CHC NEWS

For Community Health Councils

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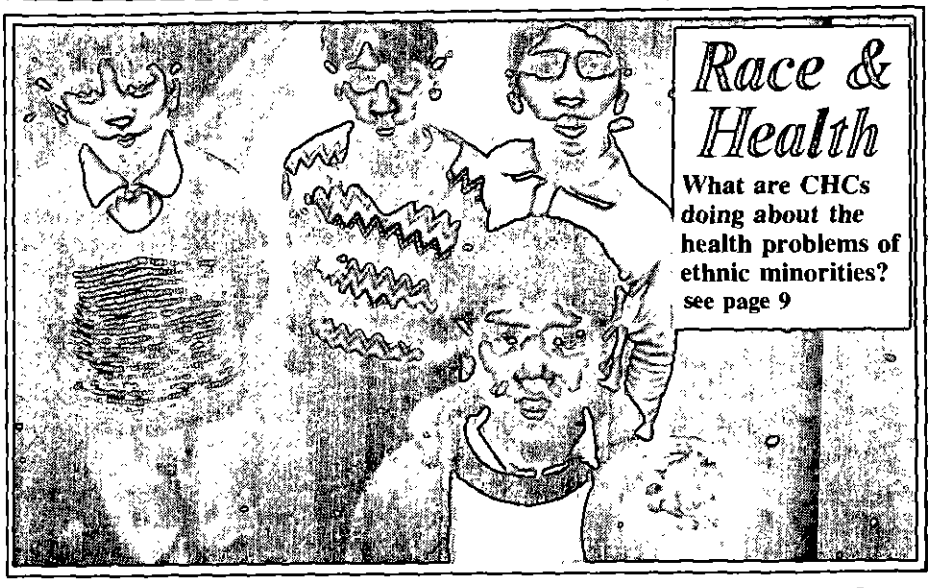

Race & Health

What are CHCs doing about the health problems of ethnic minorities?
see page 9

THAT'S LIFE!

For the first time since CHCs were established, a TV programme has investigated in some detail the problems people may have in making official complaints against doctors. On Sunday 9th January, Esther Rantzen's "That's Life" on BBC television described the case of a lady living in Norfolk who had complained to the Family Practitioner Committee that in her view the failure of GPs to visit her elderly parents at home when they had become ill was a contributory factor to their later deaths in hospital.

She alleged that repeated requests for home visits from herself, the district nurse and others were ignored, but the FPC service committee did not find the doctors to be in breach of their terms of contract although it admitted there were administrative problems in the GP practice concerned. The FPC decided to take no action and the woman appealed against this decision to the Secretary of State. He upheld the FPC's decision even though the evidence of a key figure — the district nurse — was never asked for. The local CHC helped the woman both at the service committee and in lodging her appeal, and the TV programme explained how CHCs could act in this way to assist individual complainants.

As a piece of factual reporting the TV programme was very well done, according to many who saw it. The issue is clearly a controversial one, but the CHC concerned

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Chemists' shops

The number of chemists shops is falling at the rate of over 200 a year.

The Pharmaceutical Services Negotiating Committee (PSNC) has prepared a scheme to provide financial assistance to pharmacies in such difficulties, and it circulated an outline of the idea to CHCs in 1976. The scheme is one of the subjects currently being discussed in detail by the Clothier committee — which was set up in 1975 to examine the problems of dispensing NHS prescriptions in rural areas. Representatives of the pharmaceutical and medical professions are working together on this committee and are expected to be able to make some firm suggestions by spring 1977.

If the PSNC's scheme were implemented by the DHSS, then financial assistance to small pharmacies in both urban and rural areas which qualified for help would keep shops open which would otherwise have to close. *CHC NEWS* will carry further details of the PSNC's plan as soon as these are released.

BRENT'S ACTION ON CLOSURES

Brent Council is taking legal action against Brent and Harrow AHA to obtain reinstatement of services closed at two local hospitals. This is the latest move in Brent CHC's fight to safeguard its statutory right to consultation on any substantial variations in the provision of health services locally.

The two hospitals were closed by the AHA in late 1976 with the claim that its action was temporary. The CHC considered that not only would the 'temporary' closures clearly prejudice the outcome of any discussions about the future of the units, but that since the proper consultation procedures had not been followed, the AHA had acted unlawfully in implementing them. In October the CHC obtained leading Counsel's opinion through Brent Community Law Centre which advised that the closures had been carried out illegally. The North West Thames RHA also recognised that proper consultation had not been carried out, and instructed the AHA to re-open consultations. The RHA declined, however, to ensure the reinstatement of those services which were still in dispute.

The RHA also refused to finance any legal action taken by the CHC. Consequently Brent Council was asked to consider using its powers under Section 222 of the Local Government Act 1972 to intervene in cases where the interests of local residents are in jeopardy. The Council agreed and is now taking appropriate legal action to try to get the services reinstated pending the outcome of the consultation process which has at last been set in motion.

*A full descussion of the issues raised by the Brent case will appear in the next isue of *CHC NEWS*.

YOUR LETTERS

BALANCE OF CHC MEMBERS

Dennis Baker, Secretary Northampton CHC

This CHC has put to the Secretary of State that the proportional representation of local government nominees to voluntary organisation representatives, i.e., 15 to 10, as provided by the National Health Service (Community Health Councils) Regulations 1973, is the wrong way round. This Council believes that local authority members carry so much responsibility to satisfy their district council work that they are hard put to in finding enough time to fulfil further obligations on behalf of the Community Health Council other than normal Council meetings. We have written to the DHSS about this, and Mr Moyle has replied that he is "not persuaded that it would be right . . . to seek legislation to disturb the present allocation of CHC places to local authorities and voluntary organisations. . . ." It would be interesting to find out if other CHCs share our view, i.e. that half the members of a Council should be drawn from voluntary organisation representatives.

BENYON'S ABORTION BILL

Lady Houghton, Chairman Birth Control Campaign, 27-35 Mortimer Street, London W1

On 25th February Parliament will once again be asked to consider whether the 10-year-old Abortion Act should be restricted. William Benyon, Member for Buckingham, will be asking for a second reading of his Bill to implement the recommendations of the Select Committee on Abortion (First Report, H.C.573-1), the Committee from which six members resigned last year because of its biased nature.

The excuse for an amending Bill has grown very thin since the DHSS instituted its own controls for dealing with abuses. The need now is to remove those NHS regional disparities criticised by the Lane Committee and which the Select Committee admits still persist (Second Report, H.C.737). This does not require a change in the law but the establishment of separate abortion units in particular hospitals.

May I urge CHCs to make their representations to the Secretary of State for Social Services as well as to local MPs in good time for 25th February and against the enforcement of restrictions that can only make it more difficult for women to obtain early safe abortions.

HEARING AIDS

Mike Gerrard, Secretary Haringey CHC

We receive a periodical but increasing number of complaints from people with NHS hearing aids, and undoubtedly the shortcomings of the service are causing great distress. In common with other CHCs we have asked for, and managed to get, a better network of collection points for replacement and spare parts, but the problems are intractable when anything more than a routine exchange is called for. Recent instances brought to us indicate that it is very difficult for a housebound person or a person who needs ambulance transport to receive attention, and that hearing aid technicians in one district are not accepting people who have had their hearing aids supplied by another district. By a curious coincidence, this has happened once in both directions between Haringey and the King's health district in the last month. While the sector administrators and the district officers are very apologetic, it is openly admitted that this is a neglected area of the NHS. A shortage of technicians, coupled with low status and financial starvation of the service appear to be at the root of the problem.

If other CHCs have experienced similar problems, or have ideas on how to improve this aspect of health care I should be glad to hear from them. I suspect that more than localised pressure is required and if the problem is sufficiently serious and widespread, some concerted action should be taken to put it right. The situation also appears potentially alarming with regard to people needing calipers on account of leg or foot disability. I should be grateful to hear if other CHCs share this view.

X-RAY APRONS IN DENTAL SURGERIES

Michael Silver, Secretary, Socialist Medical Association Dental Group

It is now universally agreed that the amount of X-rays which people receive should be kept to a minimum. The DHSS, to give credit, has been running a rather low-grade campaign to try to persuade dental surgeons to put an apron round *all* of their patients whilst they are taking X-rays.

Unfortunately, X-ray aprons cost about £20 each and the DHSS campaign needs compulsion rather than a gentle nudge. If CHCs mounted local campaigns to make patients report to them and the FPC when lead aprons are not used, then the profession could be shamed into buying and using this vital piece of surgery equipment.

NATIONAL CONFERENCE

Ron Brewer, Secretary Tower Hamlets CHC

I am extremely sorry to note all the disagreement about the National Conference. I thought that this very difficult meeting was handled quite well, and, in my opinion, the Chairman and the platform are to be congratulated rather than criticised.

My own experience of conferences stretches over thirty years, mainly in the political and trade union fields. Whereas most of those would be guided by Standing Orders developed and refined over many years, and by precedents, custom and practice, in our own case we had to start from scratch — not an easy task — especially when the delegations are likely to be composed of controversialists and natural dissenters. My own delegation voted against a national association, but we accept the view of the verdict of the meeting and my Council will now work for the continued success of the new body.

COPING WITH REPORTS

Mrs P. Keep, Chairman Oxford Regional Association of CHC Secretaries

During recent weeks we have received a number of lengthy reports which have to be summarised before they can be of use to member Working Groups. We feel this is an exercise being undertaken by all CHC Secretaries and in view of the length of some of these reports — e.g. the Court Committee — we should be interested to hear how other CHC Secretaries are coping with this.

We have been discussing the advantage of having an abstract prepared centrally an and would like to hear the opinion of other Secretaries on this.

FPC ATTITUDES

Tom Richardson, Acting Secretary Oxfordshire CHC

I am still reeling from what seems to be an inescapable fact that there is actually a secretary of a community health council who is also a member of a family practitioner committee. This surely must be the most sprightly form of mental gymnastics that I have seen for a long time.

The main theme of Mr Harman's strange article, (CHC News 15), if I understand it, was in some way supporting the defensive attitude of many FPCs and their hostile reaction to CHCs. It Seems to me that cooperation with CHCs and the patients they represent is the only hope for FPCs and the general practitioners they represent.
they seem to have lacked so far and endeavour to examine all complaints informally in conjunction with CHCs' and only use their quite dreadful system of service committees as a long stop, then there is a strong chance that both patients and general practitioners will work together to create a better service. If FPCs do not come round to understanding the role of CHCs and community involvement then they may well become prisoners within their own statutory instruments and open to an ever increasing burden of litigation.

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.

BRIEFING FOR NEW MEMBERS

Most CHCs will have completed their first major changeover of membership in the last few months. Much of the accumulated knowledge and expertise gained in the first two years will happily remain, and experienced members will be able to offer their newly-appointed colleagues a sense of continuity in the work. As a back-up to this we are providing a brief introduction to the statutory context for CHCs, the role of the members, and some of the sources of support that are available.

BACKGROUND

CHCs were set up during 1974-75 in England and Wales to give consumers a say in the way health services are run at a local level and an opportunity to influence the planning of future services. There are 207 CHCs in England and 22 in Wales, whose members serve in a voluntary capacity. In addition each Council has a secretary and one or two assistants who work from the CHC's office. Some CHCs have chosen shop-front premises in high streets, others have offices which may be associated with hospitals or other health service premises.

(Local Health Councils in Scotland have similar responsibilities to CHCs in England and Wales.)

MEMBERS' RIGHTS AND RESPONSIBILITIES

Although there are no prescribed size limits, most CHCs have between 18 and 30 members of which:

- One half are appointed by local authorities (not necessarily all councillors)
- One third are nominated by voluntary organisations with an interest in health issues
- One sixth are appointed by the Regional Health Authority (RHA) (probably including a trades council member, a disabled person and individuals with other relevant experience).

People who become CHC members are expected to have regard for the need to represent the interests of the community as a whole, and should not see themselves exclusively as representatives of the body or organisation which nominated them. Circular HC(76)25 gives guidance on eligibility and selection of CHC members. It emphasises that people appointed should be prepared to give a considerable amount of time and energy to the CHC's work, and should either live in the district or have clearly demonstrated a commitment to it.

Anyone who becomes a member of an RHA, Area Health Authority (AHA) or Family Practitioner Committee (FPC) is automatically disqualified from CHC membership. And if a CHC member fails to attend the Council's meetings for six months, the relevant nominating body can be asked if it wishes to replace him or her.

CHCs have certain basic rights: they may visit and inspect any NHS premises in the district; and they must be consulted when any substantial variation in the provision of local health services is proposed (fuller details about this kind of consultation are given in circular HSC(IS)207).

CHCs also have a right to the information they need to do their job properly, and District Management Teams (DMTs) and AHAs are expected to provide this. Councils should also have access to recommendations made by the Health Advisory Service about any establishments in the district. A spokesman from the DMT is expected to attend CHC meetings when invited, and to answer questions in public.

Each CHC is entitled to send an observer to meetings of its AHA. He or she has the right to speak but not to vote, and should normally receive all the papers considered by the AHA. The observer should be excluded from confidential discussions only in very exceptional circumstances.

REGIONAL AND NATIONAL GROUPS

Several CHCs have joined some form of regional grouping, where representatives meet 4-6 times each year to discuss shared problems and joint action. In some cases the group is a formal association whilst in others the gatherings are called more informally. These groups do not yet exist in all regions of England. The Welsh CHCs have formed their own Association which meets regularly and can raise issues with the Welsh Office.

A national body for *all* CHCs is in the process of being set up (full details in *CHC NEWS 12* and *14*).

CHC Secretaries have their own regional groups, and representatives from them meet together as a Federation of Regional Association of CHC Secretaries in England and Wales. The Welsh Secretaries also have their own association.

TRAINING COURSE AND MEETINGS

New CHC members can attend introductory courses about the role of the councils and their place in the National Health Service. The RHA has the responsibility for arranging these courses and should be contacted for more details. In addition, on-going courses can be arranged by CHCs to help members with particular problems and issues — universities, colleges and the Regional Training Officer may all be able to help. Very many organisations with a health interest arrange meetings and conferences which can also be worthwhile attending for interested CHC members.

INFORMATION SOURCES

CHCs have a very wide range of concerns, both within the framework of the NHS, and in the broader context of health generally. As well as the reference material that individual CHCs have compiled, there are various other information sources which you can make use of.

CHC NEWS is supplied free of charge every month to each CHC member and secretary. The paper covers a range of topics — news and contributions from CHCs, articles on aspects of health care, summaries of statutory information, book reviews, new developments in the health and social services.

The *CHC NEWS* office also provides a service for CHCs in response to individual requests from members and staff for information or advice. Contact us by letter or telephone 01-267 6111, ext. 267.

Libraries which have a specialist interest in health provide another helpful resource. The Kings Fund Centre Library in London for example has a large stock of material and offers an information service on health service topics. University libraries, local and national voluntary organisations, and the RHA's statistician may all be able to provide useful data.

DHSS circulars are a further important source of information. They give details of changes and developments in health service policy, and are now circulated to all CHCs: your secretary will have them on file. Your secretary will also be familiar with the regular health service journals which can provide background information and commentary on various aspects of the NHS and issues of current concern.

SUGGESTIONS FOR READING

General references: (1) *The Reorganised National Health Service* by Ruth Levitt (Croom Helm, 1976, £2.95 and £6.95). (2) *CHC NEWS* (previous issues available at your CHC office or from us; also, there is an index to all the issues published in 1975 and 1976).

Official information: Circulars: HRC(74)4: *Community Health Councils*; HC(76)25: *Appointments to Community Health Councils*; HSC (IS)207: *Closure or change of use of Health Buildings.*

Statutory Instrument: No. 2217 1973: *NHS (Community Health Council Regulations) 1973*; No. 791 1976: *NHS (Community Health Council) Amendment Regulations 1976.*

EMERGENCY DENTAL SERVICES

by Cyril N. Gumbley, Secretary of East Dorset CHC

In the Autumn of 1975, the Council's Rural Surveys Project Group focused attention on problems which could be encountered trying to obtain dental treatment in an 'emergency'. The views of the Area Dental Officer were obtained.

Mr J. B. MacLachlan, Area Dental Officer, reported that there was no established procedure for patients requiring emergency dental treatment. Where a patient had a jaw bone injury, this would be treated by a Consultant Oral/Dental Surgeon in hospital. A patient with severe toothache however would be prescribed an analgesic by a GP until his or her own dentist could be consulted. A patient's own dentist would normally provide emergency treatment but did not have to accept 'casual' patients for such treatment. He explained that the DHSS were conducting experiments having dentists on call for emergency cases and also investigating the provision of emergency dental services in conjunction with hospitals.

In September 1976 a local GP complained to the CHC of the inadequacy of emergency dental services, and explained how GPs were frequently called upon to solve out of hours dental problems. He felt that the dental profession was inviting adverse publicity by not providing some form of emergency service. To ascertain what progress was being made in establishing an emergency dental service nationally, the Council sought the comments of the Chief Dental Officer to the DHSS, Mr G. D. Gibb.

Mr Gibb supplied Council with a copy of the *Interim Report on Emergency Dental Services* (published in December 1973 by the Working Party on Dental Services).

This report concluded that "the only satisfactory way of determining the true extent of this problem (i.e., obtaining emergency dental treatment) is to organise a properly designed and monitored experiment to assess the need for an emergency dental service, the times at which it should be provided and the type of demand for which it should seek to cater."

The Chief Dental Officer further reported that "the Department have since been discussing with representatives of the dental profession setting up emergency dental services on weekends and bank holidays on an experimental basis at four selected sites in England. The purpose of these experiments will be to assess, over a two-year period, the extent of the unmet need for such emergency services and the cost. The results will then be made known to Area Health Authorities". He added that he was "not yet in a position to say when the experimental schemes will begin as this depends on the progress of our negotiations with the profession".

Mr Gibb also stated that "any authority may make arrangements for an emergency dental service in premises belonging to them if they consider a need exists and sufficient priority can be given to such a service, provided that the following conditions are met: (i) the dentists taking part must be included in the FPC's dental list (community and hospital dentists can be included in the list for this purpose if they wish to take part); (ii) the dentists cannot be paid more than £11.60 per session of three hours; (iii) the dentists must be paid from the general dental services fund; (iv) the dentists must complete forms FP17A for each patient and submit them to the Dental Estimates Board; (v) the normal statutory charges will be collected from the patients and paid over to the FPC. Arrangements for such schemes should be made by the AHA in full consultation with the FPC.

The Council has urged the DHSS to expedite its experiments to assess the extent of unmet need for these services.

MEALS ON WHEELS

The Meals on Wheels service in Britain has grown dramatically since it was founded by the Women's Voluntary Service) now the WRVS) during the last war. But developments have been patchy, depending on the individual local authorities and local voluntary bodies involved.

Section 31 of the National Assistance Act 1948 empowered local authorities to contribute to the costs of voluntary meals on wheels organisations, but it was not until 1962 that councils were empowered to directly finance the building of kitchens and the purchase of transport and food containers (National Assistance Act 1948 Amendment Act, 1962). In the year ended March 1973 about 135,000 people in England received over 18 million meals, at a cost of over £3m. to local authorities. Nearly 11 million of these meals were provided wholly or in part by voluntary organisations. The last comprehensive government document on meals on wheels is DHSS circular 5/70 which appeared in March 1970, though the Department is now emphasising that the contents of this circular need to be seen in the light of the changing economic situation.

Circular 5/70 defines people eligible for meals on wheels as "the elderly or handicapped living in their own homes who cannot provide for themselves a hot main meal daily and cannot be provided with one in any other preferable way". Possible alternatives include home help, home adaptations rehousing, "good neighbour" schemes and the provision of meals in lunch clubs and day centres.

"It should be clearly understood . . . that meals services make a significant contribution to nutrition only if they assure to the consumer at least five hot main meals a week. Meals on wheels may contribute to this objective by providing a meal on the day or days in the week when relatives, neighbours, lunch clubs, etc., cannot do so, . . they may have to meet the full need . . .". In 1972 only 18 per cent of recipients were at or above the five meals per week level. When allocating fresh resources, some local authorities have aimed to increase the numbers of people getting a meal every day, whereas others have preferred to spread their efforts more widely and thinly. The person needing help from meals on wheels may be brought to the service's notice by neighbours, or by health service or social workers. Medical certification of need is not necessary, but when a health problem is involved, the GP should be notified. On charges, circular 5/70 says: "The general practice is to make a fixed charge for meals well below cost. It is important that any charge should not be so high as to deter elderly people from accepting all the meals they need . . .". A study of meals on wheels work methods showed that total cost per meal varied from 14.4p to 44.5p, and that subsidies ranged from 5.4p to 37.0p (*Meals on Wheels*, Short term study for DHSS by PA Management Consultants Ltd., 1973).

In August 1972 DHSS circular 35/72, dealing with the development of social services over the next ten years, suggested a guideline for meals on wheels provision of 200 meals per week per 1,000 elderly. The national average figure was then about 80 per 1,000. The DHSS is now planning to sponsor research into alternative ways of developing meals on wheels services, the PA study being the first stage of this research programme. DHSS circular 52/72 offers advice on meal delivery, cooking and food costs, based on the PA findings. Both this circular and the PA report refer to the preparation of a "manual of guidance" primarily designed for meals on wheels supervisors, but this useful-sounding project is reported to have been shelved.

PERSONAL VIEW

by Nancy Wansbrough, Member of Winchester and Central Hampshire CHC

To my mind, both David Ennals at Friends' House and your recent personal viewpointer Caroline Langridge have drawn the wrong conclusions from Rudolf Klein's and Janet Lewis's research finding that the middle classes are over-represented in the present composition of CHCs. Surely this is not an unfortunate accident to be set right, but a logical reflection of the fact that for years the middle classes have pioneered and manned the voluntary organisations. (Whether they will do so in the future is perhaps less certain, but does not affect the argument that the middle classes are clearly preponderant in voluntary bodies at present.)

In any case, the proposition is advanced that it is less important to consider the composition of CHCs than it is to consider how they are to undertake their task of representing their public no matter how they are constituted. This surely is the tricky question; and one to which institutions like the health service organisation unit at Brunel can usefully direct their attention. If it is not carefully considered, a CHC can fall into the trap of assuming "that it, in itself, is a totally representative body and that, therefore, its collective opinion will somehow encapsulate the interests of the community as a whole. Nothing could be further from the truth". (David Philips, Health and Social Services Journal, Nov. 1975.) Another pitfall is for a CHC to find itself tagging along after the latest and most vociferous pressure group which chooses to canvass its support.

To illustrate this one may take a concrete and typical situation with which so many CHCs, including my own, have recently been confronted — the proposed closure of an expensive, cosy, small maternity unit — grossly under-occupied. In our case, a public meeting, a petition and a number of letters all clamoured for its retention. These expressions of opinion we faithfully passed on but refused as a CHC to endorse, reasoning that as a CHC it is our job to represent all health care users, particularly the inarticulate and not only the (mostly former) users of a particular maternity unit; and that the money saved by closing it should be spent on higher priorities elsewhere.

However, before one can assess priorities, one must, it seems to me, sharpen the tools we have got to use to gather the information we are going to assess.

Hospital visits, meetings, petitions, letters — all the traditional methods will have their place but increasingly, it appears, we shall need to survey and poll in a scientifically acceptable manner on appropriate occasions. But we cannot govern by referendum, and others of your correspondents have a valid point when they advocate the development of additional methods of sounding public opinion. A good deal of work lies ahead testing out which methods suit which circumstances. My own view is that it is experimentation well worth undertaking. This is how we shall make ourselves credible both to our public and to the executive, for we shall be on firm ground.

News from CHCs

- Shoppers in Watford High Street were recently questioned by a dozen 12 and 13 year olds from Langleybury School on how much they know about the local CHC. Of 130 people 30 per cent had heard of the CHC, 23 per cent knew what it did, but only 16 per cent actually knew where it was. The survey was arranged by SW Herts CHC as part of a local Social Education Project.

- Hull CHC have suggested that packs of instant food should be given to people living alone when they leave hospital to tide them over until Meals on Wheels can start being delivered — a wait of two days after returning home is usual. It is envisaged that the packs will cost 60-70p and their contents have been suggested by the District Catering Officer — but a decision to go ahead with the scheme will have to wait until it can be decided who will bear the cost.

- Harry Baker replaces Janet Lewington at Kettering CHC. Prior to his appointment as the secretary, Mr Baker was administrator at Rushden Hospital.

- Patients in Burgess Hill, Sussex, now have an extra GP in the town following a public meeting called by the Town Council and supported by Cuckfield and Crawley CHC. Over 700 local residents attended. The CHC hopes for a similarly large audience at a meeting to be held in East Grinstead in February about closures.

- Correspondence to and from mental patients should be freely allowed according to a working party of Bromley CHC on a Review of the Mental Health Act 1959. They say that doctors should not have powers of censorship and correspondence should only be witheld if recipients request it.

- Liverpool Central and Southern CHC's new chairman is Mr T. H. Knuckey. In Northampton, Mr L. C. Softley is now chairman and Mrs S. G. A. MacQuaide is the new vice-chairman. Other new chairmen are Mr W. Hartley at North Birmingham, Mr J. Windsor at SE Cumbria, Rev. N. J. Ovenden at Winchester and Central Hampshire, Mr W. D. F. Foden at Mid-Staffordshire, Mrs C. V. Stubbs at Lincolnshire North, and Mr Eric Thomas at Dewsbury.

- In Hammersmith a new association for the disabled has been launched, following a meeting called by the North and South Hammersmith CHCs. It was attended by over 70 disabled people and representatives of local clubs and statutory services.

- North Tees CHC Secretary, John Wardle, is resigning to become sector administrator at Kingston upon Hull health district, and at Islington CHC, Secretary Julian Knox is leaving in March.

- Following enquiries from several pregnant women during the last year who were considering having their babies at home, the Liverpool Central and Southern CHC has produced a leaflet giving advice on home confinements.

- St Helens and Knowsley CHC have written to David Ennals and their local MPs proposing that a national lottery should be set up and that the proceeds should benefit the NHS.

- Leeds Western CHC's new secretary is Sue Jenkins.

- Chairman of the East Anglian Regional CHCs is Mrs E. M. E. Harland of Cambridge CHC.

- One hundred and twenty people attended a public meeting on mental handicap organised by the Basingstoke and North Hampshire CHC to try to involve parents in decisions about the future of their mentally handicapped children. Similarly, Wandsworth and East Merton CHC are helping to launch a self-help counselling service for parents of newly-assessed handicapped children.

CHCs: *The context for concern*

by Tom Heller, Member of Norwich CHC

It really does appear that the major decision-making groups in the NHS have lost contact with the people for whom the service is intended. The administration of the service and the 'professional' groups are very imperfectly accountable to the general population and the struggle for power between these groups has created enormous distortions in the service that is presently available. While the power structure of the service is organised in this way the current inequities in the service will remain, the rich specialties and interest groups will grow richer and the poor will continue to suffer.

The formation of community health councils can be taken as an opportunity to see that the people for whom the service is intended develop into a powerful voice, able to decide things about that service. It is possible that the lack of direct entry into the executive process can be used positively to ensure that the CHCs do not either become part of the management structure, or see themselves performing the same functions as the management. Even more importantly, they should not be *seen* to only be in the business of concurring with the management or professional groups and explaining to the community why the establishment acted in the way it did, etc. This obviously achieves special significance at times when services are actually being cut. There is no harm in coming to an understanding of why the management acts in a certain way, but the role as advocate for the community should never be lost from view. In this context it is especially important to be aware of the possibilities that are available for the powerful interest groups of the service to manipulate the CHCs to their own advantage.

For example, the administration can legitimise unpopular decisions by claiming that they have been considered by the CHC while on other occasions dismissing the protests of CHCs because 'they do not properly represent the population at large'. Some would claim that the CHCs have been given their present structure in order to exploit exactly dilemmas of this nature. It is similarly of great importance for CHCs to achieve a balance when arriving at decisions concerning the organisation of services, and they must ensure that they are available and receptive to the views of non 'professional' employees of the service.

The debate concerning the structure, composition, statutory power and accountability of the CHCs themselves must continue, but should not take up all the energies of the councils themselves or obscure the terrific opportunities that exist at present to pursue their role as advocate for the community. It is probably that only when they can be seen by the community itself to be stridently involved in furthering the interests of that community will they be regarded as relevant by those people that the CHCs purport to serve. In other words the legitimacy should be conferred on the councils by the community, rather than by their attempting to join the statutory bureaucracy in some minor and necessarily impotent fashion. Even more difficult is the task of concentrating on the *health* of the community rather than on attempts to distribute an illness-orientated service. There is no doubt that ensuring equitable coverage of an understanding and effective curative and institutional service is an important part of the work of CHCs, but this should not detract from the adequate consideration of the *caring* function of the service.

In particular, services should be organised to provide support for the informal, family and neighbourhood networks of caring facilities, and encouragement for self-help and supportive therapeutic groups of all types. These should be developed not only because they represent

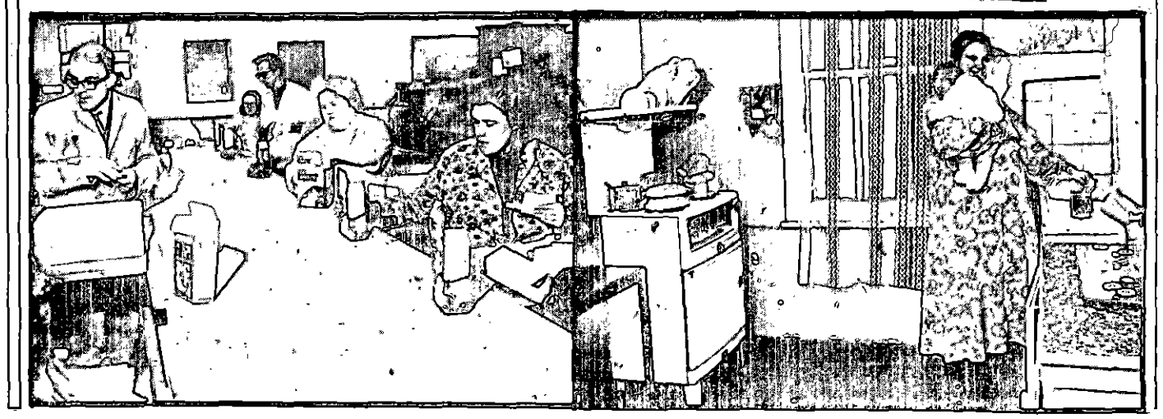
cheap alternatives to relieve pressure from the statutory services, but because they are fundamentally *better* methods of coping with illness, stress or whatever. CHCs have additionally a special responsibility to consider the effectiveness of the services provided. In particular they should not press for increased institutional facilities or advanced technological developments where more appropriate forms of care, or more effective methods of treatment should be considered.

I believe that it is also important to focus attention on those factors in society that appear to be creating illness in the first place. The social conditions that make people ill should certainly be the concern of any group allegedly concerned with the health of the community. This will include the physical and mental conditions both at home and in the workplace and also the effects of promotion of products that are known to damage health. For instance, it does appear to be quite wrong to support anti-smoking health education campaigns which tell people to stop smoking without thinking about the hundred times greater expenditure of the tobacco companies who are promoting death-inducing behaviour.

Similarly, if it is known that bad housing conditions are causing ill-health in the community, the response shold never be to add more and more facilities to the health budget to cope with the rising demand, but to insist on improvements in housing conditions.

Examples could be drawn from every sphere of social activity where change is necessary to improve the health of the people represented by the CHC, and include consideration of the entire life style that is encouraged and rewarded by the present organisation of advanced technocratic society.

It may well be claimed that none of this is the role of CHCs as presently constituted. However, there is no reason why the CHCs should not act as a powerful focus to discuss these concerns of 'health' in its widest context. Concentration on the NHS and its management structure alone will surely ensure that CHCs follow the consumer councils within other nationalised industries and become bodies in meaningless limbo, concerned only with illness and divorced both from the power structure of the service and largely irrelevant to the health of the community.



EDITORIAL

It is not difficult to get agreement with the statement that the administrative structure of the NHS needs to be improved further. Indeed, many organisations are hoping to influence the Royal Commission to recommend that either the areas or the regions are abolished.

The problem of finding the appropriate administrative boundaries within which health care can best be provided has clearly not been solved by NHS reorganisation, although no one seems to be calling for the end of health districts. It is therefore disturbing to find that the only evidence of tinkering with the 1974 structure should be happening around district boundaries. In Sheffield, the Wirral and Weston-super-Mare plans are 'under discussion' for a reduction in health districts. In all three cases the time taken to implement decisions has led to uncertainties among staff about the security of their jobs, and there has been a consequent reduction in effective management of the local services. The discussions appear to be based on financial considerations, but from CHC's point of view we need to insist that the best interests of local people who use the health services now and in the future are the deciding factor in any changes of this magnitude. We hope to discuss this question in greater detail in a future issue of CHC NEWS since it is of the greatest importance to ensure that decisions to redraw boundaries are not taken purely for reasons of financial or administrative convenience, but because health care can be provided and planned more effectively and efficiently. We would be glad to know of any other districts where the boundaries are under discussion.

CHC NEWS

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Editor: RUTH LEVITT

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BOOK REVIEWS

DISABILITY RIGHTS HANDBOOK FOR 1977

The Disability Alliance, 96 Portland Place London W1 01-794 1536. Price 50p plus 15p postage (half rate for order of 20 or more from organisations concerned with disabled people.)

This 32-page handbook, published in conjunction with ATV's "Link" series, sets out the main benefits to which disabled people are entitled. It does not claim to be comprehensive but the selection includes benefits for which most disabled people are eligible and about which questions are most frequently asked. The sections include Invalidity Pensions and Allowances; Mobility, Attendance and Invalid Care Allowances; Supplementary Benefits, Industrial Injury Disablement Pensions; help with housing costs; the Family Fund; benefits for disabled pensioners; services to help with incontinence; what local councils can do. The first part finishes with a section on appeals and a list of organisations to approach for further information — which includes CHCs.

Part II is called 'Talking Points' and includes interesting and useful discussions on policies for the disabled and a section on sex and physical disability. Part III is a long comprehensive list of organisations of and for disabled people.

The handbook would be a very useful addition to the bookshelf of any organisation or individual hoping to advise a disabled person.

PRIMARY HEALTH CARE:

a review by Donald Hicks. Published by HMSO, 1976, £9.50.

This 600-page book is presented in the form of fifteen essays which draw extensively on books, articles and statistics which have been published on the subject of "primary health care" — to the author this means "the care provided outside the precincts of the hospital".

The concepts of health and illness are explored, and the author argues that measures of health are needed in order to judge the success or failure of health care. After discussing various surveys of sickness and GP work patterns, the book goes on to describe the activities of health visitors, home nurses and social workers. One essay reviews the range of methods for helping people with mental health problems and another goes into the school health services.

Although this book is likely to be an interesting reference for background material, at £9.50 it might be too highly priced for some CHCs. But circular HN(76)203 announced that regional, area, district and FPC administrators were being sent a free copy, so CHCs may be able to borrow a copy from one of these sources.

A TEXTBOOK OF HEALTH EDUCATION

by A. J. Dalzell-Ward. Published by Tavistock Publications, 1975, £2.76

A. J. Dalzell-Ward's *Textbook of Health Education* is designed as a guide for student teachers and sees health education in the school setting largely in terms of behaviour modification on the part of the pupils.

Having said that, the book does examine the wider social and environmental issues implicit in the promotion of health. It is also full of detailed figures and information likely to be of use to anyone concerned with health education. There are among others, tables on health indices in various countries, the prevalence of physical disorder in 10-12 year olds, death rates, and causes of certified incapacity for work. Space is given to discussing most of the major causes for concern, and there is a useful section on methods of evaluation.

One or two of the chapters dealing with the role and organisation of health education in the school curriculum are of only marginal relevance to CHCs, but the general discussion is interesting, and there are a number of concise and useful background sections (for example appendices on the school health service, current health and welfare legislation, audio-visual aids, etc.) which make this a valuable addition to any reference shelf.

Lord Beveridge 1879—1963

by J. E. Pater

There is a vague but very widespread belief that Beveridge invented the NHS. This belief is quite unfounded — indeed he never had any close connection with health services at all. Why then is his name associated with the origins of the NHS?

W. H. Beveridge began as a law student at Oxford where he became a fellow of University College in 1902. At the same time he became interested in social problems and served as sub-warden of Toynbee Hall from 1903-1905. In 1908 he began his first career as a civil servant in the Board of Trade engaged in setting up some new-fangled institutions called Labour Exchanges. Unemployment became a primary concern for him, and he published one book on it in 1909 and another 35 years later *(Full Employment in a Free Society)*. He left the civil service in 1919 and started his second academic career as Director of the London School of Economics, where he remained for 18 years until he moved to Oxford as Master of University College.

It was while serving as Master of University College that he was invited to be chairman of an Inter-Departmental Committee on Social Insurance and Allied Services. This was one of several committees set up in the middle of World War II to prepare for reconstruction after it, and its particular job was to review the jungle of cash benefits and insurance contributions which had grown up over the previous thirty years. Apart from the chairman the members of the committee were civil servants of the departments involved; and as time went on they became somewhat alarmed at his bold reforming zeal and dissociated them themselves in advance from his conclusions. Consequently the report which appeared in November 1942 is more appropriately known by the chairman's name than is usually the case.*

His proposals were simple but sweeping. In place of all the many differing cash payments in sickness, unemployment, old age and so on there should be a single benefit at subsistence level payable whenever employment was interrupted or ceased for any reason, with "social assistance" in cash at a lower level for those not entitled to benefit but in need of maintenance; and there should be a single system of contributions. These proposals rested on three assumptions. Assumption A was that the state would maintain full employment as a policy; Assumption C was that there would be a national scheme of children's allowances. Assumption B provides the link between Beveridge and the NHS. This was that there would be separately provided a complete health and rehabilitation service covering the whole population, so as to ensure that cash payments during sickness or disability did not become astronomical.

So Beveridge did not invent the NHS — he merely assumed its existence, with good reason, as by the time his report appeared discussions with the doctors and others were in full swing. The effect of his report was to give an impetus and a solidity to the ideas that were in the air about a comprehensive health service which they never subsequently lost. That is one of the major reasons why a NHS came into being in 1948, having failed to do so after World War I in 1920.

**Social Insurance and Allied Services*, a report by Sir William Beveridge, HMSO, 1942, (Cmd. 6404).

Race & Health —the role of CHCs

The special needs of Britain's 1.6 million Asians and West Indians, and those of the smaller ethnic minority groups, pose a major challenge to the abilities of CHCs. Many Councihs are now getting to grips with this challenge, liaising closely with their local Community Relations Councils (CRCs).

The two main medical problems are vitamin D deficiency and tuberculosis in the Asian communities. Vitamin D deficiency, caused by diet and/or lack of sunshine, is resulting in a resurgence of the bone disease rickets amongst Asian children in some parts of Britain. In the field of mental health, research evidence is starting to suggest that the experience of discrimination and social disadvantage can in itself have dramatic psychological effects on Asians and West Indians. CHCs in Manchester have collaborated to produce posters in English, Urdu and Punjabi, explaining what CHCs do. Central Manchester CHC has also criticised its DMT for wasting staff time by using out-of-date interpreting lists deficient in these main Asian languages. The CHC also works closely with its FPC, which has discovered that many Asians are not aware of their basic entitlement to GP service. Asian-language leaflets are being prepared to correct this situation. Blackburn CHC, in contrast, has found no requirement for multi-language publicity amongst its Pakistani community. The main concern is TB — local health centres hold special classes for TB patients and the town's infectious diseases unit publishes its own material in Urdu and Gujarati, with translation assistance from the CRC. The CHC has also been concerned about the various forms of homeopathy practised within the minority communities, but checks with the BMA and General Medical Council revealed that this is in order provided there is no intent to pose as a qualified doctor.

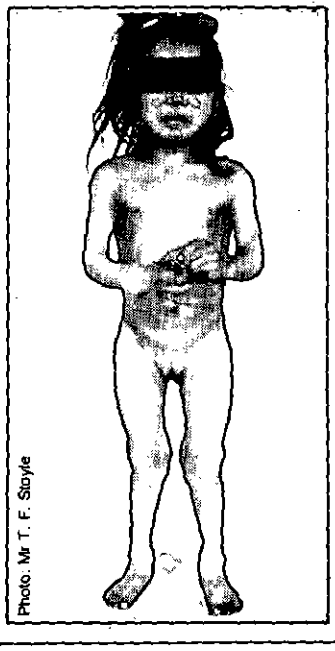


Photo: Mr T. F. Stoyle

Brent CHC, with its mix of West Indian, Asian and Irish communities in north-west London, sees TB as a major issue. Secretary Peter Hay says that the TB rate there is the highest in Britain. The CHC has approached the immigration office at nearby Heathrow airport, and the local children's health service, with a view to detecting people with the disease as early as possible.

Brent CHC has also identified a complete lack of multi-language publicity about entitlement to NHS dentistry and is considering what action it should take. The local CVS is sometimes able to make arrangements for people with language difficulties to be accompanied to NHS treatment by a translator.

At the Birmingham Maternity Hospital, prompting from East Birmingham CHC has led to the administration employing Mrs Shahida Qadri to work partly as a clerical assistant in the records office and partly as an interpreter in Punjabi and Urdu. The CHC also set up a weekly health advice session for ethnic minorities, based on the city's Saltley Action Centre, but this scheme met with poor response and is being re-thought.

Walsall in the West Midlands is an area with a wide mix of ethnic groups and CHC secretary Richard Bray notes that one problem is finding enough space on a small council for each minority group to be represented. Currently one of Walsall's Asian members is investigating cases where local NHS interpreting services, are alleged to have proven inadequate.

One recurrent health hazard within the Asian communities involves the use of traditional cosmetics and "baby tonics" containing highly poisonous amounts of lead. A case involving an eye shadow called "Surma" caused a stir in Halifax recently, and this was closely monitored by Calderdale CHC. In the event the Council was satisfied that publicity through Calderdale council's Environmental Health Committee and the local CRC had been sufficient.

In London two CHCs are challenging the Medical Practices Committee's rulings on the question of proposed GP appointments specifically aimed at meeting the communication needs of minority ethnic groups. In Camden, the CRC and South Camden CHC have for two years been arguing with the DHSS and the FPC for the appointment of a Sylheti-speaking GP to serve the Kings Cross area, where an estimated 2000 Bengalis live. One Sylheti-speaking doctor has applied three times to be allowed to work in this area and has been turned down on each occasion by the MPC on the grounds that the area already has enough GPs.

In Kensington, Chelsea and Westminster North East CHC's area a similar situation arose when a Cantonese-speaking doctor closed a branch surgery he had been running in Soho. In 1975 two Cantonese-speaking GPs applied to work in the area and were turned down by the MPC. The CHC then surveyed 300 local Chinese catering workers, finding that although 275 of them were registered with a GP, only 32 lived or worked anywhere near their doctor's surgery. A second CHC survey suggested some general under-provision of GPs in the area, and all this evidence eventually won the support of the FPC and the Local Medical Committee. An appeal to the MPC is pending.

On a sadder note, Brian Marshall, secretary of SW Leicestershire CHC reports the total failure of his council's best efforts to forge links with Leicester's Sikh community: "We don't have any complaints or feedback from them — they just suffer. If anyone can come up with any ways of making contact I'd be most grateful."

GPs' PRESCRIBING:

Where economies can be made *by a CHC MEMBER*

One of the first jobs of the National Association of CHCs should be to make a statistical survey of GPs' prescribing habits, and be in a position to recommend ways of saving money. I hope that these notes will indicate the need for such an enquiry.

The real cost of GP prescriptions has escalated year after year since the inception of the NHS. In 1975 it reached the record total of £360 million. By far the greatest cause of this increase is the ordering of expensive proprietary medicines when there are clinically identical preparations available at a lower price — usually in the *British Pharmaceutical Codex*. This fact is well known, but a few recent examples will make my point:

a) Oxytetracycline tablets cost £8 per 1000
Proprietary makes cost £11 and £14 respectively.

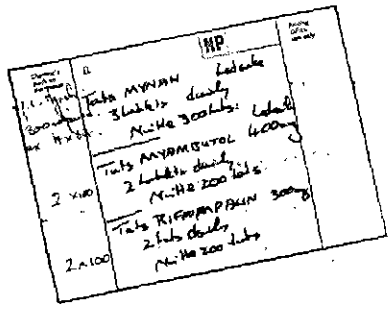
b) Pul. Mag. Trisil Co costs £1 per kilo
Proprietary equivalent costs 50p for 10 sachets (doses).

c) Mixed vitamin capsules cost £1.30 for 500
Proprietary makes cost up to 93p for 30.

What is also increasing costs is the more sophisticated preparation which gives a slow release, or long acting quality to simple drugs. There are various ways of preparing such tablets and capsules. They all have one thing in common. There seems to be no way of controlling the price. The cost-effectiveness of these systems should be examined:

a) Ferrous sulphate Tabs cost £1.45 per 1000
Slow release makes cost £4.89 for 250

b) Glyc. Trinitini cost 90p per 1000



Slow release cost £6.67 for 250 (they are stronger).

The DHSS attempts to control prices, often with some success, but this can be circumvented. As soon as a fair price has been agreed, it is a common practice for a manufacturer to vary the molecular structure slightly to produce a 'new' product at a very new price.

Patient pressure plays a big part in increasing costs. They expect to be ordered something that they cannot buy over the counter. Some excellent medicines are so 'common' that GPs dare not order them. Patients object to receiving the same tablets every November when they get their throat infections. They expect the latest treatment, especially if it is in highly-coloured capsules.

It is not for me to pre-empt an enquiry, but with the object of causing some discussion, I suggest some unusual ways of dealing with the problem:

a) GPs must be judged by their peers. The National Association should set up a pressure group of GPs to exhort their colleagues in the need for saving.

b) The most expensive prescribers and the cheapest prescribers are well known: one of the highest cost areas is Oxford where prescription costs average out at £1.80, in contrast to St. Helens where average costs are £1.30 per item. I should like to see a GP from each group argue it out on TV.

c) All advertising to GPs should be in a standard format. Many so-called ethical adverts are hardly better than TV washing powder plugs.

Another cause of the increase in costs is due to prescribing of excessive quantities. I hope to explain the reasons for this another time. To make my point look at the illustration. It is a copy of a prescription I was handed this week. It is for one hundred days' supply of three items. Total basic cost is £138.50, plus the chemist's profit and fees approximating £15. It is one of the most expensive prescriptions I have ever seen.

Drug collection schemes

The discovery of large hoards of drugs in the homes of elderly people, the growing numbers of accidental poisonings and the tendency of many pills to look like sweets are all factors causing increasing concern. Several CHCs and health authorities are responding by setting up drug collection schemes in their areas.

Worksop and Retford CHC sponsored such a scheme last November and gathered in 136 lbs of dangerous unused drugs. The week-long scheme began as a children's poster competition, attempting to educate both children and parents about the dangers of hoarding old drugs. Prizes were awarded in each of three age groups over eight years old, and the winning posters and leaflets were distributed in public buildings, GPs' waiting rooms, health centres, pubs, churches, post offices, factories and police stations. They were also displayed on the sides of local authority vehicles.

Every chemist in the district took part, their shops being used as collecting points. Members of Nottingham Drug Squad removed the drugs every day to a hospital pharmacy for evaluation and eventual incineration. Much publicity was gained in the local press and on local radio, particularly about the prize-givings. During the week itself, CHC Secretary John Kitchen was interviewed on Radio Sheffield.

In the same month, Northallerton CHC gave its support to a drug collection fortnight in the district. The North Yorkshire AHA's Health Education Department collaborated with the North Yorkshire Police and the Northallerton DMT in this scheme, and the CHC helped particularly with publicity. Contracting chemists in the district were approached, with the approval of the FPC, and 15 out of 16 agreed to help.

A committee including chemists and representatives of the police, local authorities, local Home Safety Committees and the AHA planned the scheme. Police made three collections from the chemists during the fortnight, and drugs were stored temporarily in the local police station. Used containers provided by hospital kitchens lined with a removable plastic bag made good collecting boxes. Publicity was generated via posters and letters sent to local organisations and the local media. Most of the drugs collected were stored in a hospital incinerator, and poisons were taken to ICI's chemicals plant at Wilton. Publicity cost about £100 and was paid for by the AHA. About 60,000 pills were collected, weighing roughly 66 lbs. Among the poisons surrendered were about 8 cwt of arsenic sheep dip.

Last March drug collection fortnights were similarly organised in the Bradford, Airedale and Craven areas. These were chemist-based too, with collections being made every other day by the West Yorkshire Metropolitan Police Drug Squad. Drugs were incinerated at the county council's solid waste disposal unit, except for poisons which were dealt with at ICI's Huddersfield plant. Publicity was co-ordinated by the RHA's publicity office, and identifiable costs came to about £1400. A staggering four tons and 12 cwt of drugs were destroyed, including almost six million tablets. Amongst the haul were 15 lbs of arsenic, 56 lbs of cyanide, 42 lbs of strychnine and 5100 morphia tablets.

Lord McCarthy's report on Whitley Councils

"NHS employees have a right to be consulted on all important management decisions that significantly affect their well-being" says Lord McCarthy in his recently published report about reforming the Whitley system of wage bargaining in the NHS.

Whitley Councils were set up at the start of the NHS to negotiate the pay and conditions of all NHS employees. There are now 8 "Functional" Councils:

administrative and clerical
ambulancemen
ancillary staffs
optical
pharmaceutical
professional and technical 'A'
professional and technical 'B'
(doctors and dentists' pay is now determined by an independent review body).

The effectiveness of the Whitley Councils has been seriously questioned, particularly in the light of the level of strike action taken by several NHS staff groups in the last few years. So Lord McCarthy (Fellow of Nuffield College and Oxford Management Centre, and an industrial relations expert) was appointed to carry out a review, and his findings were published in December 1976 in a report entitled *Making Whitley Work* which has been circulated to CHCs and many other bodies for comment by May 1977. In an extremely clear and readable manner the report presents an explanation of the problems, and an objective summary of the various points of view put by over 70 organisations and individuals. It starts by explaining some of the historical background to the Whitley Councils and then deals in turn with different aspects — the role of government, DHSS and management, pay principles, structure, consultation, staff representation.

The role of the DHSS appears to be a problem partly because of a lack of understanding of its exact position. On the one hand it has a responsibility to provide a National Health Service, and on the other hand the Secretary of State is answerable to Parliament for expenditure of public funds. Salaries and wages account for about 70 per cent of total NHS expenditure and the problem on the Whitley Councils is that the management sides have no absolute power to conclude wage agreements because they do not have final control over the amount of money available. Lord McCarthy recommends that DHSS representatives on the Councils should limit their involvement to such matters as the overall cost to the government of agreements and that the content of offers should be left to the health authority representatives on the management sides.

However, these representatives of the health authorities are seen to be *un*representative and lacking accountability. McCarthy recommends improved arrangements for selecting and appointing these members, that they be given induction courses, that report-back facilities be arranged within each region, and that they be regarded as the voice of health authorities within functional councils. The major new recommendation of the report is the creation of Regional Whitley Councils to strengthen decentralisation. One should be established for each region in England and their equivalents in Wales and Scotland, with the management sides representative of all AHAs in the region and the RHA, and the staff side representative of all employees in the region. Lord McCarthy hopes that efficiently working Regional Whitley Councils will help to overcome some of the contradictions in pay awards — while most of these will still be negotiated at national level, the regional councils will be able to adapt and interpret agreements to fit local conditions and needs without having to refer back to the Department for approval as at present. "Consultation must be seen as more than the mere passage of information" in Lord McCarthy's view, and he emphasises that it should take place *before* decisions have been taken and while the options are still open. He recognises that the dividing line between consultation and negotiation is a thin one and therefore recommends that the same people should be involved in both processes.

The final section of the report is concerned with the staff sides of the Whitley Councils. Many of the problems here are due to historical "accident" because certain organisations obtained seats on the councils when they were being set up, but whose functions and membership are now overlapped by other, larger bodies — usually trade unions. Many of the trade unions are not prepared to share negotiating rights with the professional associations whose functions they see as excluding pay negotiation. Lord McCarthy suggests a rationalisation of staff organisations represented on the councils, and a move towards the situation where the ratio between seats and members on a particular council is similar for all the staff organisations represented on that council.

Parliamentary Questions

PERSONAL MEDICAL RECORDS

Doctors refusing to show patients their personal medical records can justify this decision on grounds of "clinical judgement" the Commons has been told. It is a matter of clinical judgement for the doctor concerned to disclose to his patient such information as he considers necessary and advisable in the circumstances. Although he will wish to keep his patient properly informed there are many occasions when it would not be in the interest of the medical wellbeing of a patient to disclose information contained in his medical records". This was Roland Moyle's reply to a question from Nigel Forman MP asking why patients were not allowed to see or have copies of their personal medical records.

CHILDREN'S HOSPITALS

Christopher Price MP asked for a statement of DHSS policy on the retention of separate hospitals for children. David Ennals replied that children should be cared for in the children's departments of district general hospitals, but that facilities in certain specialised fields of care for children need to be provided at regional or sub-regional centres.

AIDS FOR THE DISABLED

Spending by English local authorities on aids, home adaptations and telephones for the disabled has roughly tripled over the last three years, according to figures released by Alf Morris in reply to Jack Ashley MP. In 1975/76, net actual expenditure in the above three categories was £2.3m £3.3m and £3.3m (provisional figures) which represents an average expenditure per 1,000 population of £50, £70 and £70 respectively.

EXPENDITURE IN SUNDERLAND

Northern RHA plans to make more finance available to Sunderland AHA "as quickly as practicable", Roland Moyle announced, answering a question from Fred Willey MP. Mr Willey was asking for action on Sunderland CHC's recent report which he said showed that expenditure on the town's health services is "well below the regional and national averages."

GP EXPENDITURE ESTIMATES

In 1976/7 the average English GP took clinical decisions costing roughly £36,000, David Ennals told John Cronin MP. The corresponding amount incurred by an average consultant's team was £290,000. Questioned further by Mr Cronin, Mr Ennals said that discussions should take place with the medical profession by GPs on prescribing by GPs and in hospitals "since this is a part of the NHS over which there is no control whatever."

NOTES.....

MIGRAINE

10.3% of males and 15.9% of females suffer from migraine, according to a recent survey undertaken by the Migraine Trust.

SMOKING

A survey has shown that Britain is 17th out of 20 in a European non-smoking league table, and 7th out of the 9 EEC countries. The survey covered smoking in public places and ASH (Action on Smoking and Health) now hopes to pressure the EEC Commission into ensuring that anti-smoking campaigns are coordinated and receive much more attention.

MEDICAL AUDIT

The report of a committee set up jointly by the BMA, the Royal Colleges and the Joint Consultants Committee has recommended that a doctor's competence to practise should be maintained by a system of medical audit using patients' records to establish standards. *Competence to Practise* costs £1 from 27 Sussex Place, London NW1.

ASBESTOS

APEX, the clerical workers' union, has asked the TUC to set up its own enquiry into the health and safety aspects of asbestos production and use.

MENTAL HEALTH

A policy report has recently been issued by the Association of Therapeutic Communities (which includes 35 units and hospitals connected with psychiatric care). The Association believes that treatment of the mentally ill should be more socially rather than medically orientated, and it takes the view that mental illness is a disturbance of the individual's social interaction with others rather than a disease requiring specific medical intervention. The report makes a number of recommendations for reforming the provision of district psychiatric services and calls for recognition of the importance of therapeutic community work, and promotion of research into the social dynamics of treatment units. The report is available from J. S. Whitley, ATC, Henderson Hospital, Brighton Road, Sutton, Surrey.

GPs

South East Thames RHA is mounting a research programme to find ways to help family doctors improve their services. The aim is to develop and coordinate specialised clinical services in the community for dealing with particular conditions such as diabetes or coronary disease, as well as helping doctors to review the organisation of their own practices.

INDUSTRIAL CANCERS

The Health and Safety Executive is calling for tighter controls on dust and fumes in the rubber and cable-making industries following a study showing above-average incidence of lung cancer and bladder cancer in men employed in the industries in 1967.

APPOINTMENTS TO AREA HEALTH AUTHORITIES HC(76)55

The term of office of all AHA members appointed by RHAs comes to an end on 31 July this year, as does the term of office of a number of AHA members appointed by the matching local authorities. This circular asks RHAs and the appropriate local authorities to make arrangements for their replacement, and CHCs are among the bodies to be consulted on the appointments.

The Secretary of State considers that at least one-third of AHA members should be drawn from local authorities, and RHAs are asked to appoint nominees of non metropolitan district councils where the 1973 NHS Reorganisation Act does not give these councils powers of appointment. Each AHA should include at least two doctors and a member appointed on the recommendation of the Regional Council of the TUC. Where there is a large immigrant population the appointment of representatives of such minority groups is suggested.

BENEFITS & PENSIONS

A new booklet called *Family Benefits and Pensions* has been issued by the DHSS which gives basic information about social security benefits for elderly, sick, disabled and unemployed people and families with children. The information in it is up-to-date as at November 1976 when new scale rates for some benefits were introduced. The 48-page booklet starts with a very useful checklist of benefits and services under headings such as "for people with low incomes" or "for handicapped and disabled adults and children and those caring for them". Another valuable innovation is a list of relevant leaflets for further information. The booklet (ref FB1) is available from local social security offices for people giving advice on benefits and services.

Exhibition stands

A set of exhibitions stands is now available on free loans to CHCs.

The kit has 10 poster-sized panels and when assembled, the 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 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. Please note the following changes:

Page 2: South East Cumbria CHC
Chairman: Mr J Winder
Page 7: Dewsbury CHC
Chairman: Mr Eric Thomas
Page 7: Leeds Western CHC
Secretary: Sue Jenkins
Page 8: South Derbyshire CHC
Telephone: Derby 366346 (or if this is unobtainable: Derby 362221 ext 240)
Page 9: Lincolnshire North CHC
Chairman: Mrs C V Stubbs
Page 29: Winchester and Central Hampshire CHC
Chairman: Rev N J Ovenden
Page 31: Kettering CHC
Secretary: Mr Harry Baker
Page 31: Northampton CHC
Chairman: Mr L C Softley
Page 36: Mid Staffordshire CHC
Chairman: Mr W D F Foden
Page 36: North Birmingham CHC
Chairman: Mr W Hartley
Page 40: Liverpool Central and Southern CHC
Chairman: Mr T H Knuckey
Telephone: 051-708 8008
Page 52: East Anglian Region
Chairman: Mrs E M E Hartland
Page 58: Wessex Region
Address: c/o Winchester and Central Hampshire CHC, St Paul's Hospital, St Paul's Hill, Winchester. Telephone: Winchester 60661.

That's Life!

Continued from page 1

feels that the case was fairly and accurately presented, and that the programme managed to convey information to the public about the role of CHCs that is difficult to get across.

On 23rd January "That's Life" went on to highlight the problem of a CHC secretary in another region who has been removed from his GP's list. The GP objects that the secretary is, in the course of his work, helping a patient, registered with the same practice to make a complaint to the FPC.

The programmes have explained that CHCs are keen to serve as a channel for people who want to express their appreciation as well as for those who have problems. More TV coverage like this could do a lot to inform the public about their right to express views on the health service, and to explain that CHCs exist to represent their interests.