CHC NEWS
For Community Health Councils
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Association chooses Mike Gerrard

Mike Gerrard starts work this month as first Secretary of the Association of CHCs. He is 42 years old and has been Secretary of Haringey CHC in north London for the past three years and is convenor of the CHC Secretaries in the North East Thames region.

Mike was brought up in Haringey and lived there again when he was first married. He now lives in Harlow, Essex, with his wife and four school-aged children.

Mike studied philosophy, politics and economics at Oxford University, and then spent several years as export manager of a firm of printing ink manufacturers, travelling widely throughout the world. But he also found time to be active at home as a local councillor with special interest in health and social services. He is a member of the Executive Committee of Harlow Council of Voluntary Service and Chairman of Child Poverty Action Group in Harlow, as well as being a member (formerly vice-chairman) of West Essex CHC.

He believes that the Association has potentially got a lot to offer CHCs in terms of assistance and advice, and that the services it does offer will be the "shop window" by which outside bodies and non-member CHCs will be able to judge it. "It is up to the Association to show CHCs that their national body is worthwhile," he said "and one of the ways I intend to demonstrate this is by visiting individual CHCs. I hope to start in the autumn and the West Midlands, Wales and the South West and North East will be the priority areas."

He is also interested in collaboration with the Scottish local health councils and hopes to forge links between them and the English and Welsh Councils.

"I interpret this job as being an ambassador; but strictly as an adjunct to local people wherever they are, not as a mouthpiece for the centre. I think CHCs can play a big part in ongoing policy discussion by sitting down with government, the professions and the trade unions to air the voice of the public. The Association can assist in this by putting forward people nominated by local CHCs whenever there is the opportunity."

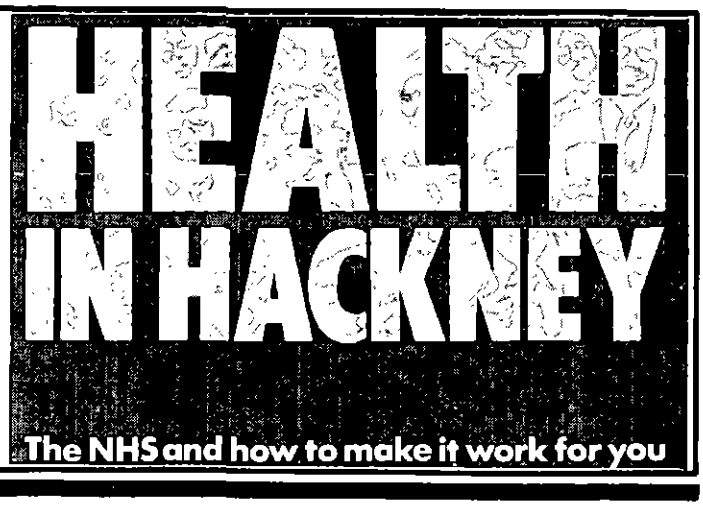
Mike Gerrard knows there is not unanimous approval for the Association's base to be in London, and he said "I would be happy if it was in the geographic centre of the country. However, the Association is the sum of its members; the majority want it to be in London, and there are very good reasons why it should be there."

He feels optimistic about the success of the Association because he sees its aims as a way of "getting to the source of policy decisions. For those CHCs who are concerned about influencing health policies, they can use their Association to strengthen their efforts to put over the patients' views unequivocally."

Scots News

- Local health councils in Scotland are meeting in Edinburgh on 30th September with a view to setting up their own national body.
- The Scottish Association of Local Health Council Secretaries held its inaugural meeting on 10th June and members appointed the following officers: Mr M G Taylor (Inverclyde) — Chairman; Mr M G Haughey (North Ayr and Arran) — Vice-Chairman; Mrs D L Maybury (Borders) — Secretary/Treasurer; Miss L Headland (Aberdeen & Kincardine) — Asst. Secretary/Treasurer; five other LHC Secretaries were appointed to the Executive Committee.

City & Hackney CHC has printed 8500 copies of a guide to *Health in Hackney*. Its 112 pages are clearly laid out with many illustrations and cartoons. Maps are also used to show the locations of health service facilities in the district.



YOUR LETTERS

RELATIONS WITH TRADE UNIONS

J. P. Moyses, Chairman Liverpool Eastern CHC

I have always considered that the main purpose of a community health council was to represent and protect the interests of patients.

Although CHCs are encouraged to seek the views of trade unions, I cannot recollect any terms of reference which state that a CHC should become actively involved in union matters. Cuts in the health service, including closures of hospitals, are of the utmost significance both to the CHC and the unions, but each must approach this issue from very different angles.

Recently, because of severe cutbacks proposed by the Liverpool Area Health Authority, union support was sought from my council in resisting the Authority's attempt to rationalise services. Personally, I disagreed with this type of approach because I felt that the council could be seen to be supporting action which could harm the interests of patients.

I feel the CHC's duty is to protect the interests of patients and to try and ensure that the quality of care does not suffer. The union's prime responsibility is to safeguard the interests of its members by protecting jobs and wage levels. Whilst there is often common ground between the CHC and trade unions, there are times when they will be in opposition to each other.

I would appreciate comments from the Chairmen of CHCs on this issue and would be pleased if they would write to me.

CHC APPEALS ALMOST LOST BEFORE START

Fred Smith, Chairman Aylesbury & Milton Keynes CHC

When a CHC objects to the closure of a hospital it is laid down in the "apeals procedure" that the CHC must submit an alternative proposal properly detailed and thoroughly costed, and then is added "The Area will give all assistance in the preparation of this alternative scheme" — fine comfortable and helpful words — but what does it mean?

The AHA will make available — assuming their good sense — the best and most knowledgeable officers they have — and these should therefore be the officers who have already prepared the AHA scheme; is it logical that these officers will really extend themselves or expand their expertise in the preparation of a scheme good enough to cause their own AHA scheme to be rejected? Not a hope!!

FPC COMPLAINTS

Jean Robinson, The Patients Association

In the April issue of the *Family Practitioner Services Journal* there is a reference to family practitioner committee disciplinary procedure. They say "Despite criticism of the machinery, practitioners and contractors, in general, are satisifed with it and have confidence in its fairness. There has been a minimum of criticism from the public: quite often appreciative comments are made on the fairness and understanding shown at the hearings and on the help given by the FPC's staff". Since we have innumerable examples of public complaints about the unfairness of the procedure, we wonder what sort of cloud-cuckoo land FPCs are living in.

We have brought a number of cases where we feel the procedure has acted unfairly against the complainant to the attention of the Council on Tribunals. May we suggest that all CHCs should do the same? Although the Council does not have the power to intervene in individual cases, it does act as a watchdog organisation, keeping an eye on how tribunals of all kinds operate, and can be influential in getting regulations changed.

We would be interested to hear from CHCs who have had difficulties with medical service committee hearings, and who have information about complainants' allegations that they were discouraged by FPC staff from making formal complaints, or that reports of hearings were not fair representations of what actually took place at the hearing.

NON-SMOKING CLINICS

Angela Alder, Secretary West Essex CHC

Circular HC (77)3 on smoking in health premises prompted my CHC to survey the opinions of 750 patients, staff and visitors in the district's hospitals and clinics. Most people agreed that smoking was an unhealthy habit and that partition of smoking and non-smoking areas was more realistic than trying to impose a total ban.

One of our questions related to the possibility of setting up clinics to help those who would like to give up smoking and who need the extra group stimulus that this would provide. The majority of those questioned felt that such clinics would be helpful. It was, however, apparent from the number of unsuccessful attempts to give up by several smokers that additional support and motivation was widely needed. Several patients who had stopped smoking after their operations were genuinely afraid that they would be tempted to smoke again once they were back home.

We suggested to the AHA that group therapy clinic sessions could perhaps be developed by the Area Health Education Officer through the community clinics, with the help of volunteers. Have other CHCs had experience of successes in this field?

CHCs ON THE AIR

W. Ashworth, Chairman Burnley Pendle & Rossendale CHC

I hope other CHCs will follow the example of Kent's 6 CHCs who have their own local radio programme every month — see *CHC NEWS 20.*

Our CHC has arranged a weekly programme for several months now on Radio Blackburn as advertised in *Radio Times* (NW Edition). It took an appropriate gestation period of 8-9 months before the programme was born, but once on the air the local radio staff knew they had some good material to use. Persistence is an important CHC virtue!

We have used local medical professionals with our Chairman and Secretary in the programmes. For instance, we persuaded a forceful local chemist to discuss drugs and sales of analgesics, a local GP to talk about self-treatment and another GP to discuss the Court Report.

There is immediate attention from the listener when you have a chemist who says "I warned a customer the other day about so and so", or a GP who says "I had a patient in the surgery yesterday, who had such and such".

We have presented definite health topics rather than CHC news items, which are often reported in news programmes anyway, and Radio Blackburn hope to broaden out into a general health education series later using a wide range of practising professionals.

ACTION FOR EPILEPSY

Shelagh McGovern, Campaign Organiser, British Epilepsy Association, 3-6 Alfred Place, London WC1E 7ED.

The need to achieve positive attitudes towards epilepsy amongst the public as well as amongst families living with the problem was behind the launching of the "Action for Epilepsy" campaign in 1974.

This is a national network of voluntary groups organised and guided by the Association. The groups aim to give the support and information needed by those with epilepsy and to seek ways of enlightening the local community so that epilepsy can be recognised for what it is, namely a condition which can affect any member of the population at any time and which is a handicap only when fits or seizures occur.

The Campaign now numbers over 90 groups active or forming and these groups would welcome liaison with the community health council in their area to set up a channel of mutual support. If you contact me at the above address I can provide further information.

Two further points must be stressed; the Association is a lay organisation and its groups are neither qualified nor authorised to handle medical matters. In our view it is vital to dispel the sense of isolation that the diagnosis of epilepsy so often brings and to achieve total integration. Our groups are therefore primarily self-help groups and are never allowed to disintegrate into "tea and sympathy".

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.

Mrs Fitzgerald (CHC Chairman) interviewing members of the public.

CHC takes to the road

Doreen Sinstadt, Secretary, Plymouth CHC

In May of this year Plymouth CHC undertook a week-long publicity tour of the rural areas within the Plymouth health district. The Chairman, Vice-Chairman, Secretary and Assistant took part and members with close connections with the rural areas participated during the week. One member took a week of his annual leave to drive the minibus which was generously provided by Plymouth health district.

The media and in particular our local radio station, Plymouth Sound, gave the venture considerable publicity and in general we found the people living in the villages knew of the tour and its purpose. In addition, Clerks and Members of District and Parish Councils were extremely helpful in posting notices, giving us advice on the itinerary and indeed meeting the vehicle and introducing us to the public.

The week's tour covered 500 miles and we stopped in 40 villages or small towns. In one, Ugborough, a delegation of 20 were waiting. At the rest of our stops one member would wait in or by the vehicle to talk to those who actively found us while the rest of us made random house calls and talked to the public in the street.

Publicity leaflets were freely distributed and the opportunity to discuss the service was welcomed. One comment was "I may not be able to do very much or be helpful but how refreshing to be asked." We had prepared a questionnaire with 13 questions and 419 survey forms were completed – we had only 10 refusals throughout the week.

The aim of the questionnaire was to assess in a basic way how people saw the Health Service: what additional services should be provided, what were the satisfactory aspects of the service and what were the difficulties. The question "are you or a member of your family receiving treatment or attention from GP, hospital or other services at the present moment?" was used to try to assess whether replies were based on experience or were apocryphal. In effect, approximately half of those questioned were receiving treatment or were in contact with a member of the family receiving treatment.

The majority of people expressed themselves satisfied with the services but it is interesting to note that even those people with a fairly serious problem rated their general satisfaction as high.

The key to service satisfaction in the rural areas appears to be the quality and availability of the GP services. Where these are adequate, most other services are also considered adequate by the patients.

The high number of replies received indicating that the population in even small villages do not know which services are available, either for the elderly or for children, was a disturbing and unexpected feature of the replies.

Transport problems are shown as a complex and major difficulty in the smaller, isolated communities. Public transport services are becoming more infrequent and fares have increased sharply as has the cost of petrol and taxis. It cannot be assumed that the family car is available during the day: the breadwinner uses it to reach his or her employment. Not only are the elderly isolated, the mother with young children is often cut off from immediate medical care.

Public telephones should be readily available and accessible. Perhaps it would be possible to provide a "service" line direct to health centres or the Central Ambulance Control who could relay messages (rather as AA telephones are provided) in specific villages where isolation is a particular problem.

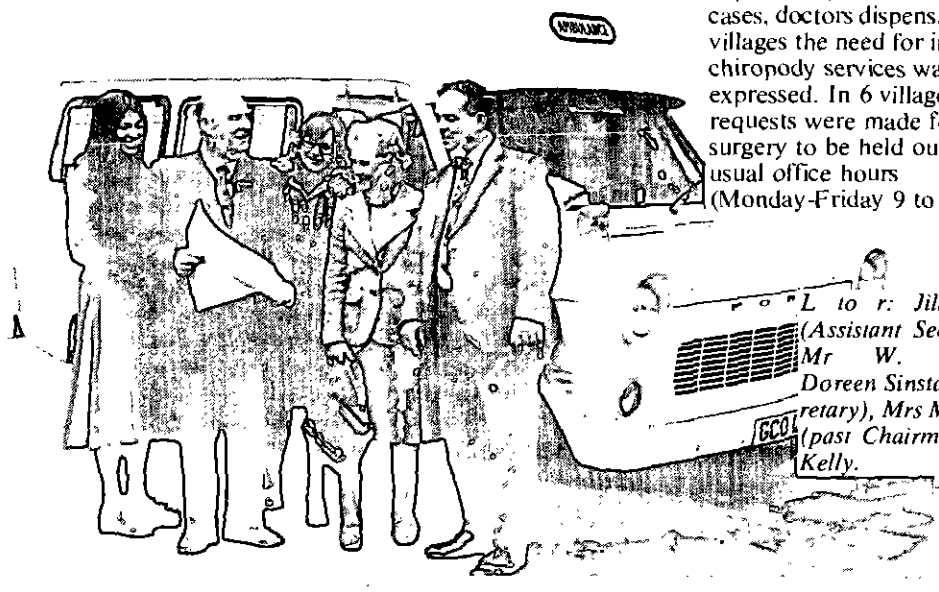
In many villages the patients considered themselves well-served by GPs. Difficulties were mentioned with deputising and weekend relief services both where "ansaphones" are used and when deputising GPs are unfamiliar with a wide geographic area.

Requests were made for evening surgeries even if only once or twice a week. We were told of a number of instances where people had to lose a day's work when they or a member of the family had to see a GP, either because of surgery times or because of poor public transport. Other suggestions are that a pilot scheme for two-way radios in doctors' cars might be undertaken (the local vet has one) and that the name and telephone number of the duty doctor could be advertised in the local press as is the duty chemists' rota.

Comments on GP services included: "The GP is our lifeline, I cannot thank him enough." "The doctor is quite human if you can only get past the receptionist." "I had an accident on my horse – the vet came in ten minutes and the doctor took two days."

Other needs were expressed for further baby/child health clinics, further involvement of the District Nurse, chiropody services, more help for the elderly and better prescribing facilities in the villages. We are hoping to explore the possibility of a mobile chemist.

In summary, the survey found the following: all villages expressed concern on waiting lists. In 27 villages concern was expressed with transport – either not enough or expensive (or both). In 11 villages concern was expressed at the attitude of receptionists. Some felt that they stood between the patient and the doctor. Others felt that their attitudes were frightening to patients and acted as a deterrent to communication. It was felt that they should not attempt diagnosis or give advice to patients. In 9 villages the need was expressed for some regular form of visiting support for the elderly, especially those on drugs of some sort. In 9 villages the need for a chemist was expressed (even with, in some cases, doctors dispensing). In 7 villages the need for increased chiropody services was expressed. In 6 villages requests were made for a surgery to be held out of the usual office hours (Monday-Friday 9 to 5.30).



L to r: Jill Smith (Assistant Secretary), Mr W. Davies, Doreen Sinstadt (Secretary), Mrs M. Owen (past Chairman), Mr Kelly.

Information centre at Middlewood*

Anne Giller

In May 1976, following an approach from the hospital, Pitsmoor Citizens Advice Bureau (Sheffield North) opened an extension bureau at Middlewood. This was an innovatory step, the Citizens Advice Bureau (CAB) being the first comprehensive advice centre in Britain to be based actually within a psychiatric setting.

The idea for an information centre was first raised by the principal social worker at the hospital. It was envisaged that the centre would function to supply information and advice on practical problems and queries rather than duplicating the social casework service. It would contribute in some way towards normalising the situation of institutional dependence by offering patients free access to a self-referral agency, encouraging them to use their initiative to seek our advice from the centre on their own behalf. The CAB would also help to provide a useful link between the hospital and the community.

The CAB has attracted considerable interest and publicity, particularly because the question of rights and responsibilities of patients, relatives and staff, within the mental health setting, has been the subject of some debate over recent years. The MIND special report "A Human Condition" set out proposals for an advocacy system, with patients' advocates attached to all psychiatric and mental handicap units. The DHSS consultative document "A Review of the Mental Health Act 1959" also comments on the potential for patients' advisers, possibly using community health councils, and makes reference to the Middlewood project.

CAB at Middlewood has built up a set of files covering all aspects of mental health law and procedures. It does however offer a service more broadly based than that envisaged in most writings on patients' advisers.

Also, the confidential service is available to all comers from the most senior consultant to the most disturbed patient. The experience at Middlewood would indicate from the nature of referrals that this more comprehensive information service is entirely appropriate. Certainly as many, if not more of, referrals have been concerned with problems outside the immediate field of mental health legislation. The experience would also bear out the point made by one of the senior consultants at the hospital, that "many Middlewood patients present social rather than medical problems".

At present CAB opens two days a week: Wednesdays 11.00 am — 4.30 pm and Thursdays 2.30 — 4.30 pm and Wednesday evenings 6.00 — 7.30 pm. So far it has handled over six hundred enquiries from patients, relatives and staff, ranging from appeals to Mental Health Review Tribunals to noisy neighbours. The most frequent requests from patients have been for assistance in finding employment and housing. Although the CAB does have a wide knowledge of Sheffield, these problems can seem intractable when tinged with the added difficulties of the stigma attached to mental illness.

From September 1976, under a Job Creation Programme grant from the Manpower Services Commission, Pitsmoor CAB has been able to allocate one of its workers to the hospital full time. This grant has now been extended for this post plus two others until March 1978. This increase in manpower means that CAB will be able to look at extending the hours and scope of its service. Negotiations are also under way with the DHSS to look at ways of funding the project on a permanent long term basis. The mainstay of the CAB workforce however, will continue to be its volunteer workers, who receive specific instruction in mental health procedures as well as the customary CAB basic training course.

Anyone wanting more information on the CAB at Middlewood should contact Anne Giller, CAB, Middlewood Hospital, Sheffield 6. Tel. Sheffield 349491 ext. 240.

**Middlewood is a 1,250-bed psychiatric hospital situated in Sheffield and serving most of South Yorkshire. It started life over 150 years ago as the South Yorkshire Asylum.*

Medical needs and council housing

Mike Crook, housing research officer, London Borough of Southwark

The demand for council housing far outstrips the supply in many parts of the country, so when allocating housing most local authorities are prepared to give a higher priority to applicants in special need as a result of an illness or physical disability. For instance, a person having great difficulty negotiating the stairs up to or inside their home is commonly given precedence over an able-bodied applicant living in a similar house or flat. Most authorities have a procedure which enables people in extreme need arising from a medical condition to go straight to the top of their waiting list. However, the allocation of council homes is very much a local affair and no uniform criteria exist to decide who deserves the top priority treatment or how much special consideration should be given to those in less dire straits.

Many councils also award "points" for less extreme medical conditions, just as they give points for having too few rooms, an outside toilet, etc. But the relative importance attached to medical factors varies widely. For instance, two thirds of the London Boroughs give points on medical grounds, but the maximum influence of these medical points on an applicant's total score ranges from the marginal to the decisive. Where there is no provision for medical points the effect of medical factors is more likely to be marginal, though they may still be taken into account in less formal and systematic ways.

Once rehoused council tenants often find it hard to move, and for many a medical problem which warrants different accommodation may be one of their few ways of getting a transfer. Councils which allow tenants greater mobility sometimes have a points scheme for transfers, and medical factors may again be included.

When giving special treatment on medical grounds, a council will need to be satisfied that a different dwelling is required to improve the applicant's health, to prevent it deteriorating or to enable him or her to lead a more normal life. Such judgments clearly require medical knowledge but also leave room for a large measure of discretion, since the range and diversity of relevant complaints is vast. Relatively few applicants have clear-cut problems like not being able to cope with stairs, and many describe their problem as "nerves" brought on or played up by their dwelling, neighbours or environment. Who can decide with confidence whether a new home will cure such troubles, or indeed whether "nerves" shoud be considered a just cause for priority at all?

Faced with such ambiguities the great majority of authorities involve their District Community Physician, both to provide medical expertise and to accept responsibility as an independent and therefore impartial judge for what may sometime appear arbitrary decisions.

The way relevant information is collected also varies. Sometimes a report is prepared after a home visit by council staff, who may or may not be qualified nurses; sometimes the DCP relies entirely on statements from the applicant's GP or hospital. The former method is perhaps more likely to produce consistent results, but can prove expensive when a council may have to cope with 3,000 or more such applications per year. Councils are very unlikely to challenge assessments or to check on their consistency, although grading can change abruptly with changes of assessor.

Although a rigid set of rules can obviously not be set for grading medical need, variations in approach between councils do seem at present to be undesirably wide. CHCs wanting to find out more about conditions locally should contact the appropriate local authority housing department.

PERSONAL VIEW

We should make more use of local radio

by Susan Jenkins, Secretary of Leeds (Western) CHC

The Child Care Switchboard came to Leeds, if not with a flourish of trumpets, certainly with a ringing of (telephone) bells. The CHC was phoned a week beforehand and asked if we would like to participate in one of the four phone-in radio programmes in which a "panel of experts" would try to answer questions and help with any problems relating to the care of children. With my strong guilt feelings about not exploiting the media adequately, I could only say "yes", and as the most experienced CHC member was not allowed time off work, I duly turned up myself to join the panel of health visitor, speech therapist, educational psychologist and education adviser.

The type of questions we were asked brought us down to earth with a salutory bump. Potty-training, bed-wetting and dummy-sucking dominated the air, though it was nice to offer advice to a mother whose child was terrified of going back into hospital — and she later contacted the National Association for the Welfare of Children in Hospital branch as a consequence. There was also the problem case who needed more help than we had time to offer, but the telephone lines were open during the day for longer discussions when the programme was not on the air and this was reassuring.

The National Education Research and Development Trust will be assessing the experimental switchboards held in various parts of the country, but meanwhile what about the usefulness of local radio to community health councils and the public we represent?

Firstly, I am increasingly conscious of the problematical nature of the CHCs' selling points. The public is no doubt interested to hear what we say, but may want to know what we *do*. However, our most obviously "sellable" activity — advising and assisting with complaints — is that which is most liable to disturb the health authorities and FPCs with whom we deal. We have to be conscious of this when designing posters which we wish GPs to display — how much more so if we are participating on radio or TV programmes as the consumer's guide in the welfare maze.

Secondly, there is the question of whether we assist the public most by reassurance or by agitation. This was raised most appositely when a Gingerbread member phoned to voice her feelings about the inadequacy of child care both normally and especially during holidays. Should we speak consolingly of nursery schools, child-minders and play-schemes, or should we openly admit that provision is shameful in its inadequacy? One may know one's position normally in a face to face situation, but to be both on the air and in personal contact with someone with a problem brings home with force the question of whether the advice which is best for the individual is necessarily best for society at large.

Personally, I think that on both issues we can only speak out — but I do not see the way ahead being any smoother for so doing.

News from CHCs

● Nearly 200 people were interviewed by Rhymney Valley CHC during a survey at University Hospital, Cardiff. The object was to look at travelling difficulties and associated financial problems. Average travelling time was 30 minutes to one hour with a maximum of two hours while the average return fare paid was £2 with a maximum of £7. Four patients and 17 visitors incurred a loss of earning as a direct result of their visits. Respondents made a number of suggestions for improvements mostly related to improving public transport facilities and for more services to be provided locally.

● South East Staffordshire CHC has printed 10,000 leaflets on patients' rights which are being distributed in pubs, clubs and bingo halls. The CHC is also considering ordering beer mats. One side would contain a few sentences on the work of CHCs and the other would have a picture of a telephone dial. Unfortunately, the minimum order is 25,000 so the CHC is looking for other CHCs prepared to join the venture and share costs.

● "Look after someone special this week" was the title of an exhibition about mental handicap held in Stockton library in June. The exhibition was organised by two workers with North Tees CHC's Job Creation Programme. The year-long scheme, due to finish in October, has been helping to increase public participation in the health service and other projects have included a handbook on local health services and a travelling exhibition about the CHC.

● Crewe CHC has done a survey at Leighton Hospital to find out patients' views on "continental" (ie uncooked) breakfasts. Only 38 of the 154 patients interviewed said they would object to having continental breakfasts, and about half said they would "sometimes" go continental if given a choice. The survey estimates that an average English (bacon-and-eggs) breakfast costs 10-12p as against 4-6p for a continental breakfast.

● Hereford and Worcester AHA has been offered permanent use of two beds for terminal patients in a hospice now being built in Birmingham. The annual cost will be about £13,000 and in view of the lack of any similar facilities in the district, Bromsgrove and Redditch CHC are asking the AHA to accept the offer.

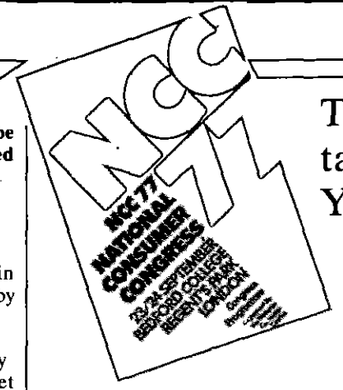
● Hartlepool CHC have suggested that some out-patients' clinics at a local hospital could be moved from Monday mornings to ease congestion. There have been no weekend X-ray facilities at the hospital for several months and each Monday morning about 40 patients who had accidents over the weekend come for treatment. The CHC is also hoping that a weekend X-ray service can be re-introduced.

● West Lancashire CHC was unsuccessful in its attempt to be represented in the selection process for a new District Administrator. The AHA said that the composition of the selection committee is laid down by agreement with the national staff committee for administrative and clerical staff and could not be varied.

● Dartford and Gravesham CHC has taken legal advice in its fight against the closure of the Livingstone community hospital. Reasons given by the AHA to justify the closure have altered during the consultation period and the CHC is concerned that this closure should not be considered in isolation from discussion of local health services generally.

● John Silverthorne, Secretary of North Staffordshire CHC, has been appointed Deputy Chairman of the Midlands Electricity Consumer Council.

● East Cumbria CHC will be running a nutrition campaign during the autumn half-term holiday aimed at creating good eating habits in the young. Activities include a children's poster competition, an exhibition with posters, films, talks and a tape-slide presentation, a competition for Womens Institute members and a TV advertising campaign.



This month the National Consumer Council's annual congress takes place in London. The NCC's retiring chairman, Michael Young, talks to *CHC NEWS* about his views and ideas on CHCs.

CHAMPIONS OF THE CONSUMER

Why should a body like the National Consumer Council be interested in patients, or indeed in the people who benefit or suffer from any of the social services?

I think in some ways the consumers are better treated in the high street than they are by the social services. For one thing they have somewhat more choice — it isn't a very great choice, one supermarket may look very much like another but at least they can go from one shop to another, they can compare products and where there is some competition it does, I think, work to the advantage of the consumer.

One of the points in referring to users of the social services, like patients, by this slightly foreign name of "consumer" is that it does suggest, by analogy, that the users of social services should be at least as well treated (preferably better treated) in that capacity as they are in their everyday capacity as shoppers. But socialists of various sorts, like me, who have helped to build up the social services rather decried the working of the competitive economy. That is thought to be all part of capitalism while the health service and so on are part of the new glorious commonwealth. Because of that many people, including those who are not socialists themselves, have closed their eyes to what could be learnt from the way competitive private enterprise works.

There is a great deal to be learnt. By and large I do not think that people whose salaries are not immediately dependent on the amount of custom they get do behave worse to the people they are servicing. They don't see themselves in any way as servants of the community — consumers, users, patients, parents, children or whatever they are. Because their salaries come out of some common pool they are somehow more responsible to the local education authority, the government or some other authority which is living on the taxpayers' money, than they are directly to the taxpayer.

Within that, do you think there are problems that consumers of health services face that consumers of other social services perhaps don't face?

In the health service I don't think that the choice is as ample as it could be. One argument against, say, health centres, particularly in a rural area, is that there may only be one group of doctors that it is possible to go to. If one looks at this sort of issue from the point of view that it is desirable to encourage choice then perhaps the health centres (which I certainly used to be very much a fan of) do have that disadvantage, although they do also benefit the patient in other ways. Where it is fairly evenly balanced whether or not to have a health centre then I would think that the importance of choice should tell against having a health centre.

Patients should be given much more information about how to choose doctors to the best advantage. I'd like to see all CHCs going in for that, especially in districts that have an inward migrant population. It would be nice if everyone that came into a new housing estate had the opportunity of a talk with the CHC about local GPs: who they are and what their different qualities are. Of course they would have to be careful about it but there is quite a lot they could say about ages, training, how long in the district, what sort of people have found it very satisfactory to be with that doctor, whether the doctor is prepared to have some sort of weekend service and night service or not, and so on.

A much more delicate issue of course is private medicine and one on which I am divided. I can see all the traditional disadvantages of having private practice in or out of hospitals; but I can also see great advantages of people being able to go to someone who isn't inside the health service if they feel they really can't get satisfaction.

What sort of thing would you like to see CHCs doing?

I'd like them to have much more guts than I think they have, although they vary enormously. I'd like to see them build up a local body of opinion and a local constituency. As long as they are seen to exist and do exist on the sufferance of the bureaucracies and the professions, as long as they are paid for entirely by the government, they are never going to enjoy the sort of respect that they should have. They are never really going to be the champions of the consumers against the monopolists. Obviously they couldn't be self-financing the way things are — they would all disappear. But it would be a worthy aim to think about in the long run.

The way to that goal would be to establish quite a lot of local organisations and local roots so that someone would actually care whether they existed or not. I think CHCs should be trying to set up patients' organisations wherever it makes sense to do so in their area. I'd like to see them proposing to every GP that they have at least some sort of regular meeting with such of their patients as want to attend. I would envisage each of these "patients' committees" being directly affiliated to the CHC. Some may be represented in the membership.

In long-stay hospitals too, I think the same kind of thing could work. Meetings where patients were actually consulted about what is done inside the hospital could be very effective.

What about self-help groups?

There are hundreds of groups for people with specific ailments and handicaps, and the parents of such people. But there is no reason why this should not be extended towards many other sorts of groups. A CHC would first try to create links with all such organisations in existence and then think about new ones: for people who were going to have children, or mothers who had just had children, or people on kidney machines, or whatever — people who are not joined together at the moment but could be usefully linked. Not only would it be good for those people with common health problems, but it would also be good for CHCs because it would begin to give them the relatively mass backing which they need if they are going to cut any ice with the entrenched medical profession.

It is said by some that the only way CHCs can develop their constituency is by being elected from within the district. Do you think there is any sense in that?

No. But I think there is a lot of sense in the idea of an elected body which is mainly concerned with consumer interests, not only in the health service. They could be called community councils (there are already such bodies in Scotland) and they would have committees for the nationalised industries, for schools, for old people, and, I suppose, one for local shopping facilities. The elected health committee of such a body would have more of a cutting edge with the people on the inside than one that wasn't.

Do you think that for CHCs to really move any ground, they need more statutory powers and, perhaps, greater finance?

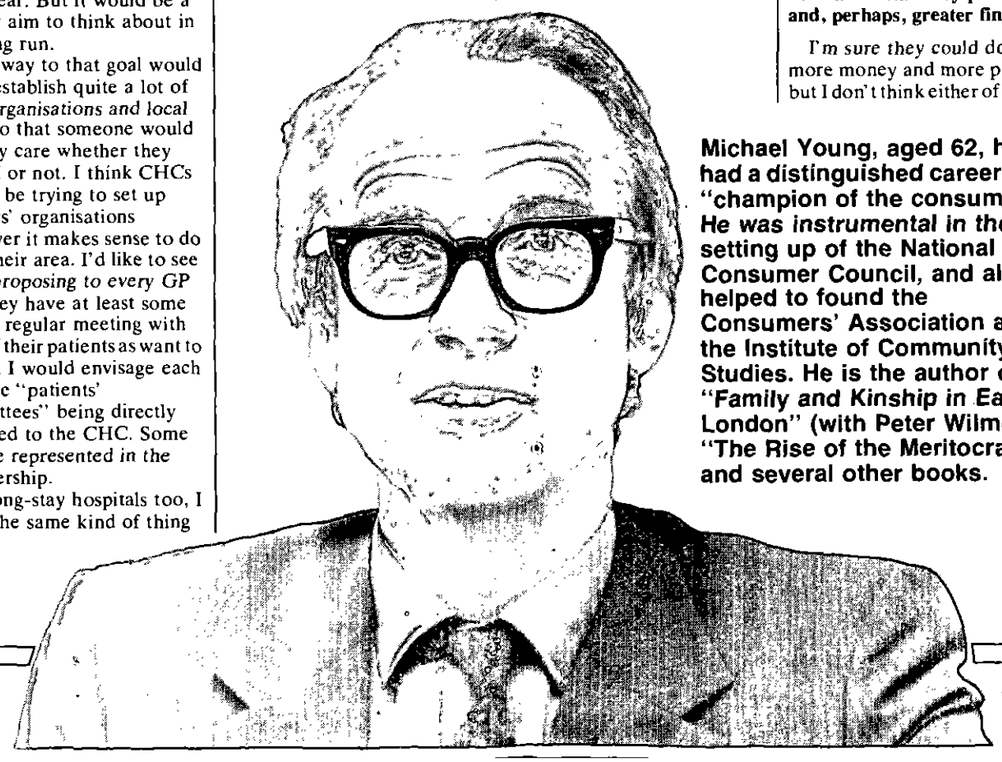
I'm sure they could do with more money and more powers but I don't think either of those matter as much as the militancy. Powers, whatever they are, can't possibly be sweeping otherwise you will really muck up the efficiency of the service. But if there are a lot of local people concerned who are going to raise their voices and make things slightly uncomfortable for people who are making a mess somewhere in the health service, that's what really will tell I think — plus of course the newspapers and the media.

What about support at national level? As you know, the Association of CHCs is just getting off the ground. Do you think that is an important feature of consumer activity?

Yes I certainly do because so much policy is decided at the national level. The National Consumer Council is mainly concerned with national policy (and European policy now) and it is clear that such a body as the Association of CHCs can only be effective if it is prepared to take a small "p" political line and, of course, be prepared to be partisan but well supported by facts. Our main successes have been where we have managed to gather support, whether from the government itself or from people who are strongly opposed to the government.

Quite often we have proposed things that haven't suited anyone and so nothing has happened — we have just added to the stream of reports and statements that have created a mild stir or no stir at all and don't lead to action. You don't want the Association to work just with government support: that would be rather hopeless. But if it can anticipate what might be practical politics for a government, and move a little bit in advance, then it can perhaps stimulate action that might not otherwise have occurred.

The best issue of all would be something which is the chief problem of the whole service in the context we are talking about, that is, on the one side there are all the professionals with very great power and on the other side there are the patients with practically no power at all. Choosing issues that are in the realm of politics and which symbolise that conflict (if you can call it a conflict when the sides are so unevenly matched) would be the best sort of issue to take up.



Michael Young, aged 62, has had a distinguished career as a "champion of the consumer". He was instrumental in the setting up of the National Consumer Council, and also helped to found the Consumers' Association and the Institute of Community Studies. He is the author of "Family and Kinship in East London" (with Peter Wilmott), "The Rise of the Meritocracy" and several other books.

EDITORIAL

Specialist advice-giving in Britain is booming. Superimposed on an already thriving network of Citizens Advice Bureaux, this boom has created problems of liaison and referral which are only now coming under close scrutiny. The National Consumer Council has just published *The Fourth Right of Citizenship: a review of local advice services**, which CHCs could find useful as a guide to the working of other local advice agencies.

Although this discussion paper nowhere mentions CHCs, the NCC definitely sees users and potential users of the NHS as coming within its definition of "the consumer" (see interview opposite).

CHCs have much to learn from and teach to the broader consumer movement. Apart from improving their knowledge of where best to refer non-health enquiries they could gain a much better impression of the extent of dissatisfaction with local health services. The NCC paper shows that in 1975-6 British CABs handled 113,000 health enquiries, 4.2% of their total work-load. Law centres too deal with health matters, and do not always contact their local CHC about them. CHC staff, particularly those working from shop-front premises, might benefit from training similar to the introductory courses run for CAB workers.

In trying to draw closer to their local advice agencies, CHCs might also find it necessary to add their voices to the campaign for more equal provision. The NCC paper, shows, just for example, that north Lancashire has no housing advice centre and that about two thirds of Britain's law centres are in London.

*75p inc post from NCC, 18 Queen Anne's Gate, London SW1.

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BOOK REVIEWS

BETTER PROSPECTS
£1.50 from MIND, 22 Harley Street, London W1N 2ED

According to this MIND report, many long stay mental hospital patients are ready to return to the community now. But because of inadequate residential, day-care and employment facilities, most of them will remain in hospital indefinitely.

MIND conducted a survey of the rehabilitation facilities in 84 of the larger mental hospitals. The results are set out in a very readable way and data from named hospitals can be easily identified. The picture that emerges is ". . . disheartening for both patients and hospital staff working in rehabilitation. With a few notable exceptions, the prospects of resettlement in the community for long stay patients are poor".

The survey covered the population of patients ready for rehabilitation; the existence of committees and consultants with special responsibility; liaison with social services departments; wards, day hospitals and other special placements; which domestic and social skills are taught and by which staff and the type of work opportunities and accommodation available for discharged patients.

MIND's main recommendations are that all hospitals with over 400 beds should appoint a consultant psychiatrist with formally recognised responsibility for rehabilitation; every patient should have his or her own rehabilitation programme and hospitals should appoint resettlement officers.

There are several other suggestions, and this report should be useful to CHCs, not only as a factual reference but as a checklist for assessing local arrangements for rehabilitation.

CONFLICTS IN THE NATIONAL HEALTH SERVICE
Keith Barnard & Kenneth Lee (eds) Croom Helm. 1977. £6.95

In this collection of ten essays the writers have attempted to identify and clarify some of the key conflicts and tensions in and facing the NHS. It is very much a book of the moment, having been written during the recent crises of cash limits, expenditure cuts and hospital closures.

The essays on participation are not optimistic about the future abilities of CHCs "in the light of the roles they have so far adopted, the limited resources available to them, the attitudes of health service managers and experience of consumers' councils in nationalised industries. One is therefore left to look further afield."

On health service administration the writer points out that to improve recruitment to the NHS salaries had to be offered which could compete with the private sector and that to justify the high salaries "pyramidal career structures were devised and to justify the structures functional management theory was cited and invoked".

The unreliability of population forecasts for the purposes of planning are explained and that the so-called *technical* judgements always include *value* judgements about whose needs are greatest.

As a whole, the book is thought-provoking and, in parts, contentious and will be of interest to anyone wishing to delve into the thinking behind the provision.

PATIENTS AND THEIR HOSPITALS (46 pages) PSYCHIATRIC HOSPITALS VIEWED BY THEIR PATIENTS (50 pages)
both by Winifred Raphael. Published by King Edward's Hospital Fund for London and distributed by Pitman Medical Publishing Co Ltd. £3.75 each.

These are the third and second editions respectively of the reports Mrs Raphael produced on patient attitude surveys in general and psychiatric hospitals.

WORLD HEALTH

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". CHC members may have heard this quote before, but may not recognise it as the first principle in the constitution of the World Health Organization.

The eighth of the WHO's nine principles may also strike a chord with CHCs: "Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people".

The WHO was set up in 1948 as part of the United Nations system, "to protect and promote health among all the peoples of the world." At the request of member countries it assists in fighting disease and building health services, particularly to ensure that primary care reaches people in remote rural regions.

In collaboration with local experts, WHO field-workers are assisting in areas such as: mother and child health; family planning; nutrition; water supply and sanitation; production of drugs and vaccines; and control of diseases such as malaria, tuberculosis, leprosy, yellow fever, cholera and plague. Smallpox has been virtually eradicated thanks to a global programme coordinated by the WHO, and a major project in Africa's Volta River basin is now attacking onchocerciasis or "river blindness", which is carried by flies. Every year thousands of front-line workers in sanitation, nursing and health visiting are trained in national programmes supported by WHO.

The organisation directs its major efforts towards the countries of the third world, because of their problems of poverty and underdevelopment. But much of its work is of global applicability, and some — for instance projects on rheumatism and mental health — relates specifically to the major health problems of developed countries. One interesting project in the North Karelia area of Finland is working towards a community approach to the control of cardiovascular disease, by emphasising the dangers of smoking, high-cholesterol diet and hypertension.

The WHO also supports biomedical research in 500 national research centres, maintains an international classification of diseases, sets standards for drugs and vaccines, makes International Health Regulations to protect travellers and prevent the spread of disease across national borders, collects and publishes health statistics and research information. Its Environmental Health Criteria Programme collects and publishes information on pollution and health. Its International Agency for Research in Cancer, set up in 1965 and based in Lyon, looks at possible environmental causes of cancer, such as asbestos.

150 member states currently belong to WHO, which employs a secretariat of about 5000 people, working at the Geneva HQ, in the six WHO regional offices and in field projects. A monthly magazine called "World Health" describes the varied work of the organisation. WHO's Regional Office for Europe is at 8 Scherfigsvej, 2100 Copenhagen Ø, Denmark.

MEDICAL AUDIT

Quality of patient care cannot be defined and measured precisely. We used to think rather naively that the mortality rates, showing premature deaths, were the only true indicator but now other, often conflicting factors must be considered also. For example, there are the morbidity rates which show how much and what kind of illness there is in the community; measures of function which indicate how far patients are restored to their normal life; indices of patients' satisfaction with their doctors and doctors' satisfaction with their patients; and the cost of prevention, sickness absence, diagnosis and treatment which can be calculated for many diseases.

Audit, meaning literally 'an official examination of the accounts', is used in medicine to describe the several ways in which individual doctors present their work for self criticism, inspection by their colleagues, or review by an outside body using the kind of indicators mentioned.

STANDARDS

Medical audit was first introduced in United States hospitals to control costs and some aspects of clinical work.

Today, the US Professional Standards Review Organisations (PSRO) set formal criteria of performance even though experience suggests that it is impossible to lay down absolute standards for the diagnosis and treatment of most diseases. Thus doctors are often resentful of attempts by 'experts', whose criteria may be faulty, to criticise their clinical judgment and occasionally to impose sanctions.

In Britain we are trying a different approach. Here, the idea is to encourage doctors to devise their own standards by consensus, to find out whether as individuals they meet these standards, and when they do not, to offer further education and advice to help them. There are two advantages: because all participating doctors are involved in standard setting they assume responsibility; and, because the audit is not punitive, it tends to make doctors more self critical and willing to criticise their colleagues than they would be if it was in the hands of an external authority. The principle of self assessment, of knowing oneself, can be extended to small groups of doctors.

IN HOSPITAL

The Hospital Inpatient Enquiry and Hospital Activity Analysis are examples of statistical audits of work in hospitals. They have had little impact on clinicians. The Scottish Consultant Review of Inpatient Statistics (SCRIPS) tried to give individual clinicians such information about their hospital inpatients as the percentage in surgical units undergoing operation, and the duration of stay in hospital prior to operation. These data were also largely ignored by consultants because, with hindsight, it was evident that consultants had to interpret the data themselves and did not or could not always do so. By contrast, the Confidential Enquiry into Maternal Deaths, first begun some 25 years ago, has done much to reduce the maternal death rate.

Here, consultant obstetricians give honest information to trusted colleagues knowing that it will remain confidential, and they will not be disciplined. The lessons learnt are explained to the profession particularly by the Royal College of Obstetricians and Gynaecologists. Taking another view, Professor Hugh Dudley, a surgeon, is using a type of flow chart to audit procedures or diseases he and his surgical colleagues think are important. In choosing subjects they ask as a guide: Is there reason to think that performance or delivery (of care) is substandard? Is the maintenance of a particular standard of high clinical or economic importance? Is information needed to establish baselines for performance? The method seems acceptable and effective.

Dr Donald Irvine, Hon. Secretary of the Royal College of General Practitioners

Mary Evans Picture Library

IN GENERAL PRACTICE

Variations in the quality of general practice are not easily overcome because so much of the work is difficult to measure. Nevertheless, there is scope for initiative. In Northumberland and Durham, for example, several groups of family doctors in the Royal College of General Practitioners (RCGP) have been meeting together to examine the adequacy of their records, to work out how best to investigate raised blood pressure and urinary tract infections in their practices, to analyse their deaths and to discuss problem cases which seem to have gone wrong.

In Cleveland, East Anglia and several other centres there are more groups of family doctors, mainly in the RCGP, who are working along similar lines. The Birmingham Research Unit and the *Journal of the RCGP* have now begun a new experiment. Members of the College have been invited to take part in an analysis of general practice which includes the punctuality of appointment systems, choice of antibiotics, investigation procedures, the use of psychotropic (tranquillising) drugs, referrals to specialist and home visiting. Each participating doctor will provide information from his own practice. Later, when investigations are complete, he will receive his own practice profile for comparison with the general analysis from all contributing practices.

IN SUMMARY

The medical profession in Britain, especially the Royal Colleges, is trying to involve doctors in a self critical examination of their own work. Better records, information systems and postgraduate education are essential for success, and must be given a higher priority by the NHS.

Focus on mental handicap

Fears about national development team

The National Development Team for the Mentally Handicapped was set up in Spring 1976. Its three main tasks are to provide "advice on service planning, advice on the organisation and operation of services and advice on the planning and operation of services for mentally handicapped children". The Team consists of a director and three associate directors, and a panel of specialists in a number of categories including medical, nursing, education and training, field and residential services, and parents.

Campaign for the Mentally Handicapped (CMH) wrote to David Ennals in April 1977 because it was worried lest the "secrecy" with which it thought the Team had been set up would persist now the Team was at work. It raised a number of specific points including the suggestion that panel members' qualifications and experience should also be published so that any gaps in expertise could be commented on. It wanted to know how Team visits could be encouraged, since these are only made by invitation. Could mentally handicapped people themselves, or staff or parents request a visit, even if the authority did not think there was a need? The status of Team reports and recommendations was also queried by CMH, who suggested that reports should be published, even if they were critical, or that reasons why publication was not possible should be publicly stated. Equally CMH wanted to know how implementation of Team recommendations could be monitored, and whether guidelines for Team visits would be prepared and issued publicly. Finally CMH said it was looking forward to the updating of DHSS policies for mental handicap services.

David Ennals replied that he planned to review the Team's methods and operation in the autumn, and he reminded CMH that the Team operates independently of the Department. On the specific questions he replied as follows:

Selection of panel members: "I see no merit in publishing criteria for selection and the choice must, in the last resort, be a matter for my personal decision."

Visits by the team: "It was decided at the outset that the Team should only visit a unit or advise on local services at the specific invitation of the authority concerned. The Team's advice is also available to voluntary and private bodies who provide services for the mentally handicapped . . . Special arrangements have been made to provide advice about services for mentally handicapped children and the Team intends to seek invitations to look at all services for mentally handicapped children over a period of time."

Status of Team's advice: "The Team's reports — which are not always in written form — are made to the authority or authorities seeking advice. It is for these authorities to decide whether any written report should be published and what action to take on the Team's recommendations. The Team keeps my Department informed of any points of national significance arising from its visits and any necessary consequent action in the short term is taken through normal departmental machinery."

Guidelines to the Team: "Whilst the Department's advice is freely available to the Team, I must repeat that it is an independent body and its mode of operation is a matter for the Director. I do not believe it would be helpful to standardise procedures in the way you suggest. A flexible approach is needed. I have however drawn the attention of the Director to your letter and no doubt he will bear in mind the points you make."

DHSS and policy: "I can assure you that although the White Paper (Better Services for the Mentally Handicapped) is likely to be the main guideline for some time to come in planning services for mentally handicapped people, my Department continues to keep all aspects of mental handicap policy under review."

In its summer *Newsletter* CMH interprets these answers as a brush-off and fears that the Team will have little impact on the provision of better services because of the secrecy surrounding its work.

Support for parents of mentally handicapped babies

Irene Watson, Secretary of Hull CHC

The Hull Community Health Council considers there is a need to make available to parents of mentally handicapped babies early information on services and organisations to which they can turn for support, advice or simply a compassionate listener.

To help towards this, it was recommended by the Council's Working Group on Care of the Mentally Handicapped that a register of names and addresses of all parents should be held by an accredited voluntary organisation, in this case the Hull Society for Mentally Handicapped Children.

On the face of it this would appear to be a relatively simple exercise, particularly as this information is held by the local authority. It is not. The stumbling block is officialdom's obsession with confidentiality which would be acceptable if shared by the parents also. It is not.

An earlier exercise of the Hull CHC invited parents of mentally handicapped children to give their views on the consultative procedure associated with possible sterilisation of mentally handicapped children. The degree to which the invitation was accepted forcibly demonstrated the attitude of parents towards involvement and the complete disregard for confidentiality. It is interesting to note that the Social Services Department was helpful in the distribution of questionnaires; the Education Department was not, so that, unfortunately, all parents were not afforded the opportunity to give their views.

The prime consideration of parents of mentally handicapped children is to obtain the best possible advice and assistance both for their children and for themselves. These facilities are available from the appropriate authorities but, when mental handicap is first diagnosed, an over-riding need of any parent is to discuss this new and frightening situation with someone who has endured a similar experience. This is where the voluntary organisation comes in and this is why early notification of names and addresses is sought.

A member of the Hull CHC has had a long and close association with parents of mentally handicapped children as well as having shared their experience and it is through this member that the need for early, personal advice and support on an individual basis is known.

Discussions and correspondence have taken place with representatives of the social services; the education department; a general practitioner; hospital personnel and the National Development Group for the Mentally Handicapped. Indeed, with the inception of the NDG, the Council was hopeful of support in its endeavours but this was short-lived following attendance at a Yorkshire Regional meeting when two members of the NDG spoke about their work. Contrary to expectations, the NDG was looking towards CHCs for support in its aspirations.

At this same meeting a parent of a mentally handicapped child spoke against authorities' rule of confidentiality. It is the view also of the Hull CHC's Working Group that slavish adherence to this rule is depriving parents of the maximum support available and, in any event, it should be for the parents themselves to decide whether they wish to accept or decline the aid offered by voluntary organisations.

Deafness—
the invisible handicap

As many as two and a half million people in Great Britain may be deaf to a greater or lesser degree. Classification of deafness by decibel loss may be meaningful to doctors but to the deaf person the way that their hearing loss affects their social functioning is the most important aspect.

A recent DHSS report* stressed that "effective help for deaf people and their families demands close cooperation between health, education and social services" and concluded that "multi-disciplinary teams in which a medical, educational and social assessment all make a contribution to the overall decision regarding treatment and rehabilitation should be the ideal aim". While it may not be possible to set up such schemes in the immediate future the report recommends that Joint Care Planning Teams should consider introducing referral schemes at the earliest opportunity

It is thought that around one in every thousand children is profoundly deaf but exact numbers are not available. All children should be screened for deafness between seven and eight months — the earliest age at which an effective diagnosis can be made — and again during their first year at school. Early diagnosis is essential if the deaf child is to have an opportunity to develop speech and language. Impairment of hearing and language skills leads to impairment of social and behavioural skills. Even very young children can benefit from hearing aids which enhance residual hearing but it is essential that an appropriate aid is chosen. Of equal importance is the provision of assistance, support and training for the family to help them communicate with the deaf child.

Acquired hearing loss is one of the more common socially handicapping conditions. It affects all ages but over half of the hearing-impaired population is over 65 and one in five of us are likely to become noticeably deaf in old age. Although hearing loss in adults does not affect the normal development of the individual it can have a traumatic effect. Help will be needed through the health services to obtain hearing aids although it is estimated that up to 25 per cent are found unsatisfactory. No financial help is available for people needing to buy an aid privately. Speech therapy and lip reading classes will be needed but are provided somewhat unevenly throughout the country by both health and education services. Social services departments can provide aids such as flashing lights for doorbells and telephones under the Chronically Sick and Disabled Persons Act 1970. There are shortages of teachers of lip reading, speech therapists and other professionals able to communicate with the deaf. It can take at least a year for a hearing person to acquire the necessary skills. Courses to teach these skills are rare and tend to be undersubscribed. A survey in 1976 found only 73 professionally qualified social workers in England and Wales with a formal qualification to work with deaf people.

In general, there are few links between hearing aid centres and social services departments so that many deaf and hard-of-hearing people will not take advantage of statutory and voluntary services because they are unaware of their existence.

A number of organisations exist specifically for hearing-impaired people. The Royal National Institute for the Deaf (105 Gower Street, London WC1E 6AH) produces useful publications and aids. There are a number of clubs and self help groups around the country and some 200 of these are affiliated to the British Association for the Hard of Hearing (43 Crouch Avenue, Hullbridge, Hockley, Essex SS5 6BS). The British Deaf Association (38 Victoria Place, Carlisle CA1 1HU) has recently received a grant from the DHSS to set up pilot courses to teach manual communication skills and to publish a definitive book of British sign language. Last year, the Government established the Institute of Hearing Research (The Medical School, Nottingham NG7 2U4) to provide a base for staff and facilities for a major multi-disciplinary research effort in this field.

A number of apparent behaviour problems can be caused by impaired hearing. These can include inattention or disruptive behaviour in childhood; frustration, hostility, shyness and under-achievement in adolescence; loneliness, isolation and withdrawal in adulthood and apparent senility in old age. If the hearing loss is diagnosed accurately and appropriate help and aids obtained, such problems can be minimised and even overcome. Particular help may be needed at times of stress such as during a hospital stay or for official proceedings such as a Court appearance and trained interpreters should be available. The deaf and hard-of-hearing can be helped to live full and active lives but an awareness of their problems by the whole community, and not just a few isolated professionals, is necessary.

**Report of a Sub-Committee appointed to consider the role of social services in the care of the deaf of all ages. DHSS. June 1977.*

Parliamentary Questions

RETAIL DISPENSING PROBLEMS
If the Secretary of State considers that pharmaceutical services in an area are inadequate, he is empowered by Section 43 of the NHS Act 1946 to "make whatever arrangements are necessary to enable an adequate service to be provided". He can also delegate these powers to an FPC, David Ennals told Sydney Tierney MP.

NHS DENTAL TREATMENT
James Prior MP asked Mr Ennals whether he would alter the "rule" which puts the onus on dental patients to ensure that they are receiving NHS treatment. Mr Ennals said this was advice rather than a rule, and "the question of onus has been discussed again recently with the profession and is still under consideration".

WARD COSTS AND CLOSURES
Clement Freud MP asked what it costs to run a ward of 14 staffed beds in a Metropolitan area, and what saving could be made by closure. Roland Moyle replied that the average cost in large acute hospitals in the Thames regions, in 1975/76, was £140,000. At individual hospitals the figure ranged from £100,000 to £220,000. Savings "would depend upon local circumstances, including the capacity to redeploy resources".

RESOURCE ALLOCATION
The speed at which the DHSS will implement the full RAWP proposals "must depend on the amount of money available nationally year by year", David Ennals told John Ovenden MP. Questioned by Sir George Young MP about provision under RAWP for inner cities' areas of decay and high immigrant population, Mr Ennals said he accepted the RAWP report's view that the effects of social deprivation were "not quantifiable at this stage".

ASSISTANCE FOR THE DISABLED
Regulations to extend the non-contributory invalidity pension to disabled housewives from November are before the National Insurance Advisory Committee, Alf Morris told Robert McCrindle MP. New regulations will also provide attendance allowance for foster parents caring for severely handicapped children.

FITNESS OF GPs
Nigel Spearing MP asked what procedures exist for certifying the medical fitness of GPs. Roland Moyle replied that if an FPC agrees with a Local Medical Committee that a doctor cannot comply with his terms of service, it may: (1) make alternative arrangements for the care of his patients; (2) require a medical report on "such aspects of his health as the LMC may specify" before allowing him to resume NHS work.

NOTES.....

NEW GOVERNMENT CONTROLS PROPOSED FOR MEDICAL PRACTICE

The main recommendations of the Merrison Committee on the Regulation of the Medical Profession* have been accepted by the Government, and proposals for legislation are being drafted.

The Government accepts in principle that:

- The General Medical Council should co-ordinate all stages of medical education, and should maintain a register of specialists.
- The GMC should recognise overseas medical qualifications which meet a UK minimum standard, and should only register overseas-educated doctors whose standard is up to this minimum.
- The GMC should have powers to control the registration of doctors "whose mental or physical health is such as to endanger their patients".
- The GMC should be reconstituted with an overall majority of members elected by the profession.

*Merrison Report. Cmnd 6081. HMSO. April 1975.

PATIENTS ASSOCIATION HQ

The Patients Association has moved from Oxford to 11 Dartmouth Street, London SW1 (tel: 01-222 4992). Its new secretary is Ms Audrey Goehr.

CONCESSIONS FOR THE DISABLED

Alf Morris, minister for the disabled, has drawn attention to a wide range of goods and services on which substantial cash discounts and other concessions for disabled people have been negotiated. The list includes car hire and purchase, wheelchair purchase and insurance. For full details see Mr Morris' reply to a Parliamentary Question from Jack Ashley MP on 4 July.

BREAKTHROUGH ON VACCINE DAMAGE COMPENSATION

David Ennals has committed the Government in principle to "a scheme of payments for the benefit of those who are seriously damaged as a result of vaccination", which "will apply to existing as well as new cases". No details will be announced till the Royal Commission on Civil Liability and Compensation for Personal Injury reports. The Government's Joint Committee on Vaccination and Immunisation has published a booklet titled "Whooping Cough Vaccination" (HMSO 85p) which reviews all the available evidence and concludes that whooping cough vaccination should continue to be given.

HEALTH AT WORK

Regulations governing the work of safety representatives have now become law and the Health and Safety Commission has issued a booklet titled "Safety Representatives and Safety Committees" (HMSO 35p), containing a code of practice and guidance notes. An estimated 150,000 workplace safety representatives will have been appointed by trade unions by 1 October 1978 when the code takes effect.

WARNINGS ON MEDICINES

New regulations on the labelling of retail and dispensed medicines are being phased in between now and July 1979 to protect children and ensure that more advice and information is given on the label. Almost all medicinal products will have to bear the warning: "KEEP OUT OF THE REACH OF CHILDREN" or similar words. The Medicines (Labelling) Amendment Regulations 1977 (SI 1977/996) costs 25p, from HMSO, and an explanatory leaflet, MAL 49, is available from DHSS Medicines Division, 33 Finsbury Square, London EC2.

VIDEOTAPE ON CHCs

A 45-minute black-and-white videotape about CHCs has been made for the Working Party on Dental Public Health of the University of London Board of Studies in Dentistry, as the fifth in a series of TV programmes on community dentistry. CHCs can hire the tape for £4 + VAT + postage (eight days) or buy a copy for £15 copying charge plus the cost of the tape. Contact Pat Gulliford, 11 Bedford Square, London WC1. 01-636 3104.

HC(77) 24 FOOD HYGIENE

Warns health authorities that Crown Exemption is no excuse for standards below the minimum requirements of the Food Hygiene (General) Regulations 1970. Authorities should give their local authority environmental health departments "open access" to catering premises at all times.

HC(77)25 HEALTH CARE IN RESIDENTIAL HOMES FOR THE ELDERLY

A detailed memorandum suggests ways in which health and social services authorities might collaborate to improve arrangements for health care in homes. An annex deals with custody, administration and disposal of medicines.

HN(77)97 ASSESSMENT OF MENTALLY DISORDERED OFFENDERS

Notifies health authorities of a recent Home Office Prison Department decision to allow nursing staff to accompany consultant psychiatrists visiting Prison Department establishments to assess offenders for admission into hospitals.

Directory of CHCs

This Directory gives addresses and telephone numbers for all CHCs in England and Wales, plus names of chairman and secretaries. Price 60p from CHC NEWS office. Corrections are published monthly in CHC NEWS.

Page 1: North Tees CHC
Chairman: Mrs Greta Walton
Page: 3: SW Durham CHC
Chairman: Mrs E R Wallis
Page 3: Northumberland CHC
Address: South View, Ashington
Telephone: Ashington 813428
Page 6: Bradford CHC
Chairman: Mr G. R. Turner
Page 8: Wakefield Western CHC
Chairman: Mr C. Croxall
Page 8: South Derbyshire CHC
Chairman: Mr R Cook
Page 9: Lincolnshire North CHC
Chairman: Miss Juliet Carter
Page 12: Peterborough CHC
Chairman: Miss Caroline Dobson
Page 16: Harrow CHC
Secretary: Miss Mary Walker
Page 17: North East District, Kensington Chelsea & Westminster CHC
Chairman: Mr D Collis
Page 18: Chelmsford CHC
Chairman: Mr Delmas Ashford
Page 18: North East Essex CHC
Chairman: Mr E Moore
Page 20: Tower Hamlets CHC
Chairman: Ald R W Ashkettle
Page 23: Bexley CHC
Address: 11a Upton Road, Bexleyheath, Kent DA6 8LQ
Page 26: Cuckfield & Crawley CHC
Chairman: Mrs J A Shepheard
Page 28: West Dorset CHC
Chairman: Mr A B Mason
Page 28: Portsmouth & SE Hants CHC
Secretary: Mr E J Baker
Page 31: Oxfordshire CHC
Secretary: Tom Richardson
Page 32: Weston CHC
Chairman: Cllr Mrs E Nicholls
Page 32: Cornwall CHC
Chairman: Major K H Leadbetter
Page 33: Plymouth CHC
Chairman: Mrs B Fitzgerald
Page 39: Chester CHC
Chairman: Mr G A Isted
Page 40: Halton CHC
Chairman: Dr D E Robertson
Page 40: Macclesfield CHC
Chairman: Cllr G Sampey
Page 41: Sefton Northern CHC
Chairman: Miss M C Smith
Page 41: Sefton Southern CHC
Chairman: Mr R E Greetham
Page 41: Wirral Northern CHC
Chairman: Mrs Marie Jones
Page 42: Wirral Southern CHC
Telephone: 051-334 4000 Ext 409
Page 43: West Lancashire CHC
Address: Government Buildings, Moorgate, Ormskirk, Lancs L39 4SA
Telephone: Ormskirk 77376
Chairman: Cllr Mrs M D Rees
Page 46: Wigan CHC
Chairman: Mr J Derbyshire
Page 49: Rhymney Valley CHC
Telephone: Hengoed 812290
Chairman: Mrs O Jenkins
Page 50: Vale of Glamorgan CHC
Chairman: Cllr M L Pound
Page 52: Regional Meetings of Chairmen and Secretaries, East Anglian Region
c/o Ipswich CHC, Room 36, County Hall, Ipswich, IP4 2JU
Chairman: L J Bowling
Secretary: Mrs M E Bateman
Telephone: Ipswich 55801 Ext 236
Page 53: South West Thames Regional Association of CHCs (Chairmen and Secretaries)
c/o East Surrey CHC, 69B, Bell Street, Reigate, Surrey, RH2 0SL
Chairman: Cllr R V Stephenson
Secretary: Miss Y D Wills
Telephone: Reigate 41686