has been taken.

Firstly, each CHC will have an opportunity to influence decisions about the staffing, location and other activities of the Association by briefing their region's representative on the Provisional Standing Committee. The Provisional Standing Committee wil also need to think about the relationship between the CHC NEWS services and the Association, because the draft constitution does not specify what this might be. Secondly, each CHC will have an opportunity to decide whether or not to join the Association. The Provisional Standing Committee will be aware of the range of views held by CHCs about the Association, and part of their job will no doubt be to work out practical details that prove acceptable to the maximum number of CHCs.

Stroke Patients Survey

by Myrddin Davies
Secretary Ogwr CHC

In CHC NEWS 2 (July 1975) there was an invitation from the Stroke Unit at Charing Cross Hospital, London, to participate in a survey of stroke patients. The aim was to identify the needs of these patients in terms of community and rehabilitative services, and my CHC accepted the invitation. The first essential was to try and identify the patients and the facilities which are available to them through the health service, personal social services and the family practitioner services. Twenty of the patients responded to an appeal in the local press by contacting the CHC office and details of the facilities available in the Ogwr District were obtained from the Ogwr District Health Office and the Ogwr District Office of the Mid Glamorgan County Council Social Services Department. A questionnaire covering the extent of disability, the ambulance service, health service, social services, community services, holidays, visits from relatives and friends, speech therapy and general communication with the public was completed, in confidence, by all the patients participating in the survey.

The outcome of the survey showed:
(a) They all require considerable help in the home.
(b)They all require aids of one sort of another to get about (ranging from an ordinary walking stick to a wheel-chair).
(c) Visits from health service staff (District Nurse, Health Visitor) varied from no visits to six-monthly visits.
(d) Visits from social services staff are rare.
(e) Little use is made of community services — the supporting spouse doing the meals, cleaning etc.
(f) They all had fairly regular visits from relatives/friends.
(g) None has had specific convalescent or recuperative holidays. Some have outings arranged by relatives or friends and some have had holidays at the 'Rest', Porthcawl.
(h) They all attended for physiotherapy and/or occupational therapy immediately following the stroke but there was little follow-up on their 'discharge'.
(i) The provision of handrails (bathroom, stairs, garden) through the Social Services was very slow.
(j) Visits by the GPs were only on request.
(k) The few who suffered from a speech defect expressed the need for more speech therapists.

Arising from the comments and observations made during the interview, the following emerged: (1) There is an indication of the need for more frequent visits from the health, social services and F.P.S. staff. These would bolster the morale of the patient and the supporting spouse with the knowledge that there was a "caring" follow-up service for this group of patient. (2) There is a need for an expanded day hospital provision to enable the stroke patient to have the required physiotherapy and occupational therapy treatment. (3) There is a need for day care accommodation where the patients can be encouraged to help one another and which also allows the supporting spouse to have a break from his/her responsibilities. (4) There is a need for short term holiday admission accommodation for those patients who need medical attention — this would encourage the home support to continue with the fine work they are doing. (5) The provision of medical aids in the home, including hand-rails, would encourage the patient to be self-reliant and give him a degree of independence and relieve the supporting spouse of some responsibilities. (6) Routine visits by the GPs if only to check the efficacy of the D.I.Y. therapy practised in the home, the need for repeat medication, and to give advice on the facilities available to the physically disabled.

To summarise, there is a need for continued growth in the development of community care and priority should be given to maintaining, and where possible, improving existing standards in the domiciliary services in order to keep vulnerable groups, like the stroke patients, in the community rather than in the more expensive residential care provided by the hospital and social services. There is a demand for day hospital and day care accommodation and additional physiotherapists and speech therapists.

My CHC asked the County Council Social Services Dept., the Local Medical Committee and the DMT for their observations on the survey, and several constructive ideas and proposals have been forthcoming from them.

News from CHCs

- Local GPs welcomed a recent enquiry from Southend CHC requesting their views on admissions and outpatient appointments. Two thirds of the 50 doctors who replied to the CHC felt that the waiting period for outpatient appointments in the district was too long, and many had to refer their patients to London teaching hospitals in order to get an appointment within an acceptable time. The doctors supported the CHC's intention to bring these and other matters to the attention of the appropriate authorities.
- Kitchens at a large mental hospital in the North East are to get a major overhaul, following a critical report from Darlington CHC.
- At a recent meeting CHC secretaries in the SW Thames region agreed to form themselves into an Association, and to join the Federation of Regional Associations. Their representative pro tem is Mr A. H. Harman of Cuckfield & Crawley CHC.
- Mr H. E. Skaife is this year's Chairman of West Lancashire CHC. Other recently elected Chairmen include C. C. Caffrey at Bury CHC, and Mrs Jane Saxby at Liverpool Central & Southern CHC.
- Over 200 people attended a one-day symposium on drug abuse organised by Bolton CHC in response to growing concern about the town's drug problem. Among those present were teachers, sixth formers, social workers, probation officers, doctors and representatives of voluntary organisations.
- Mr J. H. Kitchen has been appointed as Secretary to Worksop and Retford CHC. He replaces Gordon Lockwood who resigned in June.
- As a result of Gateshead CHC's campaign on asbestos danger, the AHA has allocated £24,000 for the provision of safety measures.
- Doncaster CHC has a new Assistant Secretary. She is Mrs Olive Turvey who has lived in Doncaster for two years.
- New Secretary at NW Surrey CHC is Christine Davy. Miss Davy took up her post in October, and replaces Mrs Linda Bailey.
- As part of their campaign to gain publicity for the Council, Bury CHC held a "CHC Week" at the beginning of October. During the week, the CHC sponsored a number of events, including a swimming gala, a concert for the elderly and handicapped, and a poster/essay competition for Bury school children.
- Roehampton CHC has a new Assistant Secretary. Evelyn Darnet took up her appointment on November 29th.
- Gloucester CHC solved a problem in an outlying part of their district when they were approached by the local GPs. Patients at their morning surgery either had to make a long journey to Gloucester to deliver samples for tests, or the doctors themselves had to take the samples to an inconvenient collection point. The CHC managed to obtain a slight re-routing of hospital transport from Gloucester, and the samples are now collected from the surgery itself.

Al-Anon Family Groups *by a member*

Al-Anon Family Groups is a fellowship of men and women who share their experience, strength and hope with each other in order to solve their common problem of living with an alcoholic. The only requirement for membership is that our lives are, or have been, deeply affected by close contact with an alcoholic. There are no dues or fees for membership and we are self supporting through our own voluntary contributions. Al-Anon is not allied with any sect, denomination, political institution or organisation. It has no opinions on outside issues and neither endorses nor opposes any cause. Our primary purpose is to help families of alcoholics. We do this by practising the 12 steps of Alcoholics Anonymous ourselves, by giving encouragement and understanding to the alcoholic and by welcoming and giving comfort to families of alcoholics.

We operate through group discussion meetings, (there are about 400 groups throughout the U.K. and Eire) which usually have one of the steps previously mentioned: an Al-Anon slogan such as "A Day at a Time" — "Easy Does it" — "First Things First" — "Live and Let Live" etc. as a basis for discussion, with most groups allowing time for airing of problems and giving time to newcomers and their difficulties.

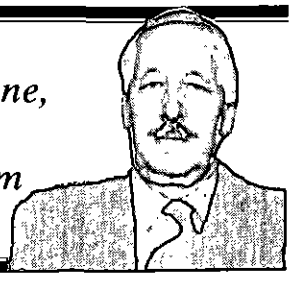
In Al-Anon we learn to unhook our concentration from the all consuming problem of alcoholism, which has come to occupy our every waking moment, and to reclaim our own lives and live them. So often we find that we have allowed our own lives to deteriorate into an unhappy, fearful and anxiety ridden existence, living always in the shadow of the alcoholic's illness. In Al-Anon, the strong bond of shared problems and the knowledge that our fellow members know how we feel removes the terrible feeling of having to struggle on alone with this seemingly insuperable problem. Many of us, when we come into Al-Anon, have deep feelings of inferiority, inadequacy and worthlessness, generally the result of allowing a sick alcoholic to transfer his negative feelings on to us. Once in Al-Anon we thrive on the atmosphere of love and acceptance we find in the group where our failures and mistakes are minimised, and our smallest efforts to improve are recognised and praised. We begin to like ourselves and to attempt things we previously believed beyond us. The importance of treating alcoholism as a family illness cannot be overstressed, since all members of the alcoholic's family become sick, and sometimes sicker than the alcoholic. This is usually the result of the family assuming the consequences of the alcoholic's drinking — and thereby leaving the alcoholic to drink freely without having to face the results of his actions. In Al-Anon we learn to let go of these consequences and to leave them to fall where they belong, with the alcoholic. We believe it is only by concentrating on our own faults and shortcomings and putting them right, that we are able to overcome (what frequently amounts to almost an addiction for many of us) our persistent management of the alcoholic and our families. When one member of the family begins to think and act sanely, the whole family situation improves.

Since alcoholism is an extremely complex illness, it has been found necessary, through experience, to adhere closely to our 12 Traditions as guide lines for our groups, one of which precludes affiliation with any outside enterprise "lest problems of money, property and prestige divert us from our primary spiritual aim". We are happy to cooperate with any other agency working in the field of alcoholism and certainly this tradition does not prevent individual Al-Anon members from attending CHC meetings as observers.

Al-Anon publishes an extensive list of literature dealing with the fellowship, and the effects of alcoholism on families. This literature may be purchased by post, and in fact many CHCs buy regular stocks from our General Service Office: 61 Great Dover Street, London, SE1 4YF.

Personal View

by R. L. Payne, Secretary, Rotherham CHC



It is my point of view that the success of any Community Health Council will depend, largely, on the amount of information it can gather, from a variety of sources, relative to the matter under consideration. It is also my point of view that the true meaning of information is not fully understood. As CHC Secretaries we may all be totally unaware of the many different channels of information open to us, and because this is so, we tend to place too much reliance, and dependence, on that which is fed to us through official channels; rather like new born babes at the breast. Information is a basis of knowledge and we should all be aware of benefits to be gained from being well informed. Also we should all be aware that real information is not easy to come by. No Health Authority from any level will ever knowingly supply a CHC with information that the CHC could use to its own advantage. We should not be so naïve as to think otherwise. If we want information we shall have to go and find it. Secretaries must know at all times what the alternative sources are.

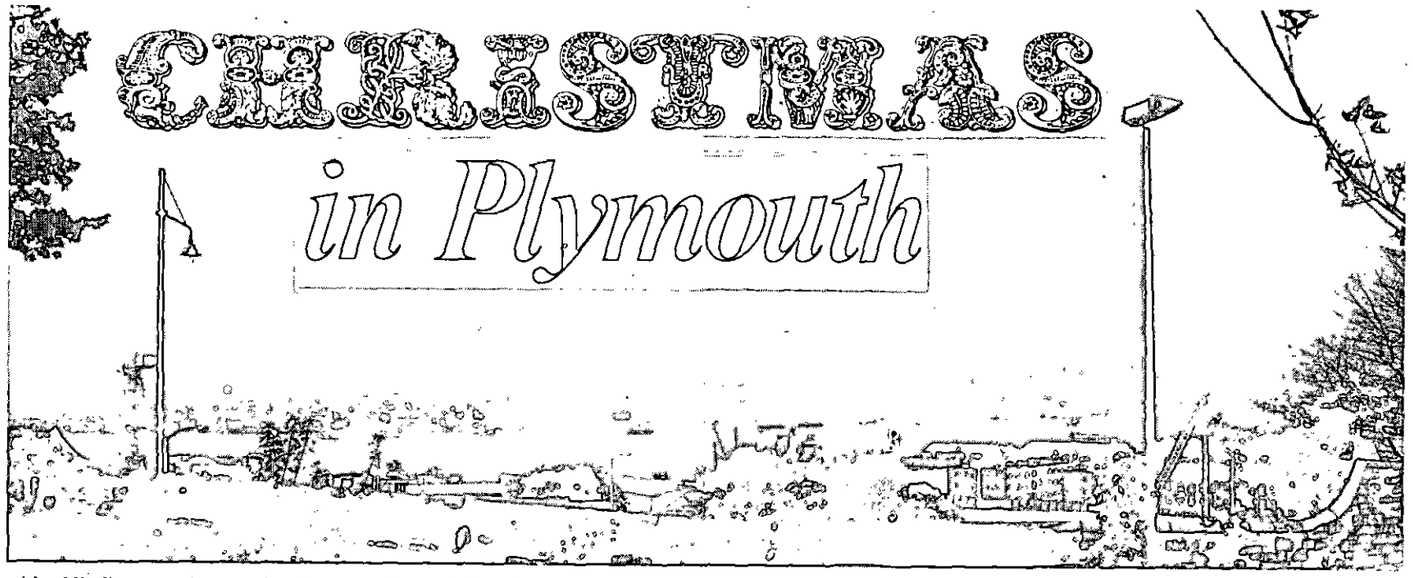
I suggest that it is therefore necessary that we should create for ourselves our own alternative channels of supply. Perhaps we are also ignoring useful sources of information by not devoting sufficient time to just listening. Maybe because we are all too busy churning out masses of "bumpf" designed to satisfy our hungry councils we are not appreciating the value of the spoken word.

Perhaps we all see the spoken word as not always being reliable and we have all fallen into the pedantic trap of wanting every word in writing. How tragic. Just to listen is often the key to opening a source of information which may otherwise be denied us; those who have mastered this art learn quicker and above all a good listener invites information.

If we are always going to look for reliable hard facts then we must always seek out those "in the know". But who does know? That surely is the question we should always be asking. I wonder if it is appreciated that very often the best source of this form of information about day to day affairs is that person who, because of the task performed, merges into any background and listens. The chap that sweeps the floor or someone who brings the tea — these are often very knowledgeable people. I am convinced that we cannot neglect such a source, even though it may be somewhat "un-British" because I am also very certain that in this particular field there is no room for scruples and always wishing to be seen as the nice guy.

It therefore remains in my point of view that if we as CHC Secretaries are ever to arrive at the truth of the matter we must, of necessity, adopt a very positive and almost ruthless attitude in our quest for information. If we continue to "play the game" especially to rules not of our own making we may be in danger of being steered by those who regulate the stream of information and instead of going ahead, as we should, we may find ourselves at a standstill and even worse going astern.

CHRISTMAS in Plymouth



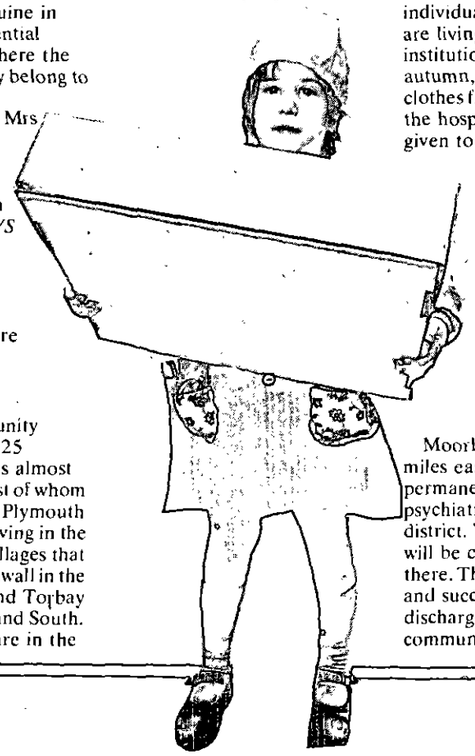
For some people the National Health Service has become a vast bureaucratic and technological machine which, especially since the reorganisation, has appeared to be progressively less able to provide really personalised, individual care to patients. Although there are many examples to back up these charges, it seems that Christmas time encourages the NHS to show its human face, and to create a genuinely friendly atmosphere.

Certain problems are particularly associated with the Christmas season: road accidents, family violence, loneliness and hypothermia are some of them. General practitioner, Dr Stuart Coverley, thinks that Christmas does give people a healthy break from work and the usual routine, and the main symptoms he expects at this time of the year are the after-effects of over indulgence and a mild disinclination to go back to work. Mrs Li Claidon, principal medical social worker, thinks it is a fantasy to say that Christmas is a happy and joyful time. Rather, it creates problems for families — couples squabble about which in-laws to go to, lonely old people suffer, and the commercialisation of Christmas forces people into spending a lot of money on presents and cards that they do not necessarily enjoy. She does think that the Christmas feeling is more genuine in hospitals and residential homes, however, where the people tend to really belong to a community.

Dr Coverley and Mrs Claidon are staff working in community services of Plymouth Health District. *CHC NEWS* recently visited Plymouth to explore the particular problems and practices that are associated with the health service at Christmas time.

Plymouth Community Health Council has 25 members, and serves almost 350,000 people, most of whom are concentrated in Plymouth itself, with the rest living in the smaller towns and villages that extend as far as Cornwall in the West, and Exeter and Torbay districts in the East and South. The CHC's offices are in the old public dispensary in central Plymouth, and through hard work Mrs Doreen Sinstadt the secretary has become well known to health service staff and other local organisations in the past 18 months. CHC members are also becoming very well informed about local health service, partly as a result of their vigorous schedule of hospital visits. Mrs Sinstadt was able to arrange for *CHC NEWS* to visit several hospitals and meet many staff to find out how they respond to the particular demands of Christmas time.

For the old people in Plympton Geriatric Hospital, Christmas is a fairly quiet time, and the staff make a great effort to create a friendly and informal atmosphere. Sister Setter feels that the staff become the patients' family at Christmas, so they spend as much time as possible being with them by keeping the usual ward work down to a minimum on the day. The hospital's League of Friends gives presents for each patient, and a Plymouth charity gives money to be spent on decorations. Mr Edwards, the hospital secretary, thinks it is important to maintain the patients' individuality, even though they are living in a communal, institutional setting. So in the autumn, patients order new clothes from suppliers who visit the hospital, and these are given to them on Christmas day, and that also goes towards making the day special. Those patients who have relatives and friends are particularly glad to be visited over Christmas, but the lack of public transport can make this difficult.



Moorhaven Hospital, 15 miles east of Plymouth, is the permanent home of many psychiatric patients from the district. This year 450 of them will be celebrating Christmas there. The district has an active and successful policy of discharging patients into community care and an impressive community psychiatric nursing service is being developed. The problem though is that those patients remaining in the hospital tend to be the older ones with less chance of being discharged and, perhaps, less continuing contact with friends and relatives. In the hospital there will be a competition for the best-decorated ward, and the patients begin working on this early in December, generating enormous excitement about who will be the winner. At the Christmas Bazaar, patients contribute articles they have made during the year at occupational therapy sessions. The Fancy Dress Ball is another high spot in the Christmas festivities, and music is provided by a dance band and a beat group in the hospital's recreation hall, which has one wall decorated by a remarkable mural.

Reg Crook, hospital secretary at Moorhaven, says the staff put a lot of energy into making Christmas time something that everyone can join in and enjoy, and although it may tend to be a little artificial, the staff give each patient a present; and there is a specially friendly atmosphere in the hospital.

It is a much easier task to create a festive atmosphere in a maternity unit, and Miss Liz Picken, divisional nursing officer at Freedom Fields Maternity Unit, says you don't know you are in a hospital at that time, the mood is so informal. All the wards are decorated, and one pupil midwife with a particular talent for painting has coloured many of the windows with beautiful pictures and designs. They expect about 10 babies to be born on Christmas day this year, and the first one will receive a special present. On the afternoon of the 25th, all the visitors join the staff and patients for a special tea. Of course, people avoid being in hospital over Christmas if they can, so some mothers will have been discharged earlier, and this can make extra work for the community midwives who take over post-natal care; but they are often invited to join in the festivities by the families they visit.

In Plymouth, as elsewhere, the Christmas season brings voluntary initiatives to the fore, and the League of Friends of Devonport Hospital is particularly active. This hospital, which was built by the Navy in 1863, has 133 general beds, and the League raises money to buy a range of patients' amenities and to give each patient a personal gift. On Christmas Eve the parish church congregation comes in with a carol service, and the Salvation Army band plays in the grounds. Ted Pines, hospital secretary, is proud of the links that the hospital has built up with the local community, and he hopes these will be maintained.

Christmas is usually a particular pleasure for children, although in rather a different way for the 2-5 year olds at St. Nicholas's Day Unit, run by Dr. Barnardo's. The children have severe mental and physical handicaps and the staff aim to help them reach the height of their potential through specially designed play. Christmas becomes part of this scheme with the children learning to sing and play musical instruments for the carols at the Christmas party. It is quite an achievement for some of them to participate, but Mrs Marion Embry says that although the children may not understand exactly what all the excitement is about, it is a day for everyone to enjoy together — children, parents and staff.

EDITORIAL

Since CHC NEWS began in May 1975, we have tried to provide members and staff of CHCs with useful information on an appropriate range of topics. With our change of format last April, we introduced some regular articles and features including a letters page, book reviews, summaries of circulars and parliamentary questions. When the paper grew to twelve pages in June, we were able to include more news about what individual CHCs were doing, what various people involved with CHCs were thinking, and a regular slot for summaries of statutory information.

Over the past few months we have regularly given space to CHC people to write about their thoughts on health care topics, their personal view of what CHCs are about, or their experience of a particular piece of work. In each issue there is also information about some aspect of medicine or medical care, and summaries of reports, legislation and other official information. We also try to include articles on technical subjects, new developments in the health field, and related issues of current concern.

We are now reviewing the balance of topics covered in CHC NEWS and we need to know what your preferences are. Which areas of interest have we neglected? Would you like to hear from some of our authors again? Can you suggest new authors? Would you like more space for opinion? Is the coverage of statutory information satisfactory? Write and tell us what you think?

CHC NEWS

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BOOK REVIEWS

TWO TO ONE: A KITH AND KIDS COMMUNITY PROJECT

(Available from Inter-Action, 14 Talacre Road, London NW5, 60p.)

Kith and Kids is a group of handicapped children and their parents. Two to One is a summer holiday project organised by the group: a fortnight during which parents, volunteers and sympathetic professionals work together to give the children intensive help in mastering one or iore basic skills.

This handbook has been produced to enable other groups to learn from the Kith and Kids experience. It presents a thoroughly documented description of how one year's project was planned, implemented and evaluated.

A great deal of planning was done before the event: the group had to find volunteers, premises, professional helpers and funds. Individual teaching programmes were drawn up for each child: the skills to be taught included getting dressed, using a telephone, buying something in a shop, making coffee and using a public toilet. Once the project started, two volunteers worked intensively with each child. Professionals were on hand to give advice and support, and each day an hour was set aside for evaluating the progress made, and for monitoring and adjusting individual tuition programmes. Regular reports were made to the parents by the volunteers involved with each child.

Not only does this handbook provide a wealth of day-to-day detail, it gives an encouraging insight into the kind of success that can be achieved by involving parents and non-professionals in the care of handicapped children.

WHOSE PRIORITIES?

by Radical Statistics Health Group. (Copies available from: c/o BSSRS, 9 Poland Street, London W1, 45p + 15p postage).

This booklet is a critique of the government's consultative documents "Priorities for Health and Personal Social Services in England" and "Prevention and Health: Everybody's Business". It claims that much important information is omitted from the 'Priorities' document; that there is a discrepancy between some of the projections described and what is actually occurring, and that the document fails to discuss the potent forces both within and outside the NHS that tend to impede any move towards more rational distribution of resources.

The booklet points out that many of the areas to which the DHSS professes to be giving priority are not to receive any increase in their percentage share of the total budget. Some are to show a reduction. Some of the proposed 'growth areas' for expenditure will have such a slow growth rate that the targets set by the DHSS will take many years to achieve (30 years, for example, in the case of meals on wheels and home helps for the elderly).

The authors are unhappy too, with the government's statement on prevention. They feel that it attempts to put too much onus onto the individual and ignores those areas where legislation is the key to improved health. Despite gestures in the direction of preventive medicine, they point out, only 0.38 per cent of NHS expenditure is devoted to specifically preventive work, and 0.01 per cent to health education.

Whose Priorities? concludes that the two government documents "give little hope that genuinely new initiatives will come from the DHSS". Whether or not you agree with their conclusion, the facts that they adduce in support of their argument give a new perspective on the current consultation exercises.

Richard M. Titmuss 1907-1973

by John Carrier, London School of Economics

Richard Titmuss would probably have rejected a description of himself as the complete social scientist, yet he commented upon and made an original contribution to academic and practical policy issues in the fields of economics, morals, administration, law, sociology, history and social work. His writings have a profound influence upon current political thought in the fields of health and welfare. The most direct analysis by Titmuss of the NHS is to be found in two publications. The first: **The Cost of the National Health Service in England and Wales** written with Brian Abel-Smith (1956) has been called "a landmark in the history of public finance as well as a document of great political importance." It provided an additional perspective to major areas of government spending, by using social accounting techniques which related the cost of the NHS per head of population covered. It showed that traditional accounting techniques were inappropriate and inflexible. In the political excitement of the time, some ten years after the start of the NHS debates of the Bevan era, many thought the Titmuss/Abel-Smith analysis "saved" the National Health Service and guaranteed its institutional existenco. (See Gowing's pamphlet, especially p.20).

In **Essays on the Welfare State** (1958) Titmuss' attention was turned upon the NHS again, this time for American university audiences. He showed by sociological analysis that the process of the division of labour in society in general had affected medical practice and its practitioners in particular. He was thus able to show that far from the NHS encroaching upon the freedom of the GP it had rescued him from the unacceptable conditions of practice which had prevailed before 1911. (See 1976 edition, p.172).

This theme is revisited in Part IV of **Commitment to Welfare** (1968). Here Titmuss spells out for the reader his personal and subjective views of the NHS and the general practitioner as family doctor: "First, I regard the National Health Service Act as one of the most unsordid and civilised actions in the history of health and welfare policy." His second 'article of faith' (his words) is "a belief in the importance to society of the generalist." "The role of the family doctor is in part to protect the patient from the excesses of specialised technocracy; to defend him against narrow-mindedness, and to help him humanely to find his way among the complex maze of scientific medicine without resort to self-diagnosis or charlatanism."

This defence of the NHS is based upon its social rather than its economic character. In the fiercely argued last essay of the book, "Ethics and Economics of Medical Care", the economic model of man in the medical market is shown to be deficient; "Classical supply and demand analysis may help us to understand the social institutions of very simple and primitive medical economies. But it is singularly unhelpful when applied to the immensely complicated play of forces operating in the field of modern scientific medicine". Administrators within the NHS with complicated systems models of resource allocation might take note.

Richard Titmuss' intellectual strength was, above all, his ability to see all institutions as made by human beings and therefore being capable of rational assessment within a stated position of values. His book **The Gift Relationship** (1970) proferred a powerful defence of the NHS as the base for a voluntary blood transfusion system, relying on the altruism of anonymous donors, which on every criterion (technical, medical, economic and administrative) Titmuss argued is superior to the free market system of blood collection and transfusion in the USA.

Three important references on Richard Titmuss' work are: ***Essays on the Welfare State*** *(3rd edition, 1976) and* ***Commitment to Welfare*** *(new edition, 1976) (both with new introductions by Brian Abel-Smith); and* ***Richard Morris Titmuss*** *by Margaret Gowing, from The Proceedings of the British Academy Vol. LXI 1975, Oxford University Press.*

FOCUS ON HEALTH EDUCATION

As the financial resources available for the NHS become more scarce, talk of "prevention" increases. In the forefront of the growing movement to control consumer demand on the NHS is the Health Education Counci. Established in 1968 (following the recommendations of the Cohen Report published four years earlier), the Health Education Council has, according to the DHSS's consultative document **"Prevention and Health: Everybody's Business"**, a major responsibility for the promotion and development of health education.

CHC NEWS talked to Alastair Mackie, the HEC's Director-General, about the scope of the Council's work. "The HEC has blinkers on, and we cannot go beyond those blinkers," he said. "We have a specified ambit. Our blinkers are those which keep us to specific topics of health: from aspirins to zoonosis; from head lice on top of the head to verruccae at the soles of the feet with stops at the eyes for eye care, the mouth for teeth, the breasts for self-examination, the belly for diet, the genitalia for use and abuse thereof, the legs for exercise — and that is a terribly conpartmentalised way of approaching health. Of course we admit this."

"Our work is to offer choices," Mr Mackie continued. He feels that health education is about presenting information in a straightforward way without moralising or making judgements. "If as a boy you behave as a tomcat, that is your affair. But it is demonstrable, not on moral grounds but on good epidemiological grounds, that on the whole your potency and your capacity to make stable relationships with anybody is reduced. Even more so in the case of women, whose internal machinery, if they are promiscuous, will be damaged."

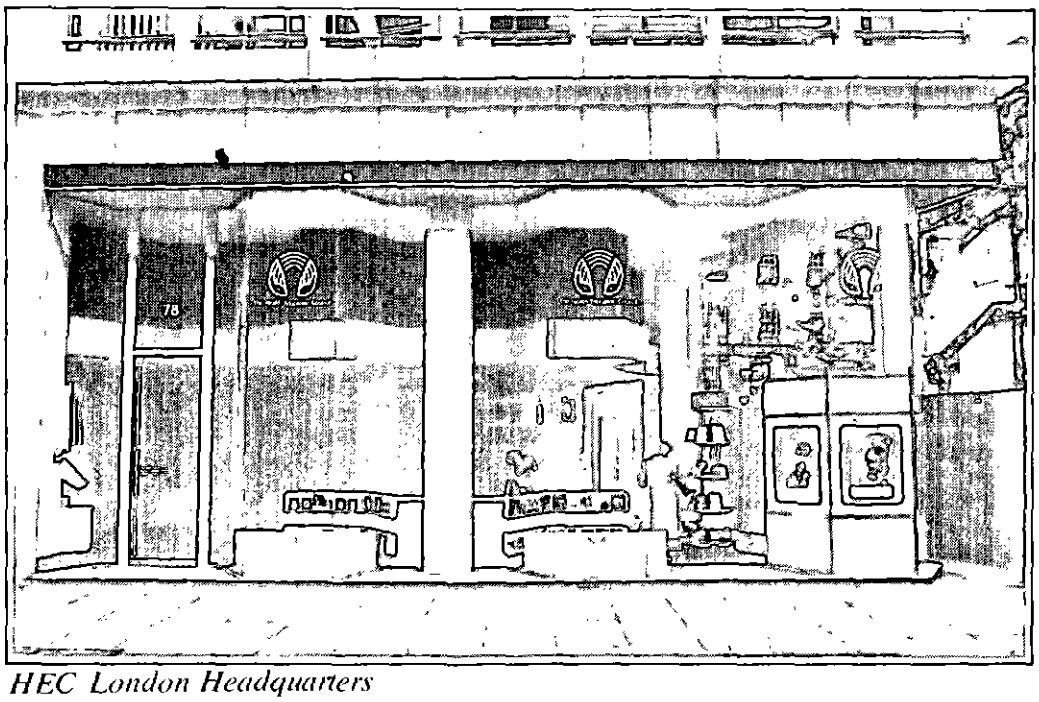
ALASTAIR MACKIE Director-General of the HEC

Mr Mackie acknowledges that much of today's ill-health is self-inflicted only in the sense that it is a predictable response by the individual to social and environmental pressures. "The balance of choice scarcely exists if you are an innocent, not very bright person. Your life gets siezed by advertising and is perverted." He continued: "To try and treat alcoholism by giving people posters and leaflets is all very fine — it may do some good. But until you get at horrible housing, until you do something about rotting city centres. . . . Inner cities are cesspools, not of the kind of infections we used to think about — measles, diptheria and all that — but of social infections."

The HEC seems therefore to be attempting to educate the public on isolated aspects of health, even though it realises that these are only the symptoms of much more complex underlying factors that are beyond the individual's control. Even on this scale, it is difficult to evaluate whether the HEC is doing a good job, and CHC NEWS asked Mr Mackie how CHCs could make a judgement about whether the public is getting value for money from the HEC.

"I don't think you ought to measure us by the smaller number of dead bodies in the mortuaries," he replied. "That really is rather tricky. We can't say we exercise a direct effect on this or that for a very long time, except in quite immediate things like immunisation, which is quick to show results. If we were asked to do a local immunisation exercise in conjunction with an AHA (and this is by no means impossible) and if we claimed, as we would, to be able to do things, and if broadly the things we said ought to be done were done, and if it then failed — we would be in the dock. The local CHC would be entitled to say "You spent X on this and told us we were going to get these results, and they didn't come. Why not?" That would be a method of evaluation."

But Mr Mackie does not think health education will be effective if it is about "doctor-bashing" or if it is critical of the DHSS. "We cannot be anything but grateful for what must be one of the finest medical services in the world; and the Department is totally for prevention. It is rather a matter of securing recognition of the limitations of medicine's relationship with health . . . and of finding out how to intervene, especially locally, with the steady plod towards self-destruction that so-called freedom of consumer choice obliges many of us to take."



HEC London Headquarters

MANAGERIAL ATTITUDES

by Charlotte Williamson, Member of Northallerton CHC

It is easy for CHC people to slip inadvertently into managerial attitudes when they visit health service premises and when they consider their experiences afterwards. We need to be alert to this tendency in ourselves for it impairs effectiveness in our CHC role. Here are some of the ways it shows itself, drawn from several CHCs.

(1) **Thinking about the likely reactions of staff to any new proposal for change before thinking about the advantages to patients.** This is not to say we should not care about staff: but it isn't up to us to decide that an improvement for patients would be too demanding on the numbers or abilities of staff; too inconvenient for them; or would lower their morale. These are the proper concerns of the DMT, after we have put forward our views, for it has the responsibility for the deployment, training and support of staff.

(2) **Accepting the explanations of consultants, sisters, etc., for deficiences in the standards of care we see.** Their explanations will be true as far as they go, but not always complete. Naturally they will seldom point how their own attitudes can affect patients adversely (even if they are aware of this) and some of their genuinely held opinions about what patients like or need are wide of the mark. It is the DMT who must offer explanations and ultimately answer for deficiencies. If we are satisfied by explanations 'lower down' we deprive the DMT of some of the impetus and information that could help it in its own responsibility for standards and services.

(3) **Adopting the views of any individual member of professional group of staff.** However much we agree with their specific ideas and admire their work we still have to look from a somewhat different perspective. This is not just for reasons of impartiality or breadth but is because very few professionals — perhaps none — can think and feel like patients as our lay role in part requires of us.

(4) **Trying to sort out difficulties for staff or get them equipment, etc., they need.** It may disappoint staff when CHC members do not replace former HMC members in giving personal and practical help, but it is important to show that our primary preoccupations must be for and with patients. The argument that better conditions for staff would help patients indirectly, though partly true, can lead to the misuse of CHC time and energy as well as blurring our non-managerial role.

(5) **Making suggestions for furnishings, etc., or minor changes in practice to ward level staff.** This encroaches on the authority of the DMT and can lead to conflicts of loyalty if such suggestions are not acted on. 'Sounding out' staff about major changes in practice the CHC is considering recommending can also put the DMT, the staff and us on the spot later on, for the same reasons.

(6) **Regarding with more sympathy or respect the views of staff, particularly senior staff, than the views of patients and their relatives.** Ideally both are of equal importance, but the present systems of health care and professional training so generally favour staff that we must work towards redressing the balance. Until this happens, our understanding must be more closely identified with the receivers of health care than with the givers: that is the purpose of CHCs.

Home Confinements

A survey of maternity services carried out by Northumberland CHC showed that 20 per cent of the women interviewed wanted to have their babies at home. Almost 100 per cent were in favour of retaining a choice in the matter; and among those women who had experienced both, the vast majority preferred home to hospital confinements. Surveys in other parts of the country have produced similar results.

The 1946 NHS Act states that: "it shall be the duty of every local health authority to secure . . . that the number of certified midwives . . . who are available in the Authority's area for attendance on women in their homes as midwives or as maternity nurses during childbirth . . . is adequate for the needs of the area."

However, despite the requirements of the Act and the expressed wishes of the consumer, a number of health authorities are implementing policies which, in effect, mean that the availability of domiciliary services is substantially restricted. In East Hertfordshire, the CHC is worried by a suggestion in the draft Area Strategic Plan that provision should be made for 100 per cent hospital confinements. The CHC feel that there will always be a proportion of mothers who prefer to be confined at home, and that their right to choose to do so should be maintained. As a compromise they have suggested the delivery by community midwives in hospitals and discharge after 48 hours, coupled with really adequate support at home for the new mother.

Other CHCs are increasingly disturbed at the difficulties being experienced by women seeking medical attention for home confinements. The majority of doctors are, it seems, reluctant to attend women at home. A GP is not obliged to provide maternity services for a patient at all, but each FPC is required to make available a list of doctors in the area who are willing to do so.

Ideally a patient who wants a home confinement should discuss with the doctor concerned his willingness to attend her at home before she registers with him for maternity services. In practice it is often a difficult and time-consuming business to find an acquiescent GP. (Sefton Northern CHC were approached for assistance by an expectant mother who contacted every GP in her locality without success).

The process could be simplified if FPCs were willing to provide a supplement to their obstetric list, giving names of doctors willing to consider undertaking home confinements. Northumberland CHC asked for such a list to be prepared, but the request was refused. Sefton Northern CHC has written to every doctor providing maternity services in its district asking whether home confinement medical services were also provided. While the difficulties continue at district and area level, as far as the DHSS is concerned the position is clear: statutorily AHAs have a duty to maintain a domiciliary midwife service 'adequate for the needs of the area'; and the Department has said that although it is current policy to encourage hospital births, it has never been the intention that health authorities should refuse a home confinement to a woman who wants one.

HEALTH STATISTICS

The DHSS currently collects a considerable range of statistical information about the NHS and social services. There are official forms which specified authorities have to complete and send in at regular intervals. Summaries are prepared at different levels, and the DHSS publishes a certain amount of this information. For the rest, the authority which completes the returns or makes the summary may be able to supply further details. CHCs may like to know more about these statistics which could help them in their study of local services. A small selection is presented here, and the complete list is published by the DHSS in a booklet called **A GUIDE TO HEALTH AND SOCIAL SERVICES STATISTICS** (copies can probably be found at DMT, AHA offices, reference libraries; otherwise apply to the DHSS).

The Guide contains tables showing the data collected on the hospital services, family practitioner services, community health services and local authority social services, as well as on the various departments and authorities themselves.

For example, form SBH 140, which is completed yearly by each AHA, gives details of all the cervical cytology work undertaken in the area: the number of cases examined; the number of positive tests, listed by age groups and source of smear; the results of the biopsies in positive cases; and the numbers of part-time and whole-time equivalent pathologists and technicians employed. All this data is also summarised at both national and regional level, and is published in the Annual Report of the Chief Medical Officer, and in the Health and Personal Social Services Statistics.

Another yearly return, SBH 112B, is completed for each hospital, and deals with mental illness units in general hospitals. As well as quoting the buildings used and the policy for admission to them, it lists the numbers of new patients and attendances, subdivided by age-group, the number and kind of staff employed, the number of available staffed beds, and the number of resident patients. It also gives details of social and recreational facilities, patients' amenities, time and choice of meals, liaison with local authorities and the Department of Employment, and the activities of voluntary organisations.

Various statistics collated by FPCs include, for example: the number and type of maternity medical cases attended by obstetricians and GPs; an analysis of sight tests and the type of lenses prescribed under the general ophthalmic services; the number of pharmacies, drug stores and surgical appliance suppliers operating in the area; and an analysis of the FPC's income and expenditure.

AHAs compile extensive data on community health services. Form LHS 27/3, for example, lists: the number and types of cases nursed at home; deliveries attended by domiciliary midwives; and the number of health education sessions and case conferences attended by health visitors.

Data is also collected by local authority social service departments on their work. Residential accommodation of various kinds is statistically documented, as are day care facilities for children and the mentally ill and handicapped. Details are also compiled on home help services, meals on wheels, and other local authority administered services.

One other form that should be mentioned is the Hospital Return, SH3. Completed annually, it gives detailed information about activity in each hospital. The data covers too wide a range to summarize here, but provides all the basic information about in-patient bed-occupancy, waiting lists, accident and emergency activities, admissions and discharges and numbers of patients and attendances for each speciality and department.

Summaries given here are only some examples of the kind of statistics collected by health authorities and social services departments. CHCs will find it useful to look closely at the whole range listed in the Guide, when they are considering what information could reasonably be expected to be made available to them.

CIRCULARS

HC(76)46 Social Security Payments for Hospital In-Patients

This circular announces changes in the reduced level of social security benefits payable to hospital in-patients. Appendix B gives details of how soon after admission a patient's pension or other benefits are to be reduced. (This part of the circular should be read in conjunction with Appendices A and C of circular HSC(IS)208, which remain in force.)

HC(76)46 also deals with the extension of mobility allowances, the introduction of the invalid care allowance, and the therapeutic earnings limit for patients receiving social security benefits.

The categories of disabled people eligible for a mobility allowance have now been extended to include children aged between 11 and 14. In order to benefit from the allowance, a person must be virtually unable to walk, but in a position to benefit from increased facilities for mobility. The circular also specifically mentions that long-stay hospital patients who meet these criteria should be encouraged to apply.

An invalid care allowance is now in some circumstances payable to people who are unable to work because of the need to care for a severely disabled relative. When a person in receipt of this allowance is admitted to hospital, the benefit is to be discontinued after a maximum of 12 weeks.

The circular further announces that the amount of money a patient may earn from therapeutic work without having his social security benefits reduced has been raised from £7 to £9 per week.

HN(76)154 Pocket Money for Patients in Mental Hospitals

This circular announces an increase in pocket money for patients in mental hospitals who are without other resources. The allowance is increased from £2.65 to £3.05 per week.

HC(PC)(76)20 Family Planning in Hospitals

This circular outlines the arrangements to be made for the organisation of family planning work undertaken by medical staff in the course of their employment in the hospital service. Contraception, vasectomy and female sterilisation on other than medical grounds have not normally been part of the service provided in hospitals. Each AHA is now asked to review its arrangements for providing a comprehensive family planning service in its area, and to offer hospital consultants in relevant specialities, and other medical staff as appropriate, to participate in family planning work. The circular offers guidance on the terms under which doctors may undertake these duties, and a scale of fees for various items of family planning work is appended.

HN(FP)(76)54 Medical Evidence for Social Security Purposes

This instructs FPCs that the Terms of Service for doctors have been amended to take account of the fact that statements issued by GPs for social security purposes are to be given to patients free of charge.

HC(76)180 Electoral Registration in Psychiatric Hospitals

This circular notes the now famous county court decision that people living as in-patients at a psychiatric hospital were entitled to vote. It advises health authorities that the names of any in-patients who are considered by the medical staff not to be suffering from, or appearing to suffer from mental disorder as defined in the 1959 Mental Health Act, should now be entered on the electoral registration form received by each hospital.

NOTES.....

ORAL CONTRACEPTIVES

The Joint Working Group on Oral Contraceptives has concluded that use of the Pill carries certain risks which cannot be entirely avoided. They can, however be reduced by identification of those women who may be at special risk. The group recommend that the Pill should continue to be available only on prescription, but suggests that nurses, midwives, health visitors, pharmacists and perhaps others should be given a basic training in family planning and authorised to issue prescriptions for oral contraceptives.

ROYAL COMMISSION

The Royal Commission on the NHS has published a preliminary statement outlining its future programme of work. The Commission intends to attempt some assessment of the quality of service provided, measured in terms of objectives for the NHS and the public's expectations of it. Other broad topics to be considered include: how the demands made on the health service are likely to change in the next 20 years; how far family practitioner services meet the needs of the patient; the balance desirable between hospital services and primary care; the relationship between health and social services; whether current management arrangements help or hinder efficient resource allocation. More details of the kind of subject to be considered under each broad heading is given in "The Task of the Commission" 32p, available from HMSO.

SALE OF ANALGESICS

Roland Moyle stated in the House of Commons on 26th October that he had received further advice from the Medicines Commission about the proposal to restrict the sale of analgesics to the public. The Medicines Commission now say that there will be no need to prophit the sale by self-service methods of preparations containing analgesics when Part III of the Medicines Act 1968 is implemented, provided that the preparations are in child-resistant containers or strip packaging and are in packs containing not more than 25 tablets. The DHSS is now considering this advice.

HAS ANNUAL REPORT

CHCs are emerging as a "potentially powerful force". They have become well-informed and enlightened on the needs of the hospital service. This is the view expressed in the Annual Report of the Health Advisory Service, published by HMSO, 95p.

Most of this report is concerned with the hospital care of old people. The HAS feels that there has been an improvement in physical conditions in hospitals, and that greater attention is being paid to the quality of life of patients. But overall, the picture is still a grim one: many hospitals have continued to be understaffed, and staffing and morale in geriatric and psychiatric departments have sometimes been adversely affected by restrictions on new hospital building and by isolation from acute hospital services.

HEALTH EDUCATION (TELEVISION) BILL

Laurie Pavitt MP has introduced a Bill into Parliament to require television authorities to provide facilities for showing health education programmes.

WELSH CHCs

A deputation from the Association of Welsh CHCs is planning to meet the Minister of State at the Welsh Office to discuss the role of FPCs. At its last meeting the Association considered in detail the kind of points to be put to the Minister. Members feel that there is a need for some CHC representation on FPCs: perhaps the type of observer status that is now granted for AHA meetings.

LABELLING OF MEDICINES

The labelling of medicines will be more stringently controlled in future. The Medicines (Labelling) Regulations (S.I. 1976 No. 1726) sets out new labelling requirements for containers and packages of medicinal products which are available without a prescription. The name of the medicine, the quantity in the container and directions for use must now be shown.

A guide to these new regulations is available in leaflet MAL 42 from DHSS Medicines Division, Finsbury Square House, 33-37a Finsbury Square, London EC2A 1PP.

The Price of Deafness

Continued from page 3

aspect of their needs, and must be accompanied by a growing awareness of the experience of disability as a whole. Since most of us will experience some kind of disability at some time, self interest alone should compel us to improve existing services and allowances.

***The Price of Deafness by Irene Loach, available from The Disability Alliance, 96 Portland Place, London W1; price 60p post paid.**

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 6: Scarborough CHC
Chairman: Mr Ken Henderson
Page 10: South Nottingham CHC
Secretary: Mr J. E. C. Hewitt
Page 25: North West Surrey CHC
Secretary: Miss Christine Davy
Page 33: Isles of Scilly CHC
Chairman: Rev. M. M. Adams
Page 35: Kidderminster CHC
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Telephone: Kidderminster 60243
Page 35: Worcester CHC
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Worcester WR1 3EE
Page 39: Walsall CHC
Address: 3rd Floor
Permanent House
1 Leicester Street
Walsall WS1 1PT
Page 39: Chester CHC
Telephone: Chester 317622
Page 43: West Lancashire CHC
Chairman: H. E. Skaife
Telephone: Ormskirk 77376
Page 46: South Clwyd CHC
Chairman: Henry Williams
Secretary: Mr I. L. Roberts
Page 51: Trent Regional Association of CHCs
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Chairman: Cllr A. A. Goodson
Page 56: Trent Regional Association of CHC Secretaries
Address: c/o North Derbyshire CHC, 87 New Square, Chesterfield
Chairman: M. G. Briggs
Secretary: K. Swann
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Page 58: SW Thames Association of CHC Secretaries
Address: c/o Cuckfield and Crawley CHC, Maxwelton House, Boltro Road, Haywards Heath, West Sussex
Secretary: A. H. Harman
Telephone: Haywards Heath 50025

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 which can be used to display the CHC's own material to illustrate a talk, as part of a stall at a local show, 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.