CHC NEWS

For Community Health Councils

November 1977 No 25

Tory views on CHCs

The chairman of Darlington CHC, Coun. Alan Gill, has written to Margaret Thatcher about the attempt by leading Conservative MPs to prevent the founding of the Association of CHCs. Coun. Gill (below) received a reply from party health spokesman Dr Gerard Vaughan, which he felt indicated less than wholehearted support for CHCs. He then contacted ACHCEW, which also wrote to Mrs Thatcher, and this has led to a decision by the association to improve its lines of communication with all three major political parties. Coun. Gill describes the reasons for his concern in an article on page 10.

Health matters

Since November 1975, West Berkshire CHC's chairman Alfred Boom has been writing a fortnightly column on health topics in the *Reading Evening Post*. His CHC has now published a booklet containing 14 of these articles. The column has generated much interest locally, and the articles should be stimulating reading for CHC members, health service workers and the general public. "Health Matters" costs 50p inc post, from West Berkshire CHC, 10 Gun Street, Reading, Berkshire.

Help with Surveys

Are you having difficulty getting good advice on doing surveys? Three sources that may be willing and able to help community health councils are:

1. Social Survey Division of the OPCS (Office of Population Censuses and Surveys). This organisation is responsible for the General Household Survey and also does a number of other specific investigations. (Contact Mr F E Whitehead, Social Survey Division, OPCS, St Catherine's House, 10 Kingsway, London WC2B 6JP, 01-242 0262 ext 2242.)
2. Research units attached to certain local authority social services departments — these were originally set up to gather information on the elderly and the handicapped, and therefore have considerable knowledge of local conditions.
3. Universities and colleges, particularly those which have been engaged on health studies and research into aspects of health care.

CHCs wanting advice from sources such as these are strongly advised to think about their answers to the following points *before* making an approach:

1. What are the purpose and main objectives of the research?
2. How many workers will be available for it, and what are their skills?
3. Which group of people do you want to contact/investigate, and how many are there of them?
4. What other research expertise might be available to help you co-ordinate the work and analyse the results?
5. Will computer facilities be available?
6. How much time is there in which to complete the study?
7. How much money is available?

Waltham Forest Guardian

CHC researcher interviews mothers about pre-school children's health.

Weir Hospital campaign

YOUR LETTERS

PATIENTS' CONSENT
Joan Woodward, Member Central Birmingham CHC

I have recently been appointed as the lay representative on the ethical committee and I am very interested in investigating the concept of "informed consent" as it is understood by the consumer. This is of particular concern to me because it forms a large part of the basis on which the ethical aspect of human medical research stands.

In the first instance I want to investigate this concept as it is understood by four groups of people: adult patients; parents of child patients; medical students and technicians.

I am undertaking this investigation with the full knowledge and agreement of the other members of the ethical committee and I would do it in the spirit of someone who wholeheartedly supports the importance of and the need for research.

I am writing to ask if any other CHC members who are on ethical committees would be willing to embark on a similar project or whether they have any helpful comments to make on the subject?

GP VOCATIONAL TRAINING
Juliet Mattinson, Secretary East Berkshire CHC

Nobody has asked for a CHC view on the form and content of GPs' compulsory vocational training which is now under discussion but this CHC thinks the consumer should have an innings. Whether good GPs are born or made, there is clearly a multiplicity of factors involved apart from medical skill and my members are seeking to identify these. They would like to know of any other CHCs who are tackling this question.

CHC MEMBERSHIP
N G Downs, Secretary Tameside CHC

A situation has arisen in this Region which causes me great concern. Following the local authority elections earlier this year, control of the Greater Manchester Council passed from the Labour Party to that of the Conservatives and the controlling group subsequently sought to replace certain CHC members who had been appointed and who were still members of the local authority (although in a political minority) by other persons of a presumably more acceptable political persuasion.

This purported action by the GMC affected one of my members who retained his seat on the GMC in the election and whose term of office on my CHC does not expire until 1978 and so, I wrote to the Regional Health Authority (as the establishing authority) pointing out that the Statutory Instrument governing the appointments to CHCs (unlike the one relating to health authorities) does not permit this. The RHA has consulted its legal advisers and those of the DHSS and I understand that they support my contention.

It now appears that the GMC, being unable to have its way legally, is likely to attempt a piece of what I call political sharp practice in that the members affected will be asked to do "the gentlemanly thing" and resign their CHC membership. An important principle is involved here as I take the view that CHC members are not mandated delegates of the body which nominated them but are there to represent the public in general. Perhaps the Association of CHCs for England and Wales would like to draw the Secretary of State's attention to this immoral activity on the part of certain local authorities.

DENTAL CHARGES
Derek Smith, Secretary NW Leicestershire CHC

At the end of 1976 my CHC carried out a survey within the district to assess the public's awareness that the onus rests with the patient to tell the dentist that NHS treatment is required prior to the commencement of treatment. We also asked if a copy of "Your Guide to Dental Treatment under the NHS" had been seen in dental waiting rooms/reception areas. The figures show beyond doubt that further publicity should be made available to the public, and in relevant places such as waiting rooms.

We wrote to several people about our results including David Ennals, asking him to consider shifting the onus of ensuring NHS treatment to the dentist. The reply was not really satisfactory, and we feel that if a dentist has any contract with an FPC for the treatment of those accepted for NHS treatment, the contract should be much more binding and "tightened up" to afford greater protection than it does at present.

MOBILITY ALLOWANCE
Hugh McCartney MP and Bernard Conlan MP

No Government can ever please everyone all the time. Nor often can it please the same people at different times. At least, this was our reaction to reading Nigel Harvey's carping criticism of what the Government are doing to help disabled people *(CHC NEWS 22)*.

Mr Harvey, the Secretary of the Disabled Drivers' Motor Club, now says £7 per week in the context of today's motoring costs is ludicrous. If this is true, was it not also true of the broadly comparable £4 which his own organisation asked us to provide in August 1974?

He also says it is worth much less after tax and paying vehicle excise duty, but the proposal of his organisation in August 1974 was also for a taxed mobility allowance.

Mobility allowance improves the cash provision, and it is complemented by an increasing range of negotiated hire purchase and hire concessions which help the beneficiary to use his allowance to good effect. Mr Harvey clearly wants much more than his organisation was content to ask for in 1974, even though the country's economic position has badly deteriorated since then.

PATIENTS' ASSOCIATIONS
Kathy B Sayer, Research Assistant, Kings Fund Centre

Readers of *CHC NEWS* may be aware of the growing number of patients' associations that are being established. The Kings Fund Centre is currently compiling a directory of these associations and would welcome information about any new organisations concerned with either specific illnesses or with handicap in general, that have not as yet become widely known. Both national and local schemes are of interest.

NHS WIGS
R Owens, Secretary SW Durham CHC

Members of my Council are particularly concerned at the time it can take to obtain a wig under the National Health Service in this area, which can be from two to three months in some cases. This is particularly distressing for a lady, perhaps already emotionally disturbed through her illness.

It is accepted that many local firms are merely agents for a more remote manufacturer, but I wonder if perhaps other CHCs can help with information about waiting times in their part of the country, and advice about what can be done to improve the situation.

LIPREADING
Mrs E L Baldock, Secretary, Association of Teachers of Lipreading to Adults, 5 The Terrace, Morice Yard, HM Naval Base, Plymouth, Devon; Tel. 0752 53740 ext. 3939.

Our newly formed Association has members who teach lipreading to adults in many parts of the country. This is a very valuable part of the rehabilitation of the deafened and hard of hearing adult, but unfortunately it is a very patchy service. Some areas just do not have the necessary teachers, or the authorities are reluctant to make provision for classes. In areas where teachers and classes are available lack of publicity means that the people who need help do not always get it.

We believe that community health councils could be of great assistance with this problem by pressing for classes where none exist, and by giving publicity to classes already held in their areas. We shall be grateful for any help you can give us.

CORRECTION
The District Administrator for Hartlepool has written to correct a news item on page 5 of *CHC NEWS 23* concerning the introduction of weekend X-ray facilities at a hospital. He informs us that an on-call service has been provided there for many years. Our apologies.

PHOBIAS

Anthony W. Clare, Psychiatrist at The Maudsley Hospital, London

The term "phobia" is derived from the Greek word *phobus* meaning flight, panic or terror. In clinical practice a phobia is defined as a special form of fear which is out of proportion to the demands of the situation, which cannot be explained or reasoned away, which is beyond voluntary control and which leads to avoidance of the feared situation. Phobic patients generally realise that their fears are excessive and even ridiculous but they are unable to quell them. People not so afflicted find it difficult to understand how anyone can be terrified of a playful kitten, a minute spider or a caged budgerigar. Occasionally, the phobic patient may be regarded as weak and cowardly and is exhorted to pull himself together. Such advice, however well-meant, is almost invariably counter-productive.

Most people experience normal fears of one kind or another. In children these include fears of being left by their parents, of strangers, of noises and of unusual situations. In adults, such fears include mild fears of heights, lifts, darkness, aeroplanes, mice and taking examinations. Such minor fears do not lead to total avoidance of objects and can be overcome with explanation and persistence.

The commonest and most distressing of the abnormal fears is the so-called agoraphobic syndrome. Roughly 60 per cent of all phobias seen at the Maudsley Hospital in London are of this kind. Agoraphobic patients are fearful of going into open spaces and also of shopping, crowds, travelling and closed spaces. Most agoraphobics are women and the majority usually develop their symptoms after puberty, between 15 and 35. Psychiatrists also see a wide variety of social phobias in the form of fears of eating, drinking, blushing, speaking, writing or vomiting in the presence of other people. Social phobias make up about 8 per cent of the phobias seen at the Maudsley, start after puberty and occur to about the same extent in men and women.

The rarest kind of phobias seen in hospital practice are the animal phobias. The vast majority of animal phobias in adults occur in women. Before puberty, animal phobias are found quite commonly in both sexes. Other miscellaneous phobias include heights, wind, darkness, thunderstorms and running water. Hypochondriacal worries (e.g. of serious illness or impending death) are not uncommon in a mild form but established hypochondriacal phobias are relatively unusual.

In general practice populations, mild anxiety is quite commonly seen but established and specific phobias are uncommon. When stressed, many people may become transiently phobic and mildly house-bound or socially inhibited but with relief of the precipitating stress the phobias disappear.

Patients experience overwhelming anxiety when confronted with their particular phobic situation. They sweat, tremble, grow pale, breathe rapidly and with difficulty, feel "butterflies" in the stomach, have palpitations, get weak at the knees and are seized by a terrifying feeling of impending catastrophe. Some patients become preoccupied by the fear that they may have an epileptic fit or lose control in a public place.

The treatment of phobic symptoms consists of reassurance coupled with the prescription of a tranquilliser such as diazepam (Valium) or chlordiazepoxide (Librium). The majority of the milder forms of phobic anxiety seen by general practitioners respond quite well to such relatively simple measures. More established symptoms, however, demand more complex treatment. The developments of a number of treatments based on principles derived from behaviour modification has led to a dramatic improvement in the prognosis of some of the more severe disorders. Among the commoner behavioural techniques are systematic desensitization, flooding or implosive therapy and operant reinforcement.

In *systematic desensitization* a reassuring therapist encourages the patient to think about her phobic stress, e.g. spiders, until she can do so without anxiety. She is then confronted with a dead spider, then a distant live spider which is gradually brought closer to her. In the final stages of the treatment the patient progresses from holding a container with the spider inside to handling it herself without fear. Thus the fear response is deconditioned in a setting of complete physical and mental relaxation and is reconditioned into a fearless response.

The aim of *flooding* or *implosive therapy* is to achieve a similar result. In this case the patient is subjected to a massive phobic stress which is sufficiently severe to bring about an extinction of the original fearful response. It is as if by actually facing the most dreaded aspects of the fear that its power is broken.

In *operant conditioning*, the patient is rewarded step by step as she conquers her fear. The housebound housewife may be given strong support and encouragement as she first goes out into the garden, then into the street, then to her local shop and finally to her supermarket.

The outlook of the majority of specific phobic patients is good. Some phobias, particularly those which have been long entrenched and are complicated by additional personality and social problems may however be quite resistant to treatment. However, even for the most intractable of conditions there is some form of relief available if only that provided by the opportunity to learn about the way in which fears develop and are maintained. Many phobics are genuinely fearful of losing their sanity and reassurance on this score can provide significant relief. Some voluntary organisations, based on self-help principles, such as the Open Door Association, provide a helpful service in this regard.

Many phobics are genuinely fearful of losing their sanity and reassurance on this score can provide significant relief

Environmental health

David Ormandy
formerly of the Public Health Advisory Service

The reorganisation of local authorities and the creation of the health authorities in 1974 separated the environmental health officer (EHO; still widely known as public health inspector) from the rest of the health services. Whatever the reasoning behind the separation, it unfortunately has led to more than just a physical separation, and it is now increasingly difficult to see what connection there is between the two.

If one looks back to the development of public health administration, the links are more easily shown. For one thing, the EHO worked directly under the medical officer of health, dealing with the improvement of environmental conditions, while the rest of the department concentrated on the clinical and medical aspects of public health. However, now the role of the medical officer of health is carried out through the community physician; the health authority has little or no involvement in environmental control or improvement.

But the main link is seen when the role of the EHO is examined in detail, and especially when the basis of the role is uncovered. Perhaps the best starting point is the home — here the EHO is concerned with ensuring that the physical structure of the building is in a reasonable state of repair, and that it is free from dampness; that there is sufficient ventilation and lighting, an adequate and wholesome supply of water; and that sanitary accommodation and drainage is provided. These are minimum requirements, and the EHO is also involved with the improvement of dwellings through the house renovation grant scheme, and in dealing with special housing problems including overcrowding, common lodging-house standards, and the clearance or improvement of areas of unsatisfactory housing.

The principle behind the housing work of the EHO is fairly straightforward — that of trying to ensure a reasonable physical environment which will maintain and improve the well-being of the occupiers, and reduce the conditions favourable to disease.

The same principles apply to the condition of the environment around the home; EHOs are involved in atmospheric pollution and noise control and in the general improvement of the physical environment. Similarly with the working environment where EHOs ensure that minimum standards of cleanliness and sanitation are maintained, and in some cases are involved in safety at work.

EHOs are also responsible for the fitness and hygienic control of all food prepared for human consumption, including inspection at source in the case of animal products, and the maintenance of hygienic practices in all food premises.

The final aspect of the EHO's role to be considered is the one which forms the remaining link between EHOs and the health authority — that involving infectious disease and food poisoning. When cases occur it is the EHOs who attempt to trace the source. It would seem that the main reason for this is that the EHO may have to deal with remedying environmental conditions that have assisted in the spread of the disease, or in tracing the food source.

From all of this it can be seen that the EHO's role cannot readily be divorced from that of the health authorities. Together they are attempting to raise the physical, social and mental well-being of the public. That they are based separately is, perhaps, unfortunate, and efforts should be made to build up links so that standards can be improved quickly and effectively. The involvement of the health authorities in the physical environment should be a part of their role.

The closures game

Caroline Langridge, Secretary of Wandsworth and East Merton CHC

In a recent statement to the House of Commons David Ennals announced that only 17 closures have been referred to him for decision because the CHC concerned objected to the proposals. Is this so surprising when the experience of CHCs such as Brent and Wandsworth and East Merton who have opted for the thorny path of opposition to closures is that whatever the rules of the game are it will always result in victory for the health authorities?

Whilst the CHC can delay a closure, by objecting, so that the decision has to be referred upwards through all the tiers to the Secretary of State, the time necessary for this public exhibition of gamesmanship means that inevitably staff morale pitches to an all-time low leading to premature resignations. Local GPs stop referring patients to the hospital concerned and in effect the hospital almost closes itself. Although individual hospitals such as the Elizabeth Garrett Anderson and the Hounslow Hospital may stage work-ins they are dependent on mass publicity to whip up public support to ensure that patients continue to attend for treatment. In addition they are forced to rely on donations and union support to provide the funds to run the hospital and meet staff wages because even the most dedicated staff have to eat!

In fighting to keep the Weir Maternity Hospital open the Wandsworth and East Merton CHC used every weapon in the community activists' armoury which included setting up the Weir Campaign Support Committee to unify trade union and community support for the hospital and to provide an alternative base for those CHC members who were not prepared to play the game the AHA's way by exchanging sets of documents opposing and counterposing all the various arguments in the NHS version of the square dance.

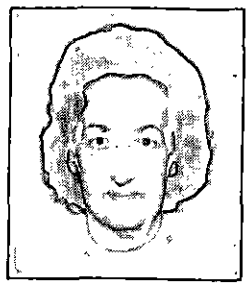
So what are the lessons of the Weir Campaign and other closure battles? Firstly, that if AHAs are determined to run down hospitals and then claim they are under-used and must therefore be closed, there is little that CHCs can do to stop them even if the CHC has enlisted considerable community and trade union support.

Secondly, if after fully examining proposals CHCs decide to object to closures, they will require more resources than the pitiful levels of staff and finance that they have at present to respond to the flood of propaganda put out in favour of closures.

Finally, if CHCs are tied down with the consideration of closures they will be effectively constrained by limits of time and resources from taking up other issues on behalf of patients. In fact, closures represent the most effective way of muzzling even the most militant watchdog because for all the effect that community protest has had we might just as well have stayed at home.

PERSONAL VIEW

Some 'nuisances' are justified



Gwen Davey, Secretary of Newham Community Health Councils

Personally writing and compiling our Annual Report seemed to take even longer this year, and at one point I felt that it would never reach publication stage. It does however give one an opportunity to analyse or self-question the work and progress of one's Council and to "monitor" oneself. I also found it very difficult to avoid the use of this word and the many cliches which are often used when CHC matters or health service problems in general are discussed.

We are always hearing "the Health Service will never be able to meet the demands on it" or, another version, "the needs can never all be met" but if this is true then it is a very alarming attitude because I am of the firm opinion that there are many people who are not making the demands on the NHS which they should.

While there are many who "repeatedly go to their family doctor for advice on colds or other slight ailments which they could easily treat themselves", there are a greater proportion who gradually sink into chronic illness because they "do not want to be a nuisance". What will happen to the "shuddering NHS" if they are persuaded that it is more sensible to ask for medical treatment before this situation is reached.

Elderly people particularly are prone to this attitude and in my own district they seem to be prevalent. The legacy of the War in which every house in the Borough of West Ham sustained bomb damage has resulted in a massive building programme and the break-down of family units. Many people born in the Borough and bringing up their families here now see a major exodus of young people as they move to other areas on marriage. Older residents are left living on their own and are trying to keep their family home going on very limited incomes. These are some of the people about whom my CHC is so concerned and who can easily slip through the NHS/Social Services net by their determination to remain utterly independent.

In the health centre in which the CHC office is located, a pilot scheme has been started whereby elderly patients are regularly medically examined so that early treatment can be started if necessary, and prolonged medication is often avoided. These are the sorts of "demands on the NHS" which I feel should be widely extended to cover as many people as possible, particularly those over retirement age. If the NHS cannot adjust to meet these needs then it is failing in a basic requirement. I do not believe that such a policy would turn us into a nation of hypochondriacs, indeed it could even prove a financial saving in the long run.

My CHC has always shown a great interest in health education and preventive medicine and has arranged joint exhibitions with our Health Education Department but, though this opened the way for discussion with specific groups, the problem of making individual people health conscious and aware of the help which the NHS can give in the early diagnosis and treatment of illness remains unsolved.

So now our Annual Report is ready for publication I am at the stage of asking "Where will our priorities lie in the forthcoming year?"

I hope that we shall become more involved in encouraging people to use the NHS in order to avoid illness and to enlarge our interest in health education. Perhaps we shall not then be regarded as "doctor bashers" or solely as a "complaints agency" by those who ignore our role as an advisory and consultative body.

News from CHCs

● A No Smoking Day in Camden is being arranged by the borough's two CHCs, in collaboration with the National Society for Non-Smokers. The day will be on Ash Wednesday, 8 February, and CHCs wanting to make this a national effort should contact North Camden CHC.

● Cardiff CHC has set up an education sub-committee, which is planning a series of talks to improve public understanding of health and disease, treatment and GP services. The sub-committee hopes to involve local GPs and consultants in its work.

● Southend CHC's annual report for 1975/76 has not yet received any public comment from the AHA, notes the Council in its 1976/77 annual report. It asks the AHA to reply publicly as required by law.

● A complaint made to Aberconwy CHC has helped to clear up a long-standing health hazard, caused by fumes from defective gas fires on a local council estate. CHC Chairman Roy Owen, who is also chairman of the local authority's environmental health committee and a member of the housing committee, took up the case and repair work is now under way.

● Oxfordshire CHC has distributed 5,000 leaflets about the problems of opening the new teaching hospital. Local voluntary organisations were invited to reserve places at a public meeting and more than 200 people attended.

● Southmead CHC has done a small, informal survey of public views about GP services. It showed that patients whose GPs had their own surgeries could get home visits more easily than people with GPs based in health centres.

● Other CHC surveys include: glue-sniffing by young people (St Helens and Knowsley); attitudes to smoking regulations in health service premises (West Essex and District); hospital visitors' views on visiting arrangements (Neath and Afan); recent inpatients' views on after-care (East Roding); community care of the elderly (West Birmingham); views on proposals for changes in hospital services (Haringey), and views on priorities (Isle of Wight); and patients' views on hospital conditions (Swindon).

● A local medical committee has challenged the appointment of a CHC Secretary as an FPC lay-member. Colin Hobbs, Secretary of Rhymney Valley CHC was nominated to Mid-Glamorgan FPC in his capacity as a county councillor. The LMC protested to the Secretary of State for Wales that the appointment threatened the confidentiality of the FPC's work, but until the Welsh Office clarifies its policy, Mr Hobbs will stay on the FPC.

● Northampton CHC has proposed to the DHSS that the health service should raise extra revenue by charging hospital in-patients for food and board. The CHC feels that many people would find such charges acceptable, provided that treatment continued to be free. It notes that deductions are already made from the pensions of long-stay geriatric patients on a similar basis.

● Swansea/Lliw Valley CHC has tried an unusual way of assessing public opinion about fluoridation. A 'public notice ballot' was placed in a local evening paper, for readers to cut out and return. The survey cost £150, including the newspaper space. 76% of the 1092 respondents were against fluoridation although the CHC acknowledges that there are several difficulties and inadequacies in this form of survey.

THE WAY FORWARD

In September this year, three important policy statements were issued. First there was the publication of *The Way Forward*, the sequel to last year's consultative document on priorities for health and social services. Second there was David Ennals' speech in Manchester about continuing the policy of resource allocation following last year's report *Sharing Resources for Health in England* (known as the RAWP report). And third there was the publication of *Reducing the Risk:* a discussion of safer pregnancy and childbirth in the wake of last year's booklet *Prevention and Health: Everybody's Business.*

These three statements are summarised on this page. This article is intended to be a more general introduction to their importance and relevance for community health councils. Of course there may be much in the policy statements that will meet with disagreement and criticism, which this article does not aim to ignore. Rather, it tries to explain that the statements can usefully be seen as a further stage in efforts to create publicly debated policies about how, when and where taxpayers' money should be spent in the NHS.

THE POSITION BEFORE 1974

From 1948 to 1974 the National Health Service was a three-armed system covering (1) family practitioner services, (2) local authority community health services and (3) hospital services. These three parts only came together at the top — at the DHSS (or Ministry of Health before 1968). Planning of a kind went on within each of three arms, but it was very piecemeal and unsophisticated, and no-one is really proud of it today. The services were each as good (or as bad) as they were because of the skills and commitment of the various professional and administrative staff concerned. Health ministers were not able to work on the basis of much comprehensive information about patterns of health or distribution of services.

The result was that by 1974, no-one could any longer ignore the problems which were growing larger every day, nor could they ignore the fact that solutions to these problems were alarmingly few and far between.

It was in this context that the administrative structure of the NHS was reorganised in 1974, and for the first time the health authorities were given responsibility for running the services on a more integrated basis. The family practitioner services were still allowed to remain relatively separate but the hospital and community services were brought under one administrative roof, thus paving the way for the services to be more closely dovetailed than in the past.

Another relevant aspect of the reorganisation was the introduction of a formal planning system giving specified responsibilities to health authorities, to advisory and consultative bodies, and to civil servants and ministers.

THE PLANNING SYSTEM

As we now know, the introduction of the planning system was delayed until April 1976 so there is not yet much practical experience of it. For many people involved in the NHS — both lay and professional — this is the first time they have had anything to do with formal planning. It is not surprising that the system still seems like a monolithic, bureaucratic monster. Only with time and a lot of effort will the system be transformed into a useful tool for guiding the endeavours of everyone concerned towards a set of agreed explicit goals.

The biggest immediate problem facing the NHS in 1974 was lack of money, of course. The economic crisis that hit the country had one major effect on the NHS — it meant that for the very first time extensions of existing services or creation of new services could only proceed if the costs could be found *within* each year's allocation.

We tend to forget too easily that before this time, underspending and overspending were not taken very seriously, and money was not shared out on a rational basis — usually those who could shout loudest did rather better for themselves.

The discipline of cash limits is now forcing the NHS (as well as other public services) to plan seriously for the first time. But another factor was the realisation that the NHS was falling short of its prime aim of achieving a comprehensive health and prevention service for the people of England and Wales. Pockets of geographical deprivation, identification of so-called "cinderella" services and, equally important, industrial relations problems really came to the fore at about this time.

THE CURRENT POSITION

So it was at last recognised that these problems should be honestly faced — not dealt with superficially and not swept under the carpet. In the period since reorganisation we have seen considerable efforts to improve things — such initiatives as the first priorities document *Priorities for Health and Personal Social Services in England and Wales*, the resource reallocation policy RAWP, the health education policy, as commenced in *Prevention and Health*, and of course the Royal Commission.

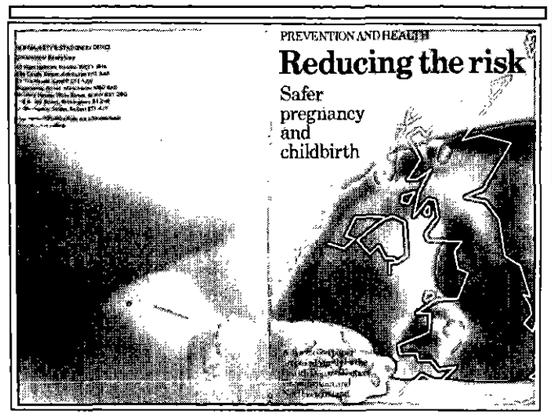
This autumn we can see the next step in the three policy statements mentioned at the beginning.

It is important to recognise the status of each of these national pronouncements and publications, and to be clear about how they are meant to affect us locally. They are not immutable orders from an all-powerful all-knowing central administration. Rather they are firmly-backed suggestions which are offered to each authority and each party within that authority for consideration and debate.

The NHS is (believe it or not) being run on the principle of consent, within the overall context of government policies. So disagreements can and are bound to arise: many people are critical of these policies and can find considerable fault with them; others feel frustrated at the difficulty of influencing the centre and at the time it takes for any changes to be implemented.

These feelings are quite rational and serve to illustrate how difficult it is to actually balance the needs of workers and users in a nationalised health service. If anyone expects the government to get it all absolutely right every time, they are in for a long series of disappointments. If CHCs for their part expect their local health services managers to make faultless decisions and provide faultless services, they too will be disappointed.

But a system based on consultation and consent, despite the drawbacks just mentioned (and many others that have been left out), does have one redeeming factor — it does at least acknowledge the ability of each party to contribute to and influence changes. As CHCs become more familiar with these policy statements and see them for what they are, they will be better armed to argue for improvements locally — armed with facts and figures, with comparative information, with historical details and, above all, their statutory right to be involved on behalf of the public.

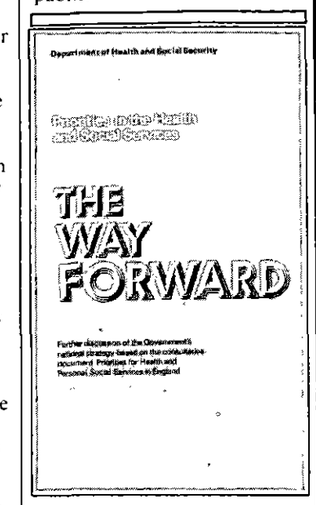


55-page booklet issued with circular HC(77)36, September 1977, as a discussion document — no apparent closing date for comments to be in to DHSS.

Overall aim of the booklet is to discuss how preventive action can be taken before conception, throughout pregnancy, at delivery and after birth, to ensure that as healthy a baby as possible is born into a well-prepared family.

Note particularly the descriptions of latest developments in genetics and pre-birth diagnosis; the case for hospital delivery in preference to home confinements; discussions of induced births and breast feeding.

Conclusion: "If this booklet does not lead to action it will have failed in its purpose. Members of CHCs will wish to discuss with health authorities and professionals how local performance with regard to maternal and perinatal mortality rates compares by reference to experience in other areas. Together they will wish in particular to examine the possibilities of improving local preventive services and ensuring continuity of care both at hospital and in the home so as to reduce mortality and handicap."



27 pages of text with five figures, followed by 23 pages of appendices

Chapter 1 explains why national priorities need to be set; says that they are not specific targets to be reached by declared dates in any locality. Not all the priorities will be reached within the next decade.

Chapter 2 describes the actual priorities under three headings: prevention, community care, hospital services. Note particularly new suggestions on health centres and community hospitals.

Chapter 3 suggests action to be taken. Note particularly DHSS guidelines on bed/population ratios, and the admission that expansion of acute geriatric services may have to be postponed until other acute services have been rationalised.

Specific references to CHCs are made in paragraphs 1.1, 1.10, 2.1, 3.15, 3.19, and para 7 of Appendix 1.

45 CHCs commented on the 1976 Priorities document.

Appendix 3 contains very useful references on better uses of resources.

DAVID ENNALS' SPEECH

Keynote speech made on 27 September to health and local authority members and staff.

Theme of speech is to link the policies of resource allocation and priorities together by discussing three particular problems: the elderly, long stay hospitals and closures. (He also identified some specific suggestions for making savings.)

ELDERLY: Questions what the balance should be between acute hospital services, residential homes, day care, rehabilitation etc. and mentions the problem of recruiting sufficient medical and other staff to work with old people.

LONG STAY HOSPITALS: Acknowledges that progress on getting rid of the old psychiatric, mental handicap and geriatric, institutions is too slow. States that these hospitals can only be replaced if three conditions are met: (1) sufficient money in order to finance alternative methods of care; (2) acceptance of the policy by local communities, i.e. a willingness to see day facilities, hostels, training facilities and occupation centres ". . . in the roads where we live"; (3) wider support from professional and public opinion for these changes even though other services may attract wider interest.

CLOSURES: Strong restatement of the need for professionals, unions, CHCs and others to accept necessary closures if they want to see other developments occur. Concludes: "But no hospital can be closed without full consultation. Public opinion must be heard; and here the community health councils, as representatives of local people, have a vital role. If the CHC is opposed, a closure cannot go ahead unless the Secretary of State agrees to it. I am the final court of appeal and I can assure you I will agree to no closure proposal that lands on my desk unless I am satisfied with the alternative services to be provided for people in the area concerned."

Ruth Levitt

Ruth Levitt will be leaving CHC NEWS on 31 January 1978 to take up appointment as a Lecturer at the School for Advanced Urban Studies in the University of Bristol.

To become editor of a new journal in your mid-twenties:

To appoint an editorial staff and share with them the planning and writing demanded:

To establish the web of an information service:

To be the one link uniting 229 highly individual CHCs developing concepts which are new, and not automatically welcome to the health services:

These have been Ruth's achievements during the last two years.

She has worked with determination and skill, and with considerable knowledge of the health service. Above all, she has undertaken this with a grace, sympathy, and good humour which have endeared her to the many officers and members of CHCs who have come to depend on her.

Our loss on her departure from the editorship to which she was appointed in April 1975 will be obvious to all who read and value *CHC NEWS*. We owe more to her in this formative period than this note of gratitude and goodwill can convey. We hope she will be happy in Bristol. Her students are going to be very fortunate.

Gordon S. Bessey

CHC NEWS

NOVEMBER 1977 **No 25**

126 Albert Street, London NW1
01-267 6111

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CHC NEWS is distributed each month free of charge to members and secretaries of Community Health Councils in England and Wales. It is also available to subscribers at £2.50 per annum (or special discount rate if five or more copies of each issue are ordered). Special and overseas rates on application.

Published by the Association of Community Health Councils for England and Wales, designed by Ray Eden and printed by The Chesham Press Ltd., 16 Germain Street, Chesham HP5 1LJ.

BOOK REVIEWS

ADULT TRAINING CENTRES IN ENGLAND AND WALES

by Edward Whelan and Barbara Speake, 1977. Available from Dr E Whelan, Hester Adrian Research Centre, The University, Manchester M13 9PL, price £2.15 inc. post.

Adult training centres (ATCs) provide training opportunities for mentally handicapped adults. They were developed following research done in the 1950s which showed that mentally handicapped people were capable of certain types of industrial work when given the opportunity and proper training. Most of this work involved hand assembly tasks which were sub-contracted to the ATCs.

By the 1970s however it was realised that a review would be necessary, partly because insufficient work could be obtained by the centres and partly because the system was not really providing adequate training. The 1971 White Paper *Better Services for the Mentally Handicapped* emphasised a new and improved role for ATCs as the focus of community-based services for mentally handicapped adults and their families, and it set a target for more than double the number of training places that were then available.

But little was known about ATCs: how they perceived their purpose, what facilities they had and how they operated. So a survey was funded by the DHSS and this book is the report of it. 338 of the 400 ATCs completed the authors' questionnaire which covered all aspects of their activities and staffing. The authors comment step by step on the findings and make fifteen specific recommendations. The book should be a useful guide to CHCs that are interested in their local ATC.

UNDERSTANDING CANCER: A GUIDE FOR THE CARING PROFESSIONS

Edited by Ian Burn and Roger Meyrick, HMSO, £2.

This 100-page booklet aims to help members of the nursing, social work and other caring professions increase their understanding of cancer. Authors of the 19 chapters have been chosen both for their specialist knowledge and for their ability to write simply for lay-people. Each chapter scores highly on clarity and brevity, and the result is a booklet which would also be a helpful introduction for CHC members and for the interested lay public generally.

Chapters deal with emotional, medical and scientific aspects, epidemiology, diagnosis and screening, surgery, radiotherapy and chemotherapy, nursing and social work, rehabilitation and terminal care. The foreword emphasises that "if we did no more than use existing methods to their full potential the mortality from cancer would be reduced appreciably. We fail to achieve this due to a combination of ignorance, delay and inadequate facilities, but gradually the situation is improving".

AVOIDING BACK TROUBLE

£1.75 (incl. post) from Consumers' Association, 14 Buckingham Street, London WC2N 6DS.

Back pain 'seems to be a feature of technically advanced communities in which people have also become less tolerant of pain' and is much more common than in the past. This book explains the causes of back trouble, with simple diagrams and a minimum of technical terms. It concentrates on the commonest area of pain, the lower part of the back. There is a chapter explaining the kinds of investigations which may be made to find out the cause of the trouble, and one on the forms of treatment.

The section on avoiding back trouble, with tips about bending, lifting, carrying, sitting and standing in the course of everyday activities such as gardening, housework and driving is especially recommended.

NEW SCOTTISH ASSOCIATION

SPOTLIGHT ON SCOTLAND

Twenty-six of the forty-eight local health councils (LHCs) voted in favour of the establishment of a Scottish Association in Edinburgh on 30 September.

Seven councils voted against the proposal and the rest abstained or were not represented. The meeting adopted a constitution for the Association that had been drafted by a Steering Committee of LHC Chairmen. It is similar to the constitution of the English and Welsh Association of CHCs in several respects.

Funds will be obtained partly through subscription from member councils and partly through a contribution from the Scottish Home and Health Department. The first President of the Association is Mr David Currie, Chairman of Western District (Glasgow) LHC, who was Chairman of the Steering Committee. Rev Frank Smith of West Fife Local Health Council was elected Vice-President.

A Standing Committee will be formed annually consisting of fifteen members — one chosen by the LHCs within each health board area — and will include the President, Vice-President and immediate past President.

Two observers elected from the Association of LHC Secretaries may attend Standing Committee meetings in a non-voting capacity.

The Association's acting Secretary/Treasurer, Mr Duncan MacGillivray (an officer seconded from the Common Services Agency), presented a draft budget which estimated a cost of £10,600 in the first year including the salary of the permanent part-time Secretary/Treasurer. Edinburgh LHC recommended that the Secretary should be a full-time appointment but the meeting was divided. The budget will therefore be considered by the Standing Committee as soon as it is formed.

Health Minister warns Councils

Mr Harry Ewing MP, Scottish Under Secretary of State for health, devolution and education, spoke to Local Health Councils at the inaugural meeting of their Association. He wished the new Association well and pledged the Government's support for local health councils.

"I think Councils will be more effective if they have a national perspective", he said, "and I hope that this will come as a result of the information and research service which the Secretariat [of the Association] will provide. I believe there is everything to gain from closer links with officials of my department to discuss general trends and principles. . . . For our part we shall look to the Association to provide an informed consumer reaction to policies and proposals which are to be applied nationally."

But Mr Ewing cautioned LHCs on their response to health board proposals for the rationalisation of resources. "It is not good enough to applaud the aims of *The Way Ahead* [Scotland's priorities document] and yet to protest when it is proposed that the services in an expensive GP maternity unit with only 30 per

cent bed occupancy should be provided in another hospital."

He echoed the views expressed by Mr David Ennals in Manchester earlier that week (see page 6). Mr Ennals hit out at those who saw every hospital closure as a tragedy and a weakening of the health service. He insisted that the standard of patient care could only be maintained if surplus hospitals were closed and services regrouped in a more efficient way.

Too many doctors?

Arthur J Willcocks, B.Com., Ph.D., Professor of Social Administration, University of Nottingham

The expansion of many existing medical schools and the development of new schools with their attendant hospitals, is adding to the resource problems of many regions and areas, already under pressure from restricted budgets. It is, therefore, inevitable that some people are asking if we are training too many doctors: unfortunately our information on patient needs and manpower resources is too rudimentary to provide a definitive answer to this apparently straightforward question. I want in this essay, not to seek for an answer, but rather to pose some of the fundamental issues that underlie any answer to the question on which analysis is anything but simple.

To take first a simple proposition: assuming the need for medical care is measurable in standard units of medical care, the number of people needing such care at any point in time will give the amount of care required. If, then, there is a person called a doctor who provides a certain number of such units of care in a period of time, the need for such persons now and in the future is a relatively simple calculation. The unreality of such a simple equation is obvious: let me examine some of the areas of this unreality.

Medical care needs cannot be expressed in terms relevant to a common unit of manpower, the doctor: instead the patients' needs for care will involve a range of medical specialists who are rarely interchangeable. Indeed one of the major ironies of today is that the distribution of the greatly increased number of doctors throughout the specialisms does not coincide with the needs of the population.

Two major areas of patient need, for example, are in the fields of the elderly and the mentally ill, but both specialties that deal with these patients' needs are in short supply. Will, therefore, the increasing number of doctors produced by medical schools mean more doctors willingly choosing these specialisms, or is it unrealistic to expect the extra doctors to choose different career specialties from their predecessors? I suspect the position of these unpopular specialties will be worsened as the increasingly high intellectual standards needed by medical recruits produce doctors finding insufficient intellectual satisfaction in these shortage specialties.

On a different but related point, extra doctors will not necessarily lead to a solution of the problem of the geographical maldistribution of doctors. Unless forced to do otherwise, it seems likely that the extra doctors will follow (or want to follow) the geographical choices of their predecessors. Whilst there remains the possibility of wider geographical choice through emigration (and new territories are now opening up in the Common Market countries), it could be that attempts to 'force' doctors to the unpopular areas by resource and finance control will turn many of them away to other countries. The unpopular areas and specialties will be left to rely on immigrant doctors, a source of recruitment with a limited future.

At the patient end of my equation, the need for medical care is neither standard nor static: many factors are at work to change the extent of the need for medical care — numbers, age structures, morbidity patterns and much else. Some of these may, to an extent, be predictable, but less so and, in some senses the more important, is what one might term the 'lay expectation' of medical care. If we come to see a condition as a medical problem, we, the public, thereby re-define our medical needs and the demands on the medical profession. There is little doubt that our concept of illness has widened over the years and will probably continue to do so: there is a time lag effect in that much illness is still not taken to the doctors because, in some cases, the sick person has not accepted the redefinition of illness.

If this diagnosis has any element of truth about it, then we need more doctors to meet the widening definitions of illness: or do we? Firstly it seems legitimate to ask if we are re-defining illness too widely in terms of the services of a doctor. Already for many minor conditions we set, in effect, a sub-category of non-doctor illnesses which we look to the chemist, the medical dictionary, the folk remedy to cure (if indeed a cure is needed). My belief is that we should look at this area of self-medication more carefully and see how far, without undue risk, it could be extended, thus reducing the need for doctor care.

By the same process we should perhaps recognise that there may be groups other than doctors who are better agents of cure for some of our problems — the priest, the social worker, the district nurse and so on. Put another way, are we demanding too many doctors by using them for jobs better done by others, often those who are less expensive and time-consuming to train? I find it difficult to resist the feeling that we have or seek too many doctors because we misuse their skills, but unfortunately our current knowledge does not enable me to even estimate the over-supply. We may do better by seeking alternatives to doctor care than trying to get still more doctors.

My equation of need for and the supply of medical care must be set in the wider context of total labour force and the economy. A labour force must be used to produce not only sufficient wealth (whether measured in money terms or in terms of goods) for the workers themselves but also for the non-productive workers — the civil servants, the teacher, the doctor, etc. In recent decades that part of the labour force that has expanded most rapidly has been of those employed in the non-productive areas of social policy, straining the balance between the wealth makers and the rest.

There must be a limit to the extent of this balance; a point at which more non-productive workers only reduce the amount of wealth available for each person. We may soon have to face this kind of dilemma in that future doctors may be at the expense of the shared productive wealth. The same argument applies to the economic system: more spending on health care means less on other headings, and I often wonder if, as a nation, our priority for health is strong enough to see much more switch of resources in this way.

Too many doctors may appear an error on the right side, but they can only come at the expense of other developments. Our current knowledge of medical needs, our cultural predilection for medical care and the laissez-faire nature of much of the system of manpower allocation, leaves some measure of anxiety and fear that we might be getting too many doctors in the not too distant future. If some of the money spent on training perhaps 20 or 30 such doctors was directed to research into some of the issues raised here, we could, in the long run, be better off.

Delivering the goods in the maternity dept

Chris Wolvin, Secretary of Crewe CHC

What does the Community Health Council do when two groups have apparent differences in philosophy and outlook? What happens when these groups meet head-on and the person who suffers is the patient?

In the autumn of 1976 I received a number of complaints from mothers who had had unfortunate experiences in our local maternity department. These mothers had undergone their ante-natal preparations with the National Childbirth Trust, an organisation with what might be regarded as radical ideas, but which were widely acclaimed. The National Childbirth Trust is an organisation which aims to help women have their babies happily and without fear. The Trust supports the idea of natural childbirth, free whenever possible, from medical intervention, with the expectant mother remaining in control. Many hospital staff prefer to be in control of the labour and delivery with the expectant mother being a co-operative partner.

These mothers felt that during labour and delivery they were not encouraged by the hospital staff to put into practice what they had been taught at the National Childbirth Trust classes, and in some cases they had been positively discouraged. This had caused some distress to some of the mothers. One woman said that a ward sister took away her confidence by expressing the opinion that Trust classes were pointless and that she would *not* be able to cope with the contractions. The woman went on to say that the sister made some cynical remarks about one of the Trust publications that the woman had with her.

Crewe CHC never set out to support either side, but to promote better understanding and better communications. The Council set out to get the two sides to talk to each other to the benefit of the mothers. The Council first wrote to all the people involved, the consultant obstetricians, senior nursing staff, and the local branch of the National Childbirth Trust. The Council suggested that from the evidence of the complaints it appeared that the preparation classes run by the Trust and the expectations of the hospital did not, in the end, meet the needs of the mother. The Council's concern was that the patients, in this case the mothers, should come first, and their interests and well-being, both physical and mental, should be preserved. The Council further suggested that both sides should meet to discuss the problem, an idea warmly welcomed by all concerned.

The Council therefore, acting in an independent capacity, arranged for some local representatives of the National Childbirth Trust to meet the staff of the maternity department. I chaired the first study session during which an NCT film was shown and the hospital staff were able to ask questions about the Trust. It soon appeared from the lively discussion that followed, that instead of being poles apart, the two groups in fact had many things in common.

Since that first session there have been more meetings during which the Trust representatives have been able to explain their methods. From this first initiative other sessions are now being held in hospitals in neighbouring districts and the hospital staff are participating in the ante-natal classes.

Tory views on CHCs

Alan Gill, Chairman of Darlington CHC

I was very concerned to learn from the July issue of *CHC NEWS* that six Conservative MPs, including Dr Gerard Vaughan and Mr Patrick Jenkin, had tabled a motion seeking the annulment of the regulations to establish a national association of community health councils.

I therefore wrote to Mrs Thatcher because in view of the present political uncertainty I think community health councils have the right to know where the Conservative Party stands on this matter and, indeed, on their attitude to CHCs generally.

I received a reply written by Dr Gerard Vaughan which stated that the Prayer was put down mainly in order to get a debate on the subject, but also because the Conservatives were very dubious about the national body. "Not only will it be expensive to run, but the whole purpose of the CHCs was that they should be local; we fear that once you start a national body they become remote and the views they give are not related to local circumstances," he says.

I feel that when the total budget for the National Health Service is taken into account, the cost — including a national association of CHCs — is infinitesimal. Dr Vaughan also says that ". . . subscriptions may have gone up from £60 to £120, and of course all this comes out of local pockets. It seems unnecessary that at a time when community health councils are having to justify the considerable amount of money spent on them (i.e. £4 million per annum) that we should establish another level of administration." In my view a national association for CHCs cannot fairly be described as another level of NHS administration.

Dr Vaughan's letter ends by saying "We are, as a party, in favour of community health councils and would want to see them continue . . ." and I welcome this, but I do not think it indicates wholehearted support. He also says ". . . community health councils vary a great deal in different areas, some are working well but in other places they have not yet settled down and there are signs that in these places where there are difficulties they are not managing to function effectively. We support CHCs but we would like to see them all working well as we believe very strongly that there is a need for a local community watch dog."

It seems to me that to do their job properly CHCs must act in the public's interest. There seems to be an implication — perhaps not intentional — that some CHCs are at fault because they have had to say or do unpopular things to achieve this; which is unsatisfactory. I am not, in any case, convinced that completely settled down CHCs are what is needed or what was intended.

My overall concern at this correspondence led me to write to the Association of CHCs asking them to discuss the matter at the September meeting of the Standing Committee. The Chairman, Mr Bessey, agreed to take the matter up, and has written to Mrs Thatcher in order to clarify some of the misunderstandings which are perceived in Dr Vaughan's letter. Mr Bessey explains that ". . . matters are continually arising which are common to many if not all CHCs and which can best be pursued at national level. It is also clear that CHCs have views on national issues arising in connection with the National Health Service which can most effectively be focused and taken up by a national body. But this does not mean that the individual CHC will in any way be prevented from expressing its own view, and the constitution of the Association specifically seeks to guard against any infringement of the rights of the individual CHC."

His letter deals with all the other points arising from Dr Vaughan's letter, and will, I hope, put the record straight.

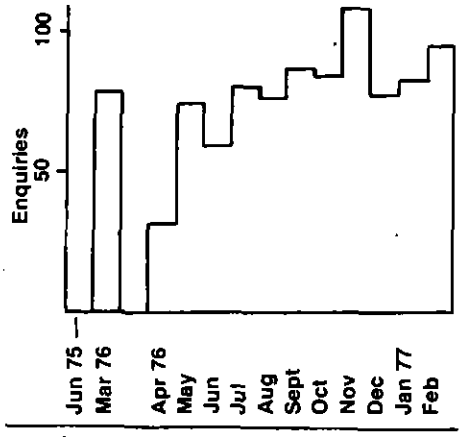
One year of the Information Service

Since May 1975, when *CHC NEWS* was first published, an information service has gradually grown up around the magazine. As part of our work we can answer enquiries about the health service, CHCs, health and illness, and related matters. Where necessary we can refer enquirers to more specialised sources of information, eg through our legal advice service (see *CHC NEWS May 1977, page 3*).

Currently we are handling about 100 enquiries per month — from CHC members and staff, voluntary bodies, health service workers, and the media.

In March 1976 we began to prepare monthly analyses of our information work, and in this article we summarise the first year's figures to show what kind of queries we handle and for whom. We hope this will encourage more readers — especially CHC members — to take advantage of the service.

FIGURE 1: MONTH-BY-MONTH WORK OF THE INFORMATION SERVICE



In the first twelve months 934 queries were answered, and the month-by-month analysis (Figure 1) shows an upward trend. The types of information given are shown in Figure 2. A complete list of subjects dealt with would take up most of this page, but these include surveys and research health centres, joint finance, private practice, family practitioner committees, resource allocation, hospital closures, Scottish local health councils (LHCs), and patients committees.

Of the year's queries, 59% were from CHCs but only 6% came direct from CHC members. Some of the queries from CHC staff may have originated with members, but we think members might find it helpful to make greater direct use of the service. 36% of the year's queries came from other organisations, including LHCs and voluntary organisations, and from individuals. The remaining 5% came from the media.

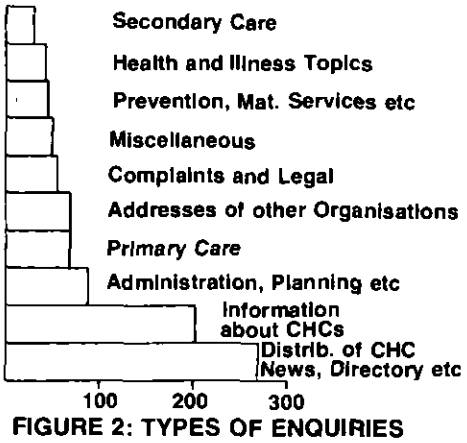


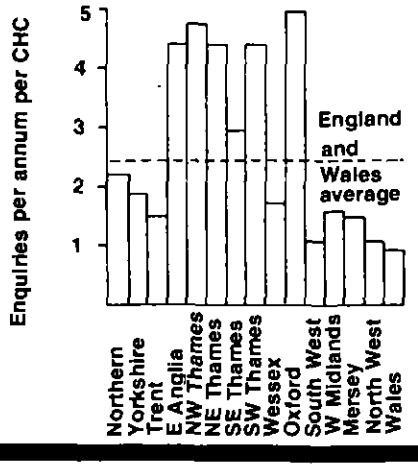
FIGURE 2: TYPES OF ENQUIRIES INFORMATION GIVEN

Figure 3 shows that the information service was better used in some regions than others. In the Oxfordshire region, for instance, the "average CHC" asked almost five questions during the year, but in Wales the figure was under one.

In the *CHC NEWS* office we have built up an information bank from which many of the queries we receive can be answered direct. Readers are welcome to use this material themselves, preferably by making an appointment before calling. It includes collections of reference books, reports and DHSS circulars, and the annual reports of most CHCs.

We also subscribe to a commercial cuttings service, which sends us about 900 cuttings a month from daily and weekly newspapers in England and Wales. In this way we see virtually everything that is said about CHCs in the written media. A recent DHSS evaluation of one week's cuttings showed that 43% of all CHCs had news stories or features published about them during that week. The main subject that currently attracts newspapers' interest appears to be CHCs' involvement in NHS closures and shortages.

FIGURE 3: REGIONAL USE OF SERVICE, ADJUSTED TO ALLOW FOR THE NUMBER OF CHCs IN EACH REGION



Parliamentary Questions

CHILDREN'S VITAMINS

From 14 November 1977 a bottle of children's vitamin drops will go up by 1p to 9p, and the price of vitamin tablets for expectant and nursing mothers by 7p to 17p, Eric Deakins told Laurie Pavitt MP. Entitlements to free vitamin supplements will be unchanged.

BOUNDARY CHANGES

Major changes in management structures are ruled out until the Royal Commission on the NHS reports, David Ennals told John Cartwright MP. However, changes such as mergers of districts might be approved if the Minister was satisfied that "the proposal would lead to a more effective delivery of services and improved management efficiency (and) that there had been full and adequate consultation with staff and with district management, local authorities and CHCs".

OPTICAL CHARGES

The DHSS is consulting local and health authorities about the exemption of the registered blind and partially sighted from NHS optical charges, Alf Morris told Michael Marshall MP. The Government intends to legislate for such exemption.

SERVICES FOR THE DISABLED

No ceiling is imposed by the Government for spending on services provided by local authorities under Section 2 of the Chronically Sick and Disabled Persons Act 1970. This assurance was given to Lewis Carter-Jones MP by Alf Morris. The services include day-centres, home adaptations, telephones, holidays, home helps and meals on wheels.

PRESCRIBING FOR OUTPATIENTS

The duty of prescribing to meet an outpatient's medical needs rests with the hospital doctor who has clinical responsibility for their course of investigations or treatment, Roland Moyle told Stan Crowther MP. This duty continues until the patient is returned to the care of the GP. HN (76)69 reminds health authorities of this.

FOOD POLICY AND HEART DISEASE

John Cronin MP asked Roland Moyle several questions about coronary heart disease, obesity and fat consumption. He also asked what dietary recommendations are being publicised. Roland Moyle said obesity may be associated with coronary heart disease and referred Mr Cronin to a Joint Report of the Royal College of Physicians and the British Cardiac Society, "Prevention of Coronary Heart Disease", and the DHSS report "Diet and Coronary Heart Disease" (Health Services Subjects No. 7, June 1974).

NOTES.....

CHANGES TO MENTAL HEALTH ACT

Proposals for changes in conditions of compulsory detention and treatment will soon be made in a White Paper on mental health legislation, David Ennals has announced. The proposals will stipulate "that when detention in hospital is necessary it is for the purpose of treatment and that it is not some disguised form of preventive detention". There will be automatic review of detained patients' cases by Mental Health Review Tribunals, whose procedures are also being examined. There will be more clearly defined authorisation and safeguards for the treatment of detained patients who do not or cannot give their consent. After the publication of the White Paper time will be allowed for more consultation.

MEDICINES COMMISSION ANNUAL REPORT

Labelling on medicines and the possibility of giving patients a leaflet or warning card with instructions about dosage, possible side-effects and precautions have been considered by the Medicines Commission. It recommends in its annual report for 1976 that there should be full consultation with bodies such as the British Pharmaceutical Society, the BMA, the Association of the British Pharmaceutical Industry and the Health Education Council before any schemes are adopted. The commission's report is published together with those of the Committee on Safety of Medicines, the Committee on Review of Medicines, the British Pharmacopoeia Commission and others. (Cmnd 6348, HMSO £1.60.)

GOVERNMENT'S VIEW ON NHS PAY AND CONDITIONS

The government has accepted the recommendation of the McCarthy report *(CHC NEWS 16, p.11)* which suggests limits on the role of DHSS representatives in Whitley Council negotiations for health service employees. In future the DHSS representatives will concentrate on the overall cost of settlements and ensuring their compatibility with national pay policy.

OMBUDSMAN'S REPORT

The fifth report of the Health Service Commissioner covers investigations completed in the period April-July 1977. The majority of complaints concern patient care and more than a third cite failure by professionals or health authorities to disclose information. Two concern health authorities' decisions on fluoridation. Five complaints involved a CHC, directly, or as a party in the dispute. One complaint involved an RHA's failure to discuss with a CHC its counter-proposals for the siting of a special unit for mentally ill and mentally handicapped patients, and the RHA's failure to allow sufficient time for consultation. This is one of the 14 complaints found to be partly or wholly justified, out of a total of 33.

HEARING AIDS

An improved type of NHS body-worn hearing aid will be phased in next summer. Over three years the DHSS expects it will replace three of the current models. Also the scheme to replace old body-worn aids with the more attractive behind-the-ear aids for people with only moderate hearing loss will be extended from the first of this month. Elderly people, so far outside the scope of the scheme, will become eligible.

ALCOHOLISM FILM

A 21-minute film about what it is like to be an alcoholic has been made by Project Icarus, a Hampshire film group which produces health education visual aids. The group has also made two films about drug abuse and one about the effect of scalding on young children. Details from Raglan House, 4 Clarence Parade, Southsea, Hants.

COURSE FOR CHC SECRETARIES

A residential induction course for new and recently appointed CHC Secretaries is being held in London on 13-15 February, 1978, and 16 places will be available. Interested Secretaries should write to the Registrar, Kings Fund College, 2 Palace Court, London W2 4HS, before 16 December if they would like to attend.

DHSS CHIEF NURSING OFFICER'S FIRST REPORT

Covers in useful detail all aspects of NHS nursing in 1974-1976, including the service in hospitals and for children, the elderly and the mentally ill and handicapped. It also discusses staffing and training. Free copies from DHSS, Room D005, Alexander Fleming House, London S.E.1.

HN(77)131: POCKET MONEY

From the 14th of this month pocket money for mentally ill or mentally handicapped hospital patients will go up from £3.05 to £3.50 per week. The rule that health authorities will only make payments to those with no other resources, such as national insurance benefits or supplementary benefits, continues.

HC(77)34: NHS LAND TRANSACTIONS

Accompanies the updated version of the DHSS Handbook on Land Transactions *(see CHC NEWS 22, p.11)*.

HC(77)19: RABIES

Accompanies a Memorandum on Rabies which includes guidance for action in suspected cases, for distribution to GPs, hospital staff and others. (HMSO 60p)

Apologies

We inadvertently left Mr A P Ridley of Wessex and Mrs V Harris of SE Thames out of last month's feature on the Standing Committee. West Midlands has now appointed Mr B Meredith as its second representative, and all three omissions will be remedied as soon as possible.

Directory of CHCs

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

Page 19: Islington CHC
Chairman: Mr E A Pritchard

Page 20: Haringey CHC
Secretary: Mrs Lilias Gillies

Page 24: Lewisham CHC
Secretary: Ms Celia Pyke-Lees

Page 25: North West Surrey CHC
Chairman: Mr K W Wilkinson

Page 27: Sutton and West Merton CHC
Chairman: Mr G J Lambert

Page 33: Isles of Scilly CHC
Chairman: Mrs B Pickup

Page 37: Central Birmingham CHC
Secretary: Steve Burkeman

Page 47: Aberconwy CHC
Chairman: Coun Roy Owen

Page 52: North East Thames Regional Group of CHCs (Chairmen and Secretaries)
c/o West Essex CHC
Bishop's Stortford and District Hospital
Rye Street, Bishop's Stortford,
HERTS CM23 2HB.
Tel: Bishop's Stortford 55863
Chairman: Dr James Fairley
Secretary: Angela Alder

Page 57: North East Thames Association of Secretaries
Convenor: Ron Brewer,
Tower Hamlets CHC,
23 New Road, London E.1.
Tel: 01-247 5454 x 311

Phone book

The Association of CHCs has arranged with the Post Office for every telephone directory to include details of all CHCs in its area. In alphabetical directories, entries will appear under the heading of "Community Health Councils"; in Yellow Pages they will be listed under "Health Services and Hospital Authorities", with a separate "CHC" sub-heading. Individual CHCs need take no action except to check the accuracy of their entries when new directories are published.

Withdrawal of Exhibition stands

Several borrowers of the exhibition stands have reported difficulties in using them. The stands have now been withdrawn from use while possible improvements to the loan system are being considered.