Health Service Public Relations

a guide to good practice

Edited by Roger Silver

King Edward's Hospital Fund for London

HEALTH SERVICE PUBLIC RELATIONS

A guide to good practice

HEALTH SERVICE PUBLIC RELATIONS

A guide to good practice

Edited by Roger Silver

Cartoons by Colin Hadley

King Edward's Hospital Fund for London

Typeset by DP Press Limited, Sevenoaks, Kent
Printed in England by Redwood Burn Ltd, Trowbridge, Wiltshire
Distributed for the King's Fund by Oxford University Press

ISBN 0 19 724628 1

King's Fund Publishing Office
126 Albert Street
London NW1 7NF

Contents

Acknowledgements

My thanks above all to Victor Morrison, Publishing and Press Secretary of the King's Fund, whose many suggestions for editorial improvements have been immensely valuable and invariably pertinent; to Sheila Hill and Carol Curtis who miraculously produced immaculate typescripts from a succession of mutilated drafts as the book grew and took shape; to friends outside the health service whose professional advice was sought and given so readily; and not least to all my colleagues in the health service for their contributions and advice.

I am also grateful to the South East Thames Regional Health Authority for permission to use its advice on public meetings in Section 7, and to the North West Thames Regional Health Authority for its guidance on Royal visits and other ceremonial occasions in Section 8. **RS**

The contributors

The main contributors to this guide and reference book are regional press and public relations officers in the National Health Service in England.

Mostly based at regional health authority headquarters, they give advice, help and support to health authorities, their managers and other senior professional staff throughout the health service in all the subjects covered by the book, ranging from public relations programmes to dealing with the press, radio and television.

They consult closely with each other between regions and with information officers at the Department of Health and Social Security. They also maintain links with public relations officers of local authorities and other statutory and voluntary organisations.

The regional press and public relations officers contributing to the book are:

John Beveridge (North Western Region)
Peter Campion (Wessex)
James Clayton (West Midlands)
Ian Dillow (Wessex)
Peter Dring (South West Thames)
John Edwards (East Anglian)
Derek Hull (Trent)
Steve Hunt (South West Thames)
Neville Jackson (Yorkshire)
Pam Lelliott (South East Thames)
Beryl Martin (Northern)
Knowles Mitchell (South Western)
Andrew Moss (Oxford)
Andrew Partington (South East Thames)
Mark Purcell (North West Thames)
Jonathan Street (North West Thames)

Other contributors:

Gordon Beverley
Paul Castle
John Every
Frank Murphy

Introduction

This guide to public relations has been written for managers of all disciplines at all levels of the National Health Service. It is hoped, however, that other people concerned with health care, from policy makers in the committee rooms to staff in hospitals or the community, will also find it helpful.

The job of health service managers – using the term in its widest sense, as this book does, to include not only general managers but anyone else with management responsibility – is to ensure the smooth and efficient running of the organisation within which health care is provided, whether the organisation is a health authority, unit, hospital, clinic or department. They cannot do that successfully without good public relations.

Many of the managers have specific responsibilities which carry with them important public relations implications – advising members of health authorities, drawing up plans, consulting with statutory and voluntary organisations, implementing policies, managing and coordinating services in hospitals and the community, negotiating with trade unions, dealing with the press, handling complaints. Part of the purpose of this book is to help managers to identify the public relations implications of these and other duties more clearly and to practise good PR more effectively.

Doctors, nurses and other staff in the health service may also find the book relevant and helpful, not so much because many of them are dealing face to face with individual people all the time, but because increasingly – and this applies particularly to doctors – they are expected to represent their service or profession to a wider public or to be involved in the formation of plans and policies which will directly or indirectly affect the local community.

It is hoped the guide will be useful to chairmen and members of health authorities by indicating ways they can improve their own public relations practice and ensure that due attention is paid by their senior managers to this vital element of their authorities' work.

Defining public relations

What exactly is meant by public relations practice? It is *not* about ducking and weaving against journalists, silencing abrasive pressure groups or covering up embarrassing mistakes. It *is* about communicating effectively, fostering goodwill and creating mutual understanding and confidence.

The Institute of Public Relations has described it as 'the deliberate, planned and sustained effort to establish and maintain mutual understanding between an organisation and its public.' It has

defined public relations – as distinct from the practice of public relations – as 'the state of mutual understanding between an organisation or individual and any group of persons or organisations, and the extent and quality of the reputation that exists.'

Public relations involves a determined responsibility to think, listen, inform, explain, discuss and act in the interests of the people served by an organisation. This responsibility becomes a duty and a moral obligation in the NHS which is paid for by the public through taxes and deals with people needing help, often when they are feeling at their most vulnerable and confused.

Part of the purpose of this book is to help managers practise good PR more effectively

Doctors, nurses, therapists, technicians, porters and other health service staff respond each day to this obligation as they go about their work in a way which rarely, if ever, attracts attention except from the people who are grateful for lives saved, limbs mended, babies safely delivered, sight restored and all the other untold successes of the NHS.

Yet, for all these successes, people still encounter surliness, unhelpfulness or bad service. Perhaps this is inevitable in an organisation whose 'customers' are numbered in millions, with hospitals alone dealing with six million in-patients a year. It is also inevitable that an organisation which spends more than £17 billion a

year finds itself from time to time in the centre of some national or local debate (say, about 'privatisation') or a scandal (perhaps about ill-treatment of patients in a long-stay hospital).

Many of these debates and scandals are reflected in, or initiated by, the news media – press, radio and television. This area of public relations more than any other can arouse deep feelings of suspicion, anxiety or anger – or a mixture of all three – among health service managers and other health professionals, many of whom regard the press and the rest of the media as synonymous with trouble. If, as the late Lord Northcliffe said, news is 'what someone somewhere does not want to see in print – all the rest is publicity', their misgivings are probably understandable, particularly if they happen to be the 'someone'.

A manager who will calmly and confidently face up to hostile members at a health authority meeting will tremble at the prospect of an interview with even the most timid journalist, dreading the consequences not only of what he might say but of what he might be reported as saying. Suddenly he feels exposed and no longer in control.

As for 'publicity', as distinct from 'news', he cannot afford to buy space in newspapers or time on television. Sometimes the most he can do is to raid the stationery budget to pay for a leaflet to explain exactly why, for example, his authority is planning to close down this hospital unit or develop that new service – and he may have to rely largely on the interest and goodwill of the media to put his message across to as wide an audience as possible. How accurately or effectively they do that is not within his ultimate power to control.

Positive approach

So, given these constraints, how can the manager and his organisation communicate positively, both inside and outside the health service, in ways which are inexpensive but effective? How can they practise public relations according to the Institute of Public Relations' definitions? How do they cope with disastrous events in the operating theatre or on the 'shop floor' which are bad enough in themselves but which may reach nightmarish proportions as Fleet Street latches on to the story? How can they create a climate of confidence and efficiency within which anything that does go wrong is seen as the unusual and untypical rather than the commonplace and predictable? This guide aims to provide the answers.

But a warning: the answers may make things like producing a leaflet, controlling a hostile meeting or enlisting the help of a nice, friendly reporter seem all too easy. They are not. They can, however, be made less difficult and hazardous by following the advice which is offered here.

The book is divided into two parts:

1 Public relations

2 Relations with the news media

It may be argued that, because of its obvious importance to health service managers, the guidance on media relations should appear in the first part of the book. The second part is, nevertheless, the logical place: good relations with the media are more likely to flow successfully from an organisation which has got the rest of its public relations right, not the other way around.

That said, it is hoped that anyone looking for advice about dealing with the media will not feel obliged to read Part 1 and put all that into practice before talking to journalists. Novel as such an excuse for saying 'no comment' would be, that is not the purpose of the book!

PART 1

PUBLIC RELATIONS

SECTION 1

A question of communication

The public served by the NHS has a hundred and one different faces: the mother-to-be at the ante-natal clinic, the lorry driver at the dentist's, the grandmother at the family doctor's, the child in hospital, the local councillor in the committee room, the businessman at the Rotary Club lunch, the volunteer behind the tea-bar, the Member of Parliament in the deputation. All of them come directly or indirectly into contact with the health service many times in their lives.

The way in which health service managers and staff present themselves to the public can affect the public's view of the service. It is, for example, all too easy for them to forget that people who become patients as soon as they enter hospital for consultation or treatment do not in the process cease to be people. If they are kept waiting for hours they are entitled to no less considerate explanation and apology than they would expect if they were kept waiting for a tenth of the time in a store or a bank.

They are also entitled to be treated with courtesy. If they are not, the price could be damagingly high. A curt and rude booking clerk at an ante-natal clinic may not only create a bad impression on a mother-to-be attending for the first time; she may also, if the woman decides not to return, put the health of the mother and her baby at risk.

Moreover, the mother will tell family and friends about the way she was treated. They in turn will be stirred to recall their own stories – probably much embellished – of rudeness, delays and confusion, and lose sight of the caring, dedication and enthusiasm demonstrated every day by the vast majority of health service staff.

The question arises: why was the booking clerk rude? The reasons might be personal – trouble at home or financial worries – or they might be rooted in the organisation itself. She might be unsuited to the job, inadequately trained, or herself the victim of rudeness and indifference from management – all possibly symptomatic of poor management-staff relationships throughout the organisation.

Mutual understanding with staff

Public relations, like charity, begins at home, and no organisation is in much of a position to 'establish and maintain mutual understanding' with its public if it lacks mutual understanding with its own staff.

Every health service manager has a responsibility to ensure that staff are kept fully informed about any matters which affect their working conditions, job content and prospects. This is especially important in an organisation like the NHS which is subject to change – different treatments, new drugs, clinical innovations, altered working patterns, shifts of emphasis from hospital to community and back again, hospital departments closing, new ones opening.

Every health service manager has a responsibility to ensure that staff are kept fully informed

Staff who are, or feel they are, in the dark about changes become demoralised and insecure. They will not understand change nor cooperate in it unless they are informed, consulted and treated in a way which demonstrates that they matter and that what they say and feel matters.

Managers must take deliberate steps to ensure that staff understand clearly issues which affect them. If they neglect to do so staff will turn to other, probably less dependable, sources or rely on hearsay and rumour. Badly informed staff, with no confidence in their employers or managers, provide fertile ground for irresponsible industrial action and militancy. It is usually no surprise that whatever the overt reason for industrial unrest the real causes are often to be found in a history of poor communication and lack of mutual understanding between management and staff.

The formal staff consultative machinery can be, of course, an important and 'official' source of information, but even that to many, if not most, employees may appear too remote. Communication through that network needs to be accompanied and reinforced by any or all of the following:

Clear information and advice along the management chain.

Staff meetings.

One-to-one counselling.

Prominently and clearly displayed notices.

Newsletters or information bulletins.

Visual or audio-visual aids in the case of major change.

Communication between management and staff should not, however, be seen as an occasional exercise to be embarked upon only in the event of change. It should take the form of a continuing dialogue. Only in that way can mutual understanding be maintained and a sense of identity with the organisation be established among staff.

Springboard for good public relations

Good internal relations can be the springboard for good external public relations. If staff are proud of their organisation and enjoy working in it, they will tell others. For hospitals, this can have an important bearing on recruitment and will influence the attitudes of potential patients. If staff dislike the organisation, its reputation will suffer and the confidence of outsiders will be eroded.

The ultimate 'target' of NHS public relations is, of course, the individual user, but there is a large number of bodies and other individuals who represent or share their interests. They include (not necessarily in order of importance):

Community health councils.

Local authorities, including county councils, borough councils and parish councils.

Members of Parliament.

Voluntary organisations, particularly those with a special interest in the health service, such as leagues of friends.

Other health authorities.

Department of Health and Social Security.

Trade unions and professional bodies.

Press, radio and television.

Schools, universities and other educational bodies.

Community groups.

Commercial and industrial organisations.

They are all part of that 'public' with which an organisation should establish and maintain mutual understanding.

Developing this understanding takes time, particularly for health authorities. They (if not the institutions for which they are responsible) are less well known than, for example, local authorities whose services touch upon the lives of every citizen throughout the year, with annual reminders of who is paying for them. And even those community health councils which conspicuously set up shop in their local High Streets took several years to make themselves known and understood.

A health authority can help people to develop an insight into its activities in a variety of ways, such as:

A simple leaflet explaining its role, purpose, membership, services and relationships with other health bodies, together possibly with guidance on points of contact and sources of help.

A regular information bulletin.

A small portable exhibition.

A video or slide-tape programme.

'Speakers panels' consisting of members and senior officers of all disciplines who are offered as speakers to local organisations.

Meetings with MPs, local council leaders and other opinion-formers, including editors.

Regular meetings with opinion-formers can be a vitally important means of helping them to appreciate opportunities and problems facing a service, and of enabling an authority to take informal early 'soundings' on national or local issues.

The 'targets' for PR programmes

In dealing at any stage with opinion-formers and other interested people, it helps to think of them as various 'publics' concerned with different aspects of the same issue.

Take, for example, a proposal to close a hospital. The local MP may wish to be satisfied that it is in accordance with DHSS policy and that alternative facilities will be adequate for his constituents. People who use its outpatients clinic will want to know where and when the alternative facilities will be provided. The local authority will be interested in the future of the site and concerned that the closure will not put an additional burden on its own services. The league of friends, having invested heavily in the hospital over the years, will be feeling sensitive about their past and their future. The news media will be interested in much of the basic information about the plan and will report on the reactions of the other groups.

These are some of the 'publics' who would be the 'targets' of any public relations programme prepared in connection with such a proposal. They and their particular interests need to be clearly identified. Unless they are, it will not be possible to anticipate or allay their anxieties or work out how best to communicate with them.

Formal procedures for changes of use or closures of health service premises are set out in the circular, HSC(IS)207, in which, as the NHS management inquiry led by Mr Roy Griffiths observed in its report in 1983, '. . . a very great deal of importance is attached to ensuring that the views of the community at all levels are taken into account in any decision'. The report continued: 'The reality is, however, that by any business standards the process of consultation is so labyrinthine and the rights of veto so considerable, that the result in many cases is institutionalised stagnation . . .'

Wide-ranging changes, which may involve the switching of very substantial resources from one place or service to another and have a profound effect on people's lives, are often launched with an obscure consultation document that may be clear to the authors and their fellow-planners but not to other readers: obfuscation leads to frustration and anger, and consultation gets off to a bad start before it even enters the labyrinth.

Problems are compounded as health service managers retire into the lowest of low profiles, justifying their retreat by pointing to the complexity of the issues. But low profiles can be inflated into high profiles as protest groups and the media go into the attack against their favourite enemies – the faceless bureaucrats with their faits-accompli.

A consultation exercise accompanied by a public relations programme which ensures that the different 'publics' understand the proposals and the reasons for them, and gives them an opportunity

to discuss and weigh up the proposals against other, clearly stated options, may still run into opposition, but at least there is a better chance that the opposition will be based, not on sheer emotion, but on reasoned thinking and realistic alternatives.

The programme should highlight the positive benefits to be gained from the proposals. A hospital closure may bring about financial savings and greater efficiency, enabling other services of higher priority to be developed. Every chance should be taken – at authority meetings, in the media, in talks with opinion-formers – to emphasise these benefits.

Coordination and timing

Close coordination between senior managers is vitally important. An over-zealous manager who, without consulting colleagues or superiors, arranges a public meeting to announce and explain the closure of a much-loved maternity unit or the opening of accommodation for mentally handicapped people in a leafy residential neighbourhood, may wonder later what has hit him. Confrontation will be inevitable unless careful groundwork has been done and unless the meeting has been phased into a *planned* programme of consultation and public relations with which every key person in the organisation is made familiar.

Many health service managers make life difficult for themselves by trying to address one interested 'public' to the exclusion of others. The immediate result is that they put themselves on the wrong footing with the excluded 'publics' who feel snubbed and aggrieved. The sense of grievance turns into suspicion and hostility, and these are channelled into protest and resistance.

The more controversial an issue is likely to be the more sensitive are managers about telling too many people about it at once. The motives may be understandable: not wanting to upset staff, embarrass another authority or annoy the community health council. But if one interested 'public' is informed and others are not, the information will 'leak' sooner or later – and the more contentious the subject the sooner it will 'leak'.

The stage at which information is first released and published is a matter of fine judgement and timing. As a general rule, it should be no later than the point at which suggestions or proposals take shape and are ready to be shared with any one of the interested 'publics'.

A fairly reliable formula in the case of potentially contentious issues is this: the greater the desire to keep something secret and the larger the number of people who are allowed to share it, the more important it is to resist the desire for continued secrecy and to release the information in a planned and controlled way.

Presenting information effectively

How information is released and presented will vary according to the target. One of the cheapest and most effective ways is with a simple but attractively presented leaflet which summarises proposals, plans or suggestions, explains the background and reasons for them in clear, concise, jargon-free language, and invites comment. Such a leaflet can be as useful to the professionally interested or involved 'public' in crystallising all the key points as it can in setting them out for the first time to other 'publics'. Moreover, leaflets go easily into envelopes with, say, consultation letters or can be distributed door-to-door without further explanation.

The value of supplying a leaflet – or, alternatively, a statement serving a similar purpose – to all interested 'publics' is that essential information is offered to everyone in a consistent way which minimises the room for ambiguity and misunderstanding. Additional information for groups with special interests can be supplied in a letter or note.

In a major consultation exercise, the primarily interested 'publics', such as community health councils and local authorities, will receive the full consultation documents, which they need to study if they are to give a considered view. It would be too expensive and cumbersome to distribute these to everyone – each local resident, for instance – but whatever information they are given should refer to the consultation document, which should be available on request. A take-up which is higher than expected will be a reflection of public interest and go a long way to ensure that no-one is denied the opportunity to contribute an opinion based on full information.

Public meetings often have an important place in any public relations programme – frequently in connection with a consultation exercise. It is better for the consulting body to take the initiative in organising the meetings than to leave it to the consulted – particularly the angry consulted. The result is likely to be a more controlled atmosphere in which to spell out the reasons for the proposals and to assess public reaction.

The consulting organisation, if it is engaged in a serious and objective public relations programme aimed at achieving 'mutual understanding', will order the proceedings of the meeting in such a way that *every* interested party has an opportunity to comment for or against the proposals. This will best be seen to be done if the organisation appoints a neutral chairman who is respected in local public life for being non-partisan and fair. The meeting will also stand a better chance of success if it is advertised widely well in advance and held at a place and time which are convenient for most of the likely audience.

Exhibitions and audio-visual aids can be used to illustrate and

reinforce plans and proposals, but they should be used carefully as complementary aids, not as substitutes for face-to-face discussion.

Everyday contact with the public

At all points of everyday contact with the public, information should be presented clearly, efficiently and in human terms. In hospitals and clinics the main initial points of contact and information are:

Telephone switchboard.

Reception, waiting and corridor areas of a hospital.

Enquiry and appointments desks.

Printed information for patients, relatives and other visitors.

Letters.

For many people, including worried or distressed relatives, the first encounter is with the **telephone switchboard** staff. They, more than any other people in an organisation, can aggravate anxieties by brusqueness or carelessness. Managers should monitor this service regularly and ensure that training is adequate.

Often the facilities, not the staff, are to blame for unsatisfactory service, particularly if they are overloaded and put the telephonists under strain. If so, high priority should be given to improving the facilities and alleviating the strain. The return for such an investment, both in efficiency and in good 'customer relations', can be immeasurably high.

A hospital, even a health centre, is a bewildering place to enter – more especially for a person who is already anxious and preoccupied. It is essential that sign-posting in **reception areas, waiting areas and corridors** is clearly displayed and unambiguous, and that maps are as simple as possible. Signs should not only point in the right direction but should state prominently each destination when it is reached.

The attitude of staff at **reception, enquiry or appointments desks** can immediately influence people's views of the organisation by generating an air of pleasant efficiency and confidence or, alternatively, creating antagonism, uncertainty or even greater nervousness than a visit to a hospital or clinic normally creates. A patronising 'there, there', a surly greeting or bored indifference can make the patient or visitor feel a nuisance, a liability or aggressive.

It has to be remembered constantly that staff throughout the health service, and particularly those at the 'sharp' end, are there to *serve* the public, who are entitled to be received with courtesy and positive helpfulness. This is another important area which managers should review regularly. They should particularly take heed of any complaints about staff behaviour or attitudes and should never shrug them off.

Printed information for patients and visitors can inspire or undermine confidence in the organisation. A batch of photocopied sheets, heavily corrected and updated by hand and made harder and harder to read by successive trips through the photocopier, will not enhance the reader's opinion of the organisation.

An increasing number of hospitals are producing more attractive and helpful literature, presented in a clear and illuminating way and covering such matters as transport, medicines and tablets, what to bring into hospital, protection of valuables, the hospital day, visiting arrangements, telephone enquiries, postal arrangements, library facilities, radio and television, catering, discharge from hospital and follow-up appointments, together with guidance on suggestions and complaints.

Letters to patients – and, indeed, to all other interested 'publics' of the health service – should be composed clearly and typed cleanly. A letter which is badly typed, or signed illegibly by an anonymous manager (no matter how desirable he considers his anonymity to be), can suggest an incompetent organisation to which the recipient would hesitate to entrust his health or sickness. Letters should be addressed wherever possible to a named individual rather than to 'Sir' or 'Madam' or, worse, 'Sir or Madam'. Letters into an organisation, however trivial, should be answered promptly and with courtesy. One of the commonest features of complaints by members of the public is an exacerbating failure or delay in communication which often becomes a greater source of grievance than the cause of the original complaint. The Health Service Commissioner (the 'Ombudsman') has highlighted many cases where the inadequate or tardy processing of a complaint has become the subject of complaint in its own right.

Handling complaints

Many complaints have their roots in failures of communication. Difficulties may arise through anxiety, deafness, language barriers or inarticulation. A sick person in unfamiliar and daunting surroundings is particularly vulnerable to lack of information about what is happening to him. Doctors, nurses and other staff may feel frustrated trying to communicate with a patient, but it is their responsibility, not the patient's, to make sure that communication is effective.

Complaints should be acknowledged immediately and investigated thoroughly, fairly and as quickly as possible. The reply to the complainant should explain the results of the investigation, what remedial action is to be taken, or why no action has been thought necessary. It should be sympathetic in tone and give support to the staff where possible.

An unsatisfied complainant should be advised to communicate with the 'Ombudsman' unless the complaint is clearly outside his jurisdiction.

Occasionally a complainant will go to the press. It is important to respond to publicity in a positive way. This may mean going beyond a simple statement that the matter is under investigation. The public comments of the complainant should be considered in the context of public confidence, and it may be wise to respond to specific criticisms publicly, while taking care to avoid going beyond the particular points made public by the complainant.

SECTION 2

Public relations campaigns

The purpose of a public relations campaign is to help influence attitudes and shape events. It should be a positive initiative designed to inform people and help them to make considered judgements.

A campaign calls for a 'high profile' rather than a 'softly, softly' approach. The 'softly, softly' approach has in the past been the hallmark of the NHS's handling of many major issues – over fluoridation of water supplies, for example, or the development of possibly unwelcome projects in the community such as medium-secure units for mentally ill offenders.

A campaign, however sophisticated and well organised, will not always be successful, but may produce some important lessons. One unsuccessful yet influential campaign was a six-month pilot programme of education in Winchester in 1979 to try to persuade front-seat occupants of cars to wear seat belts. Its failure to produce any significant rise in the use of seat belts was used to reinforce the argument for legislation rather than persuasion in the wearing of them, and its results were quoted during parliamentary debates on legislation.

The campaign was useful in another way: it demonstrated the impact of television compared with other publicity techniques. Of people who were aware of the campaign, 47 per cent had received information from television as against 19 per cent from newspapers, 15 per cent from radio, ten per cent from posters and only nine per cent from the 20,000 specially produced bookmarks which were handed out in the campaign.

The four campaigns described in this section, each with different messages and objectives, were designed to:

Extend fluoridation.

Encourage a neighbourhood to accept a new residential centre for mentally handicapped adults.

Recruit more staff to a large psychiatric hospital.

Improve knowledge and understanding of cancer.

The principles and techniques used in these projects could be applied in a wide range of other public relations campaigns.

Extending fluoridation

If a pressure group is powerful and determined enough, a health authority can find itself on the defensive, with its advisers feeling increasingly isolated. This has been the case in some areas over the

fluoridation of water.

In April 1978 the West Midlands Regional Health Authority set up a 'Fluoridation Publicity Action Group' (FPAG) to coordinate and sustain a region-wide campaign to put the positive case for fluoridation, with a multi-disciplinary membership drawn from the dental, medical, administrative and public relations professions. The regional composition of the group was important. Although decisions on the principle of adjusting fluoride levels lie with 'operational' health authorities, major water supply networks invariably serve the populations of more than one NHS district. So every part of the jigsaw must fit if a scheme is to stand any chance of success. The multi-disciplinary format is also vital. Getting fluoridation accepted is not purely a dental affair. It calls for a combination of expertise and skills.

At their first meeting, members of FPAG considered the following fundamental issues:

- What were the main practical obstacles standing in the way of extending fluoridation in the region?
- In what sequence should those obstacles be tackled?
- How much did the decision-makers, the public and news media really know about fluoridation?
- To what extent had anti-fluoridation propaganda predisposed them against health authority proposals?
- What were the arguments deployed by the opponents of fluoridation?
- Had the counter-arguments been put with sufficient force and frequency?

One thing was obvious at this early stage: the anti-fluoridation lobby held the initiative in terms of distribution of material and ability to get its case publicised. The group decided to try to turn the tables. Dissemination of information supporting fluoridation became a primary aim, especially to the key network of decision-influencers and decision-makers, including:

- Area health authority members (who took the basic decisions on the principle of fluoridation).
- Water authority members (who are requested to implement fluoridation schemes on behalf of health authorities).
- Community health council members (whose policies may influence both health and water authorities).
- Local authority members (who are also represented on health authorities, CHCs and water authorities).

Members of Parliament representing the 56 constituencies in the region.

The news media, especially newspapers and broadcasting organisations covering parts of the region for which new fluoridation schemes were to be proposed.

In July 1978, FPAG started publication and region-wide distribution of a news-sheet called 'Fluoridation News'. Articles dealt with many different aspects of fluoridation, including the dental benefits, the policies of CHCs, the occurrence of natural fluoride in water, the extent of schemes in other countries, public opinion, ethical considerations and allegations made by opponents that fluoridation causes harm. In addition, seminars were held to brief MPs, health authority members and councillors in greater depth and detail.

CHCs came to occupy a crucial position in the whole campaign. This was because the Severn Trent Water Authority (the largest supplier in the West Midlands) had passed a resolution in February 1978 which stated that '. . . no request [for fluoridation] shall be acceded to unless the AHA shall satisfy the water authority that a clear majority of consumers in the area concerned is in favour.'

When asked to clarify the resolution (that is, how public opinion would be measured) the water authority indicated that the views of CHCs representing the populations affected directly by specific schemes would be the main criterion.

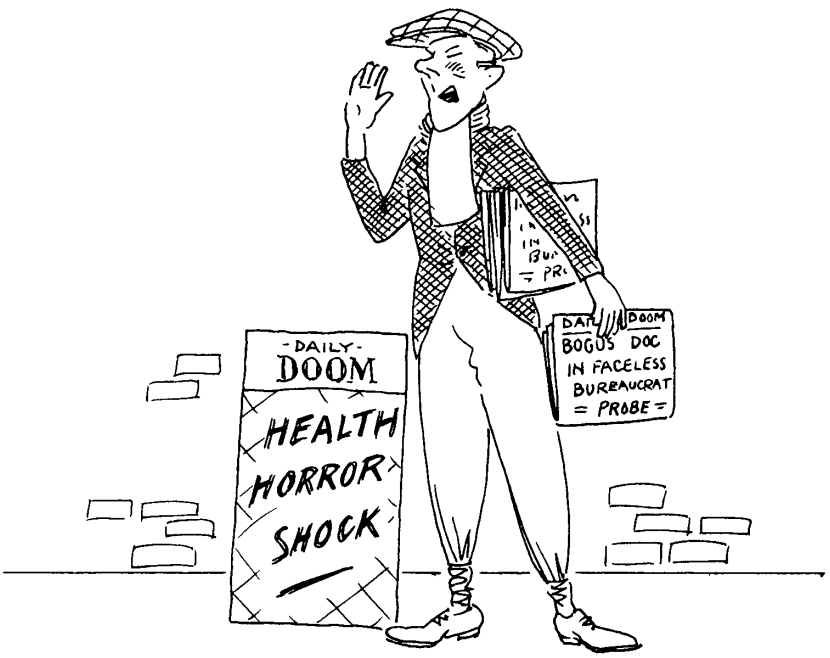
At this point only 14 out of the 22 CHCs had declared a policy on fluoridation. Of these, ten were in favour and four against. So the way in which the remainder reacted would help either to advance the NHS case or block further progress. There followed a period of hectic activity in which, one by one, CHCs debated their policies, many for the second time.

FPAG provided well-informed speakers for any meetings of CHCs at which representatives from each side of the fluoridation argument were invited to put their case. Background information was also made available to CHC members, with emphasis on the substantial dental benefits which had occurred in those areas of the region fluoridated since the 1960s.

By the middle of 1979, the extension of fluoridation was supported by 18 of the 22 CHCs. Only three were opposed to it and one CHC, in a health district already largely fluoridated, had not bothered to discuss the topic.

While focusing its main attention on the CHC forum, FPAG did not forget the influence the news media can exert on the 'climate' in which decision-makers operate. Although some newspapers persistently took an anti-fluoridation stance, most of the media were

prepared to report the facts objectively. Some newspapers – primarily those in the centre of the conurbation where just over 1.5 million people already consumed fluoridated water – came out openly in support.



Don't forget the influence the news media can exert on the 'climate' in which decision-makers operate

The deliberate 'high profile' strategy of FPAG was backed up by hard work behind the scenes to keep the group one jump ahead of its opponents.

Close and regular contact was maintained with health agencies in other countries, especially the US Public Health Service Centre for Disease Control, in order to be able to keep abreast of fluoridation developments throughout the world. The flow of up-to-date information from these sources enabled FPAG to respond quickly and authoritatively to any attempt by the anti-fluoridation lobby to give a false impression of what was going on outside the United Kingdom.

A much-used ploy of the 'pure water' pressure groups was to claim that, disregarding its scientific merits, public opinion was against fluoridation. FPAG decided to test this assertion by commissioning an independently conducted opinion research survey from NOP Market Research. A total of 1,948 adults were interviewed in 178 parliamentary constituencies. To the question, 'Do you think fluoride should be added to water if it can reduce tooth decay?', the

response was: yes, 66.5 per cent; no, 15.8 per cent; don't know, 17.7 per cent.

The success of the West Midlands strategy can be measured in terms of the number of people using fluoridated water, estimated to be nearly four million – about 80 per cent of the population of the West Midlands – by 1988.

A centre for mentally handicapped people

A carefully coordinated, short-term campaign to try to secure public support and town planning consent for a new residential centre for mentally handicapped adults was mounted by Bromley Area Health Authority early in 1980. There was no similar provision locally and therefore nothing with which to compare the new centre. The site, in the grounds of some NHS offices, was in the heart of a quiet residential neighbourhood. The whole scheme was breaking new ground in the care of mentally handicapped people.

The health authority resisted the temptation to apply for town planning consent without publicity in the hope that the project would go through 'on the nod'. Anticipating considerable public interest and even anxiety, it devised a public information programme which involved local newspapers, community and voluntary groups, individual residents and the London Borough of Bromley.

In the event, town planning consent was given and, perhaps more important, the new centre was so well received by the community that a league of friends was formed even before building began.

Four basic public relations techniques were used, with assistance from the regional public relations department: press coverage, a leaflet for the public, a video about the centre, and a public meeting. This last was the focal point around which the other activities were arranged.

Events began with a press conference for the local weekly newspapers. This was held as the town planning consent application was made to the borough council. Journalists were given a full description of the centre together with background details about the underlying philosophy of care for mentally handicapped people on which the plans were based. They were asked to give publicity to the public meeting some three weeks ahead, and were supplied with copies of the leaflet about the scheme. Between the press conference and the publication of the newspapers four days later, the leaflet was distributed to every resident within a quarter of a mile of the site, with a letter from the area administrator inviting them to the public meeting. The distribution was done through the area voluntary services department.

Members of the borough council's planning committee were also contacted during this initial phase and, at the invitation of the area

administrator, met him to discuss the plan.

In this way people with an interest in the scheme learned about it direct from the health authority. No-one had to get the information at second hand from the press or any other source.

The public meeting, advertised through the local newspapers and by posters, was held near the site for the convenience of local residents. About 250 people attended – more than the organisers expected. The first half-hour was taken up with a short explanation of the need for the centre and by a 15-minute video giving more background information. The rest of the evening was given over to questions from the floor. Many of the questions reflected a measure of public anxiety – and in some cases hostility – but, overall, the meeting was judged to be a success. A week later the local authority decided not to object to the town planning consent application.

From then on the emphasis of the campaign concentrated on building up support for the centre throughout the community. Health authority officers with a special interest in the scheme gave a series of talks to local voluntary and community groups. The video was used to introduce the subject, and it was shown more than 100 times.

The result of all this activity was the acceptance of a new kind of philosophy for the care of the mentally handicapped, the go-ahead for the construction of the centre, and a groundswell of support from local people.

Recruitment of staff

Trent Regional Health Authority decided to provide Middlewood Hospital, Sheffield, with £150,000 a year for three years to employ trained psychiatric nurses. The workforce had declined, recruitment was poor and the number of learners leaving the hospital's school and taking up work in the hospital was low.

Like many other large Victorian mental illness hospitals, Middlewood had had its share of incidents and it was short of money. Nevertheless, it had a progressive approach to patient care and treatment.

It was thought that it would need more than a conventional recruitment advertising campaign to attract and retain new staff. The district management team, on the advice of the regional public relations officer, decided to invite a number of independent advertising and public relations companies to compete for the contract. A Cambridgeshire company was chosen to be responsible for the recruitment advertising and a Manchester firm for the public relations side.

The morale of Middlewood staff was excellent and the hospital was noted for its very successful rehabilitation programmes. It was

these which had to be 'sold' by going behind the Victorian facade to show the modern wards and facilities.

Although morale was high, the turnover of nursing staff was surprisingly large, and surveys were conducted to find out the reasons. The results influenced the public relations activities and led to management action to ease the problem.

Research was also undertaken to discover where potential recruits could be found. There were parts of the country where psychiatric nurses were out of work, mostly in the north. This, combined with the fact that more people migrated south than north, led the hospital to concentrate its newspaper advertising in places like Glasgow, Liverpool and Newcastle. The advertisements featured the offer of free return railway tickets enabling applicants to visit Middlewood at little or no cost to themselves. This made imaginative use of something which is routine practice.

Other advertisements in local newspapers and the main nursing journals were based on two themes: 'If you don't like the heat of the kitchen, then don't bother to come' and 'We would rather have a happy but small team than have passengers'. The advertisements contained not only the hospital's address but the telephone number and extension to which applicants could make a direct call. They also included reply coupons to make application easier. Besides promoting the hospital's facilities it was decided to 'sell' Sheffield. The City Council's leaflet was sent to all applicants together with Middlewood's own leaflet which was designed to complement the Council's publication and not duplicate it.

Christmas was approaching as the campaign was about to start. There is usually opposition to advertising around Christmas: who is going to leave a job and look for another at that time of year? The advertising company argued, however, that it was a long holiday period and many staff would have a little more time to themselves. Christmas was the time to advertise. Taking a deep breath, the hospital agreed. Advertising was placed in *Nursing Mirror* and *Nursing Times*.

The first week of January drew no response, but in the second, third and fourth weeks applications were rolling in. People *had* read the advertisements during the holiday, and when they returned to work, to the same grind, the same problems and the same people, they remembered the Middlewood advertisements and acted.

After staff had been recruited and started work, some testimonial advertisements were prepared comprising interviews with successful applicants. (Some time later another area tried a similar testimonial campaign but the interviews were fictitious and violated the Code of Advertising Practice.)

Two other series of advertisements were unsuccessful. One used road sign themes on the lines of 'Are you going round in circles?' with a roundabout sign and 'Have you reached your limit?' with a speed restriction sign. It was too general, however, and drew applications from all manner of nursing staff, not necessarily those with mental illness experience and training. The other series consisted of 'send-up' advertisements, one featuring seduction, which led to three London nurses protesting to the Advertising Standards Authority that the advertisements were degrading the nursing profession. The complaint was not upheld but the ASA 'deprecated' the approach used in the text.

Other nurses were upset about the campaign: they were among the staff at Middlewood who, by the summer, were perturbed about the cost of all the advertising. A seminar was held for them and it was pointed out that as a direct result of the campaign additional staff had been recruited and a ward re-opened.

Middlewood was fighting to be noticed. Its advertisements needed strong visual impact if they were to compete successfully against other advertising. They also had to be worded precisely to attract suitable candidates. As the advertisements appeared, other hospitals copied them, forcing Middlewood and the advertising company to search for new ideas to keep ahead of the competition.

Despite the pressure, advertising was carried out in short bursts for maximum effect. Continuous advertising would have blunted the impact of the campaign and created the impression that there was something wrong with Middlewood.

The public relations company promoted Middlewood in three principal ways:

Writing and issuing news releases and sending out photographs of activities at the hospital. The photographs were taken during the normal working day or specially arranged to project the image of the hospital.

Encouraging journalists from local and national newspapers and magazines to visit the hospital, interview staff, patients and relatives, and write feature articles on subjects suggested to them.

Placing articles, mostly case histories, with specific journals.

News releases were issued on a wide range of subjects, including a scheme for 'adopting' patients; the success of a patients' boutique; an Easter festival; a King's Fund seminar; the formation of a hospital action group; senior appointments; retirements; behavioural psychology; an 'It's a Knock-out' competition; nurse therapists; community homes; the re-opening of wards; new building projects; a radio-cassette service for patients; patients' bank; a staff versus

patients cricket match; the work of the industrial unit. Many of these stories had local and national coverage.

The advertising and public relations effort to boost Middlewood was reinforced in other ways. A successful two-day national psychiatric symposium was held at the hospital, attended by nearly 180 delegates. This was financially sponsored by drug firms and other companies and made a very small profit. It obtained good press coverage.

Small exhibitions were held in Sheffield, and as a result of one display 500 people a day for a week visited the hospital.

A defunct hospital newspaper, revived under the title *Middlewood Times*, was produced by the PR company. Finding stories for the newspaper also provided material for news releases and other promotional activity. Care was taken to ensure that the newspaper was not seen as a tool of management; indeed, early issues contained some very contentious letters from staff which were answered by management. The staff clearly regarded the newspaper as theirs and were not afraid to use it.

Several displays of advertisements and press cuttings were mounted in the hospital, and efforts were made to keep the staff informed of advertising plans.

Forty nurses were recruited in the first year and the campaign became increasingly successful. The contract with the public relations company was ended after two years. Whether even more recruitment would have taken place if it had been retained is debatable, but the campaign had already demonstrated that having one company specialising in advertising and another in public relations worked.

Cancer education

Evidence that avoidable factors were contributing towards death rates from cancer lay behind a major campaign, 'Cancer is just a word, not a sentence', started in the North Western Region in November 1979 – first in Manchester city centre and then in eleven other towns in the north west. The factors were:

> Delay by the public between noticing possible cancer symptoms and seeking medical advice. The average delay was more than three months, with some patients putting off going to their general practitioners for a year or more.
>
> Delays by GPs, hospital doctors, nurses, health visitors and others through failing to identify possible cancer symptoms.

The campaign – organised by Manchester Regional Committee for Cancer Education and North Western RHA Public Relations Department, and later reinforced by health education officers – was

aimed mainly at the general public. Separate efforts were made to improve awareness of cancer among professional groups and included the production of a film, 'Index of Suspicion', which was launched during the main campaign.

It was believed there were two reasons for people delaying seeking advice:

Failure through ignorance to realise something serious might be wrong.

Fear that something *was* wrong.

Action to counter ignorance would be relatively straightforward. It would involve increasing awareness of cancer and educating the public about those symptoms which might mean cancer (persistent cough, persistent tickle in the throat, persistent lump or sore).

Action to counter fear would be more difficult. Generally, it was thought that information should be provided to counter fatalistic attitudes towards cancer, particularly among older people, by stressing that:

Significant numbers of people are cured of cancer each year (60,000 or 1 in 3).

More could be saved if they saw the doctor in time (another 15,000).

Specific information was provided through news releases, leaflets, posters, press briefings and speeches on the following subjects:

Smoking and lung cancer.

Breast self-examination.

Cervical smear tests.

Leukaemia.

The three basic types of treatment – surgery, radiotherapy and chemotherapy.

Cancer relief and welfare agencies.

Fund-raising for cancer research.

Facts and figures might impress an educated audience, but 'living proof' would strengthen the validity of the campaign message. The campaign therefore focused on five local people who had been completely cured of cancer. They agreed to the use of photographs in full-colour exhibition panels and the use of their names with biographical details in news releases. They undertook to attend town centre launches and to cooperate in press, radio and television interviews.

The campaign began in a large department store in the centre of

Manchester, and was officially opened by the Lord Mayor. Other speakers were the chairman of the RHA and a local cancer sufferer who had become a national media figure as a result of her much-publicised fight against the disease. The five former cancer sufferers also attended and were interviewed by press, radio and television.

An exhibition in the store provided a back-drop for the event and remained as a focus of attention there for the following week. Leaflets giving specific information were freely available.

Campaigns with a similar format were arranged in other parts of the region. Department stores with their heavy through-put of shoppers were preferred to libraries and town halls. Problems can arise, though: for example, a store manager may try to relegate the exhibition to a non-prime site in the store because of commercial pressure on prime sites.

The campaign gave general and specific information directly or indirectly to a large number of people through media coverage, leaflets, exhibitions and public attendance at the launches. A degree of increased public awareness of cancer and of potential cancer symptoms was certainly achieved, although it was not possible within the scope and resources of the campaign to measure the degree of this increased awareness or any related attitude or behavioural change. Such studies, which must be long-term and based on a sufficiently wide sample of the population, have been undertaken on behalf of Manchester Regional Committee for Cancer Education through continued monitoring of public awareness and attitude change.

SECTION 3

Leaflets and brochures

Leaflets and brochures have a variety of uses: providing information for patients and relatives, helping staff recruitment, describing new plans or developments, assisting in health education, supporting fund-raising.

A well-produced leaflet which looks smart, modern and readable will help to convey an important message. But the presentation needs to be matched to the message; in some circumstances – for example, when a service is to be reduced, with consequent loss of jobs – a 'glossy' publication could aggravate a reader's hostility.

Whatever the format, the use of printed matter gives managers control over the content and presentation of their message while being relatively inexpensive, even when using commercial printing firms.

There are a number of distinct stages in producing any form of printed material:

Selection of content and audience.

Drafting the outline of the text.

Consultation with graphic designer.

Final drafting, and preparation of any illustrations.

Artwork.

Production.

Distribution.

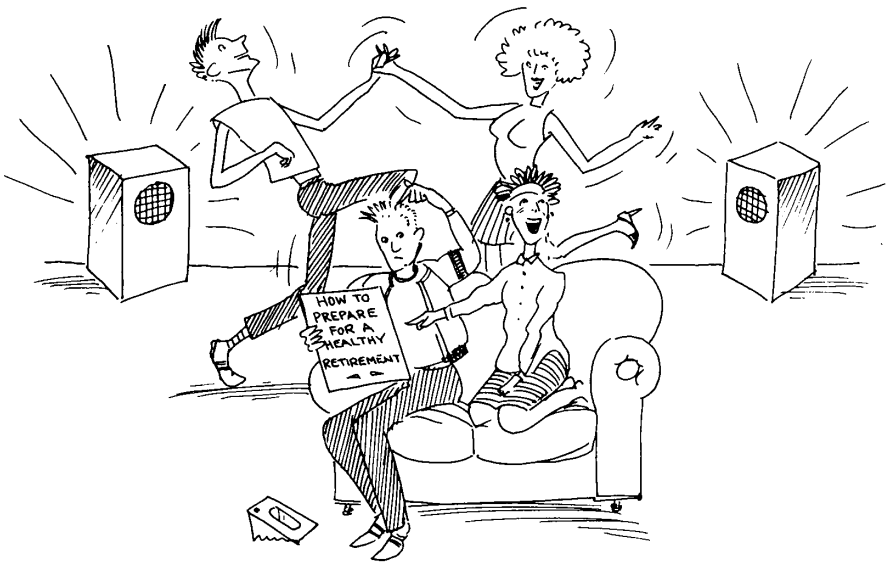
The message and the audience

The style and format of a leaflet depend on the content and importance of the message and on the audience to whom the message is directed. For example, a handbill announcing the staff social club annual general meeting will be a much simpler affair than a brochure to recruit staff for a new wing at a major hospital.

The message and the audience must be chosen carefully. Successful leaflets are those which keep their content simple and address themselves to a clearly-defined target. A leaflet which is poorly researched, or tries to cover too much ground, or is sent to an inappropriate audience, will have only limited success.

Graphic design

Good design can make sense of a complicated subject or brighten up a potentially dull one. It may look deceptively simple, but it is usually the work of a graphic designer. It is worth employing one if at all possible. Each job presents its own problems, and a professional



A leaflet sent to an inappropriate audience will have only limited success

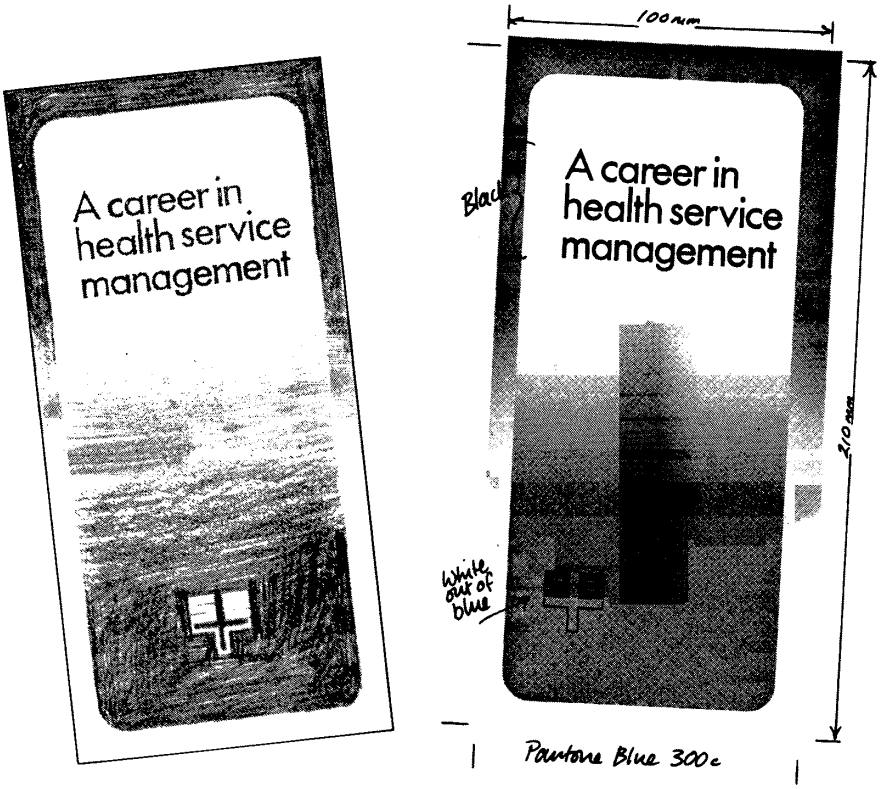
designer, working closely with the printer, ensures that every stage of production is handled efficiently in the interests of the client.

The designer is responsible for the design and for the artwork from which the final job is reproduced by the printer. Assuming, for example, that a leaflet is to be produced, the first meeting with the designer should be held as soon as ideas have become firm proposals, with the audience defined, the content of the leaflet broadly outlined and the budget set.

The designer will interpret the brief and produce a 'visual' – an artist's impression of the finished leaflet. This will indicate its shape and size, the colour or colours to be used, and the typeface. A clear and well thought-out brief will help the designer to come up with an acceptable solution at the first attempt, although the instructions should be flexible enough to enable him to make suggestions which could improve the leaflet.

Once the design is approved the designer can help to draw up specifications for printing so that firm estimates and quotations of the cost of the leaflet can be obtained from printers.

The look of a publication is greatly influenced by the amount of text it contains. A leaflet of no more than a dozen sentences will look very different from one which needs several pages to cover the subject properly. The design can affect the way the text is prepared – for example, by indicating where the words need to be broken by headings – and, for this reason, design should be done in parallel with the writing.



Two stages in producing a publication: the 'visual' or graphic designer's impression of how it might look, and the artwork on a flat board supplied to the printer with the designer's instructions

Writing and preparation

The best leaflets are often the most simple. When writing a leaflet, it is important to:

Use short sentences.

Avoid jargon.

Assume a lack of knowledge by the reader about the subject, and explain everything step by step.

Stick to the point, including only what is strictly necessary.

Avoid using phrases or information which date the leaflet (unless it has only a very short life-span).

Include a name and telephone number so that readers can obtain more information.

State who has issued the leaflet.

Check and double-check the facts.

Writing by committee is usually inefficient and non-productive. It is easier and faster for one person to prepare a draft and then obtain comments from the other people involved. Once the text has been finalised, it should be shown to one or two people who have not taken

part in the drafting and who, preferably, have no links with the project. From their different perspective they may well be able to point out gaps in the text or mistakes which need correcting.

This is also the time to start thinking, with the graphic designer, about any illustrations for the leaflet. If photographs or plans are to be used they have to be selected. If nothing suitable exists, photographs will have to be taken and plans drawn – all in time to meet the production schedule.

Artwork

With the design approved, the text written and the illustrations (with captions) prepared, the leaflet will take shape in the form of artwork. The designer has the text typeset to fit the layout, and assembles all the material on a flat board ready for the printer. The artwork will be in black and white, but marked to show where coloured areas will appear.

Depending on the size and complexity of the project, it can take from two or three days to as many weeks to prepare artwork. This needs to be remembered when drawing up a production schedule.

Checking

The manager must ensure that all stages of the work are thoroughly checked – and checked again. It is vital that the manuscript is checked word by word and comma by comma *before* typesetting. Corrections afterwards are expensive.

The manager should also check the typesetting for spelling or punctuation mistakes. He should check the artwork for any wrongly-positioned paragraphs or pages (this can happen!) and ensure that the printer knows where any illustrations should go. For the more complicated jobs, such as any full-colour work, it may be worth asking for a proof copy before the main 'run' is printed.

Production

If a commercial printer is being used all the necessary specifications will have been drawn up in advance with the graphic designer, who should also help to answer any last-minute queries. Managers need only to ensure that the production schedule and delivery date are agreed and can be met and that precise delivery instructions (name, address and telephone number) have been provided.

When cost is an important factor or the scale of the project very small, production can be done in-house without using graphic designers or commercial printers. This will save money on design and typesetting, but in costing this kind of production managers should include staff time (including any finishing, folding and stapling which may be needed) and consider the 'knock-on' effect which production will have on the work of the duplicating room. They should also bear in mind that even the best 'in-house' printing

and copying equipment has technical limitations and may not be able to match the standards of work done commercially.

However, the 'do-it-yourself' approach has its advantages. It is quick and easy and can be effective. The following guidelines will help to produce the best results:

The finished leaflet will be only as good as the master typescript, so ensure that this is carefully laid out, sharp, and clean in both senses of the word – mark-free and error-free.

Titles and headings can be done with dry transfer lettering such as Letraset or Mecanorma, but do not attempt this technique without practising first; uneven lettering looks sloppy and gives a bad impression.

Remember that most photocopiers cannot handle photographs, large areas of black ink or delicate shading, such as fine cross-hatching on plans or maps.

If possible keep to something which can be produced on one sheet of paper. Folding or stapling several sheets together can be a long and tiresome business.

Finally, it should be remembered that staff and the public are used to a very high standard of printed material and may well judge the significance of a leaflet by its appearance. For an important message, it is probably better to use a commercial printer.

Distribution

With a large quantity of leaflets, distribution can be a major problem. Points to be considered include:

Storage If the leaflets are to be used over a long period, they should be stored in a warm and dry place.

Internal distribution Can the internal post cope? Can managers at unit or ward level, for example, ensure that leaflets meant for all members of staff will actually reach them? Should leaflets for staff be sent with pay-slips, perhaps? Should advance copies be sent to anyone connected with the project?

Outside circulation Lists of addresses of people or organisations who need to see the leaflet should be prepared. The news media should be included on the distribution list if appropriate.

Mass distribution If 'door-to-door' distribution is needed the district voluntary services coordinator may be able to arrange help.

Helpful hints

Paper sizes Most headed notepaper is A4 size. A common size of leaflet is obtained by turning a sheet of A4 on to its long edge and folding it into thirds. A sheet of paper half the size of A4 is called A5 (the size of this page), and one twice the size of A4 is called A3. The

lower the number, the larger the sheet of paper.

Paper weights Paper comes in various weights. Some leaflets lose impact because they are too flimsy, but equally ineffective can be one which is so heavy that it is expensive to post. Most standard leaflets are printed on papers weighing between 100 and 135 gsm (grammes per square metre).

Paper texture A glossy paper looks more expensive but has the disadvantage that if covered with large areas of ink it will tend to show up fingermarks very quickly. For many purposes, a matt paper, preferably uncoated, is appropriate.

Colour Coloured ink costs little or no more than black ink which is, in any case, classed as a colour by a printer. The expense of printing in more than one colour is usually due to the cost of each further run through the printing press and of changing the inks and cleaning the machines between each colour. If cost is an important factor, it is worth considering printing on a coloured rather than a white paper. The effect will be to make a single-colour leaflet look similar to a two-colour leaflet.

Quantity If a large quantity will definitely be needed, it is a false economy to print 'half now and half next financial year'. It costs much more to put the work back on to the machines than to complete the job in one print run. On the other hand, it pays not to be over-enthusiastic in ordering. Managers should try to assess their needs in a realistic and not hopefully optimistic way.

If faced with a large project – an annual report or consultative document, for example – it is sometimes worth typing the text in-house and having a commercial printer produce and finish the work from the typed copy. This cuts out the typesetting altogether while still giving the document a professional finish. The technique should not, however, be used for a leaflet; the result will look amateurish.

SECTION 4

Audio-visual programmes

Audio-visual programmes, notably synchronised slide-tape presentations and videos, can be produced in a range of styles from the simple and cheap to the sophisticated and expensive. Which is used depends on the resources available, the likely audiences and the context in which they are to be shown. They are often used as part of a presentation to illustrate a talk, particularly where an audience of, say, local residents is being encouraged to support a new project in their community, or staff are being introduced to organisational changes.

Synchronised slide-tape

A synchronised slide-tape is a succession of 35mm colour transparencies, a voice commentary on cassette and a system of putting electronic pulses on the cassette so that it will operate a projector carousel automatically. It is one of the simplest, cheapest and most flexible of all audio-visual aid techniques. But, like other techniques, it can be badly done or used for the wrong reasons. A slide-tape package is most effective and useful:

At the start of a talk or lecture where a large amount of information needs to be conveyed with accuracy and in a way which will not lose the audience at an early stage. This leaves the speaker free to develop certain themes based on more detailed information already given. It also prevents the audience from getting bored through listening to the same voice and style of delivery for too long.

In a series of meetings over a period of time when a particular message or theme needs to be communicated with accuracy and consistency and when it is likely that different speakers will be used on each occasion. Whatever the individual variations of presentation and emphasis, there will always be a core of common material.

When an automatically operated audio-visual aid is needed in, for example, the reception area of a building. It relieves the boredom of waiting visitors and at the same time conveys to them a message from the organisation.

A slide-tape is relatively inexpensive; it is cheaper by many thousands of pounds than a commercially produced 20-minute colour film. A film done on the cheap is not worth doing at all: an audience so accustomed to the high technical standards of television and the

cinema is likely to react negatively to anything of noticeably lower quality. There are other reasons for using a slide-tape rather than a film:

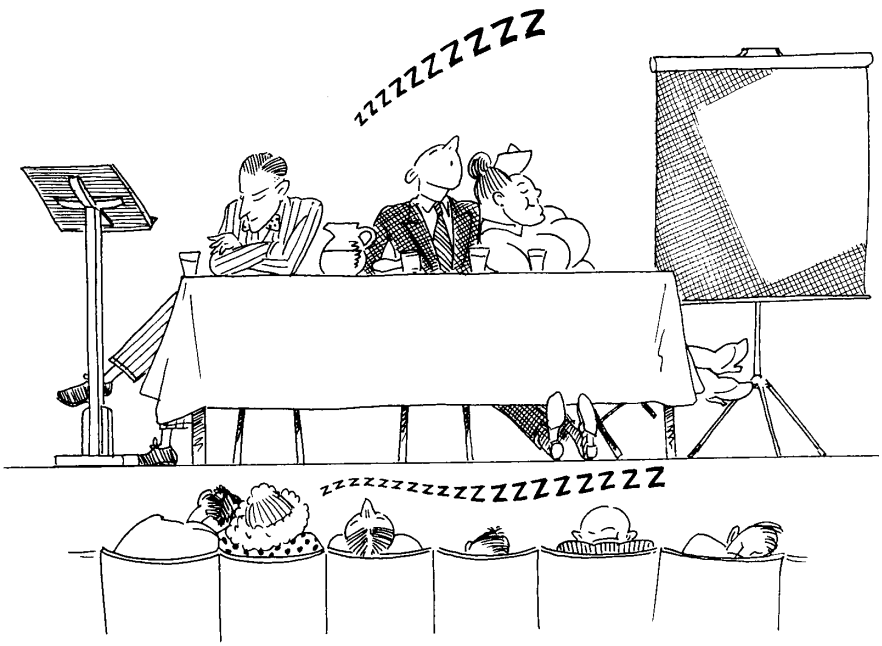
Locations for using audio-visual aids vary enormously, and a carousel-type slide projector and cassette recorder are easier to find (and easier to use) than film projection equipment.

The viewing conditions for a film may not be suitable and enjoyment of a film can be spoiled by the noise of the projector.

Statistical arguments are better presented as good graphics and stills than as a moving picture.

Out-of-date material can be quickly and cheaply replaced by substituting new slides and re-recording the soundtrack. Re-recording film is prohibitively expensive.

A slide-tape should last no longer than 15 minutes. Anything longer is likely to bore the audience. Some slide-tapes last as little as five minutes but do a very effective job.



A slide-tape longer than 15 minutes is likely to bore the audience

An organisation planning a slide-tape must decide first what it wants to say to its audience and what it wants them to think or do after seeing the presentation. The language and style of the slide-tape will be influenced by the likely target audiences.

Assuming it is to be produced in-house with minimal use of outside resources, the first step is to write the script and visualise the accompanying slides. These tasks should go hand in hand. It is a mistake to write the script first and then to start thinking about the visuals. Commentary and pictures must be complementary and mutually reinforcing, and the impact of succeeding slides as they flash on the screen can affect the content of the spoken commentary.

The script and the description of the slides should be written side by side on a sheet of paper, commentary on the left, visual on the right. If this discipline is maintained throughout, voice-over and

Sound		Visual
For example, where should new hospitals be built? Is there scope for preventing some diseases - such as those caused by smoking - rather than having to spend more money on facilities for curing them?	43.	Hospital exterior
	44.	Front cover of ASH guidebook and other anti-smoking publications
How many skilled staff will need to be trained to meet increased demands for health care? How much should be invested in new, high technology equipment like this body scanner used for helping to diagnose diseases in various organs of the body?	45.	Midwife operating ultra-sound scanner
	46.	CT scanner in operation (general shot)
	47.	Close up of patient undergoing CT scanner investigation
How can we help the elderly to live their lives as independently as possible without having to end up in hospital?	48.	Elderly couple at home
	49.	Second view of elderly couple
These are just some of the vital issues the RHA has to deal with, not in isolation but in constant dialogue with the District Health Authorities.	50.	Cartoon
Together, they work out a long-term plan known as the 'regional strategy'. It's not a rigid blueprint for the future. Who can see ten years ahead with absolute certainty? But it's a pointer to the general direction the NHS in the region is likely to be heading in.	51.	Front covers of vols 1-3 of regional strategy
	52.	Drawing depicting main goals of RHA strategy
Of course, the speed and extent of putting the plan into practice depends on the cash available. That's where the 'allocation of resources' comes in.		
Each year the RHA gets a block grant from the government which has to be shared out	53.	Drawing depicting revenue and capital allocations coming

The script and description of the slides for a synchronised slide-tape are written side by side – an important discipline if the voice-over and visual are to mix in a natural way

visual should mix naturally. Otherwise, there is the risk of an artificial match which will not work.

One of the biggest difficulties with a slide-tape is to maintain a sense of pace and movement. Because the images projected on the screen are flat and immobile – unlike the continuously moving image of a film – a slide should not be left on the screen for longer than ten seconds and the length of exposure of successive slides should be varied as much as possible. Too long an exposure will prove tedious for the viewer. On the other hand, too many slides passing through too quickly will not give the viewer time to absorb the images properly.

Although the words of the script are on paper, they are meant to be spoken and heard, and the style and phraseology must be devised accordingly. Sentences should be simple and to the point. Mannerisms of colloquial speech may be introduced, but should not be overdone for fear of affectation. It must also be remembered that there will be room for only 20 spoken words or so against each visual. The words can, however, cover more than one slide; there is one health service slide-tape which uses seven slides of a skidding ambulance with continuous commentary and sound effects.

Since the first few words and the first visual of a slide-tape will set the tone for what follows and help to make the audience more receptive, the opening sentences should be especially brief and uncomplicated, and the first visual should have particularly strong impact.

Good, simple graphics can help to tell the story, but they *must* be simple because they cannot stay on the screen for very long.

Before the commentary is recorded, together with any background music or special effects, the script should be carefully annotated to mark out the length of pauses in the narrative, whether for effect or for the later insertion of additional sound. The choice of commentator is important. Newsreaders or presenters on local radio stations will sometimes be willing to help. They have a very good idea of pace and timing, and can often use their expertise with the spoken word to improve the flow of the script.

It may prove necessary to record the commentary two or three times to achieve the right pace. This can be more difficult than might be imagined, but it is far better to be fussy at this point than to allow something to go through which is not satisfactory.

When the recording has been completed it is time to pulse the tape so that it will operate a carousel slide-projector automatically. This can be a tedious exercise, but it is vitally important if the movement from one slide to another is to synchronise perfectly with the commentary.

Video programmes

The availability of reasonably priced video cameras and recorders gives everyone the chance to produce 'instant moving pictures', but few organisations, and even fewer health service authorities, take advantage of the medium. This is a pity: a video presentation can concentrate the minds of an audience and enliven and illuminate an otherwise dull or complex subject.

Video is intimate, like the television set in the living room. It is eminently suitable for reaching small captive audiences – for example, in an ante-natal clinic to promote parentcraft classes. In a sensitive issue, such as the development of medium-secure units for mentally ill patients, it can present the human side of the proposals to help an audience see that the plans are about real people and not about some remote concept in which they have no interest or responsibility.

It is ideal for 'in-house television' for staff. Some organisations, mostly in industry and commerce, have added closed-circuit television to their array of staff communication techniques. In the NHS, Wessex Regional Health Authority has produced a series of 30-minute programmes, 'Wessex Viewpoint', dealing with such subjects as health service reorganisation, the region's planning system, changes in the nursing profession and the financing of the NHS. The University of Southampton's teaching media department provided the professional and technical expertise at minimal cost. The programmes were inexpensively copied on to video cassettes of varying formats, enabling them to be used in different locations throughout the region.

'Wessex Viewpoint' is seen as an aid to managers. Guidance notes accompanying the cassettes make it clear that each programme should be shown as part of a structured session, preceded by an introduction and followed by debate and discussion.

Among the advantages of video – some obvious, others less so – are:

It can show people moving and talking – for example, mentally handicapped patients being interviewed about their problems and their hopes, sometimes using close-ups. The human face in action is always a compelling image.

It is a highly flexible and portable system.

It is in colour, but is still much cheaper than film.

With proper editing, the tape can be used and re-used.

One disadvantage is that is not suitable for large audiences of 25 or more without banks of monitor screens. It may be preferable in such circumstances to use slide-tape which can give the impression of moving pictures by fast cutting from slide to slide and can be

projected on a large screen.

Because television viewers are a sophisticated audience, the writing, filming and editing of a video must be of a professional standard. If they are not, viewers will mentally switch off.

The message must be as simple and economical as possible. Any temptation to linger on aesthetically pleasing images should be resisted: make them half a second too long and the point could be lost.

As in television documentaries, it is better to go for real-life situations. Real people – patients, doctors, nurses – rather than, say, amateur actors recruited for the purpose, are far more effective in putting a message across, just as they would on television through an interview in the studio or on location. The interview, which can be edited afterwards, is much fresher than an 'acted' version. Prepared statements should be avoided, although the interviewee should be given the chance beforehand to discuss the ground to be covered.

Because talking heads can be boring, a video could have a voice-over commentary, and the use of credits, diagrams and illustrations produced by a graphic designer can add a professional touch to the programme.

Help in making a video can be obtained from a number of sources, including:

The regional public relations department to prepare or tighten up a script.

The medical illustration department of the nearest main hospital for technical help. These departments are usually well equipped and welcome the opportunity to make non-medical video programmes.

The local technical college or the teaching media department of the nearest university or polytechnic.

SECTION 5

Exhibitions

The underlying aim in the planning of any exhibition, small or large, simple or complex, is to get a message across to one or more of an organisation's 'publics' as effectively and economically as possible, and with the least amount of time in preparation.

A great deal can be achieved by the careful use of traditional, inexpensive methods and materials. If, as is likely in the NHS, cost is an important factor, a do-it-yourself approach will often be necessary. If speed or sophistication are vital, it is better to use outside professional help. Whichever course is adopted, it is advisable to:

Use photographs, drawings and maps wherever possible rather than words.

Keep captions and other text short. (Any additional information should be given in a leaflet.)

Ensure lettering is legible.

Eliminate anything which is not absolutely vital to the message of the exhibition.

Work out the amount of time needed to prepare the exhibition – and then double it!

Coming to terms

Preparing an exhibition does not require a knowledge of technical jargon, but it helps to distinguish between the following terms:

Display material The photographs, drawings, text and other items which convey the exhibition's message.

Boards The surface on which the display material is fixed and from which it can be removed easily. The boards may be portable or permanent fixtures like notice boards.

Panels Sheets of thick card, hardboard or other suitable material on to which a number of items for display are permanently glued. The panels are usually cut the same size as the display boards and can be quickly mounted directly on to them. Keeping display material on panels has two particular advantages: it avoids the wear and tear which the material suffers if it is constantly being fixed, taken down and re-fixed to boards, and it ensures that each item is always in exactly the right place. A disadvantage is that items such as photographs or plans cannot be easily replaced when they become out-of-date; usually a whole new panel has to be made.

Do-it-yourself exhibitions

Nearly every health district and hospital has a mass of photographs, plans, sketches, written notes and similar items which, properly presented, can make a fascinating exhibition. Most people in the health service underestimate the amount of interest other people take in their work, particularly in medical, nursing or paramedical services.

Even if a do-it-yourself approach might, at first sight, appear to be unglamorous and unadventurous, it does have advantages:

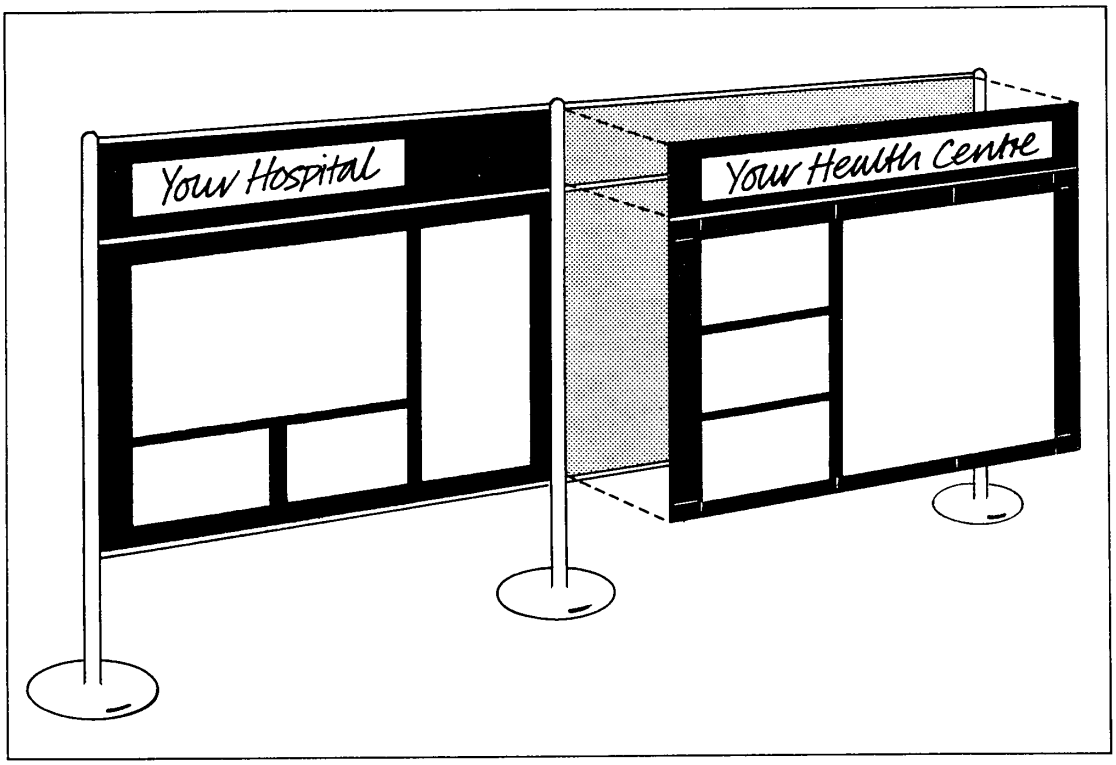
The materials are to hand and relatively cheap.

The format can be regularly and easily changed if new developments take place.

The display can be put in a corridor or mounted on a wall so that it takes up little space.

It can be taken to the audience.

There is no need for constant supervision as there might be if expensive visual aids or working models were used.



In a do-it-yourself exhibition, a panel of thick card or hardboard, with items permanently fixed, can be placed on a display board and easily removed. Doing this and using a layout based on a simple grid helps to ensure that the whole exhibition has the same cohesion and style wherever it is shown

It is important to remember that it is easy to *overestimate* the degree of practical skill needed and to *underestimate* the amount of time that will be required. The advice which follows should demonstrate the first point and help to alleviate the second!

Display boards

Lightweight, manufactured boards The boards are normally either self-standing, with permanent fixings along their edges to join one board to the next, or they clip into light metal frames. Covering is either traditional hessian or modern looped-nylon material.

Do-it-yourself boards Various materials are available for making display boards. They each have certain advantages and disadvantages, as shown in this table:

Material	Self-supporting	Weight	Durability	Easy to pin on to	Cost
Hardboard	No	Medium	Average	No	Low
Chipboard	Yes	Heavy	Good	Not very	Low
Plywood	Yes	Heavy	Good	Not difficult	High
Softboard/ Insulation board	Yes, if not too big	Light	Poor	Yes	Medium

Softboards can be protected by mounting them in timber frames, but, taking into account the labour costs involved, it is more advisable to buy ready-made manufactured units.

Some hospitals have old but perfectly serviceable plywood boards; they may have been painted or varnished at some stage, or left simply as bare wood. The simplest way to refurbish them attractively at a modest cost is to cover them with felt. Cut the felt larger than the board and fold the excess round to the back. Using an upholsterer's staple gun, which can be hired from a DIY shop, fix the felt along two edges and pull it as tight as possible before fixing it along the other two edges. Because felt tends to sag with heavy items on it, the felt should be stapled to the board beneath before items are fixed to it.

Preparing exhibits for display

In most do-it-yourself exhibitions in hospitals, clinics and surgeries, items like posters, photographs, plans and text are mounted directly on display boards. They may be fixed with pins, stuck with transparent tape or, on felt-covered boards, have pieces of sandpaper glued to the backs of them, a traditional but still effective method of mounting. Map pins with small, neat plastic heads look better than drawing pins, and modern fabric fastenings like Velcro can be used instead of sandpaper.

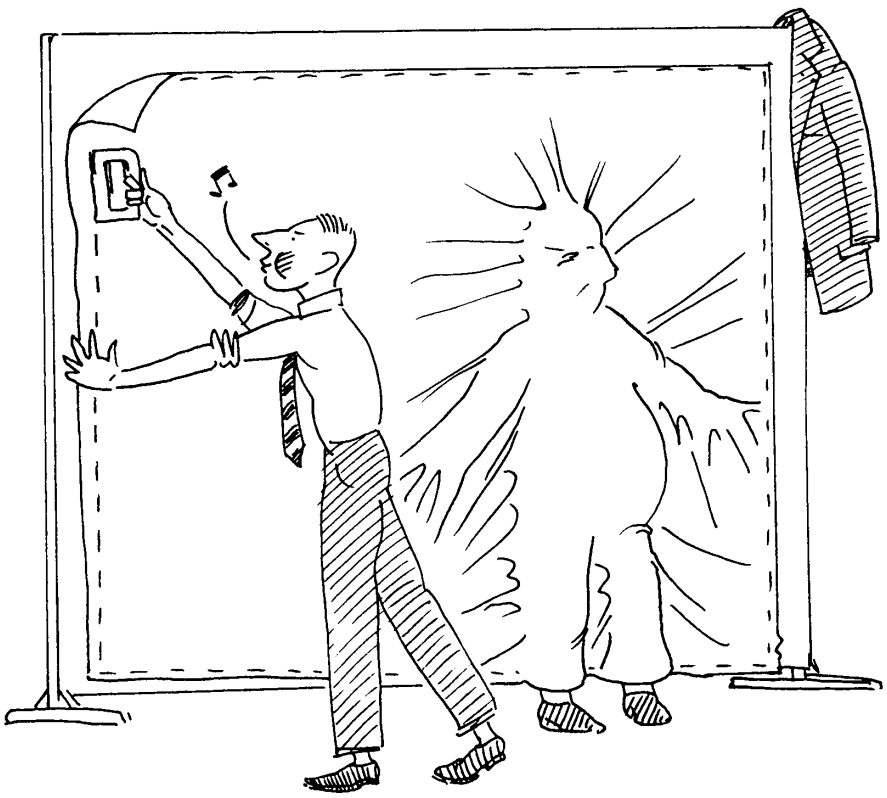
But whichever method is used, the results are likely to be disappointing. It is almost impossible to keep exhibits taut and flat without tearing, and eventually they tend to sag, distort or curl.

It is far better to mount the exhibits first on backing card. This should be not less than 12-sheet board (a little thinner than one-eighth inch hardboard). Other types of mounting card are available, but the modern, very light, very strong ones are also very expensive.

There are many different adhesives available for mounting exhibits on card, but one of the latest uses an aerosol spray. Although this is quick and simple it could be a health hazard because the liquid glue can easily get into the lungs. Even for mounting one photograph, the wearing of some kind of mask over the mouth and nose is recommended.

Two traditional methods for mounting photographs or similar items which give very good results are:

Dry mounting Dry mounting tissue should be available from most shops selling graphic designers' materials. Cut a piece of tissue larger than the photograph and sandwich it between the back of the



Using an upholsterer's staple gun, fix the felt along the edges

photograph and the card on which it is to be mounted. After protecting the front of the photograph with brown wrapping paper, run a warm iron over it. The warmth will slightly melt the tissue and produce a permanent bond. Trim off excess tissue.

Rubber solution (for example, Cow Gum) Coat the back of the photograph and the front of the card with a thin layer of rubber solution and leave until the gum is dry to the touch. Then bring the photograph and board together, keeping them under slight pressure for a few minutes.

Both methods produce permanent bonding, but there is only one chance to get it right if the photograph and backing have been cut exactly to size. It is a good idea to use, if possible, a slightly oversized photograph and trim off the excess all round when the bond has been made. Plans, text or similar non-photographic exhibits can be mounted in the same way, but paper which is very thin needs extremely careful handling to avoid wrinkling.

Many items which look perfect immediately after they have been fixed gradually assume a permanent and unwanted curved shape as the glue dries. The problem can be avoided by a technique called balancing. In the case of a photograph, for example, this involves pasting a piece of paper of roughly the same weight as the photograph to the back of the mounting card at the same time as fixing the photograph on the front. The opposing tensions on both sides of the card will keep it flat.

Lettering

Few people have a steady enough hand to prepare faultless sign-writing. It is best to settle for other methods.

Large lettering Individual, self-adhesive letters are obtainable in soft plastic or vinyl materials in a wide range of shapes and colours. They are useful for main headings, but costs can soon escalate if they are used extensively. Sometimes they can be peeled off and used again.

An alternative is three-dimensional letters cut from wood, cork or polystyrene. Although they may be expensive to buy initially, they can be used repeatedly.

A less expensive method is to cut stencilled letters from coloured card, but the cutting and mounting have to be done with extreme care to obtain a good finish.

Small lettering For almost any exhibition, standard typewriter lettering is too small. However, if it has to be used, golfball or daisy wheel typewriters, or high-quality printers linked to word processors, offer wider selections of typefaces, both in size and style.

Dry-transfer lettering is available in a large variety of typefaces and

sizes, but it is expensive to use in bulk and needs a practised hand to make it look neat and professional.

Machines are available which can print lettering in a range of sizes and typefaces on to a strip of clear, self-adhesive tape. The tape can be stuck on a piece of card and mounted straight on to the display board. However, some people prefer to photocopy the tape after it has been mounted and to display the photocopy. This prevents any light reflecting from the tape or the edges of it becoming noticeable.

This lettering system has many applications apart from displays. It can be used for slides, book titles, names on doors, overhead projection, graphs, notices or any artwork for printing or duplicating. It should enable an unskilled person to produce acceptable lettering quickly at low cost.

Enlarging and reducing captions and typed matter Almost any artwork or text can be enlarged or reduced by a competent photographer. The photographs can then be mounted on card as described earlier. For small captions, it may be cheaper to ask a print production company (not a photographer) for a photo-mechanical transfer (known as a PMT) which for all practical purposes is a very high quality photocopy.

Coloured backgrounds

Most manufactured display boards are available in a variety of colours, from the subdued to the bright. Strong background colours can add great impact provided items are displayed in a clean and uncluttered way; in a busy or muddled design they highlight defects in a way which neutral colours do not.

If the display boards available are of an unsuitable colour, they can be covered completely by display panels made the same size as the boards. The panels themselves may have to be painted or covered with, say, felt to obtain the background colour required.

Where display boards are held in their metal frames by clips, the boards can be removed completely and replaced by the newly-made display panels, particularly if the panels themselves have been made from a durable material like hardboard. Putting the panels directly into the frame gives the display a much more professional appearance.

Layout

Since an aspect of most do-it-yourself displays is lack of time, as well as lack of money, there is not much point in spending hours agonising over artistic merit. The best thing to do is to keep the display simple and uncluttered, using text and bright colours sparingly.

In the absence of a 'designer's eye' for shape and form, it is best to stick to a simple grid system for the layout. This will give even the most mundane material a sense of cohesion and style. For a more

daring approach, the display boards or panels can be treated as though they are the pages of a magazine. If a magazine page pleases the eye, the same layout several times larger on a board or panel will probably do so, too.

Using three dimensions

There is no need to restrict exhibitions to two dimensions. The introduction of a simple model, for example, will help change the 'feel' of the whole layout.

Photographs and other flat items can be displayed in a three-dimensional way by mounting them on thick material – one-inch deep polystyrene, for example – which will hold them proud of the display surface. Combining this technique with the use of strong contrasting colours can produce quite dramatic effects. Alternatively, individual items can be highlighted by enclosing them in simple wooden frames.

Space permitting, the 3-D technique can be taken further. Photographs, drawings or text can be mounted on the faces of large cubes made from wood or stout card. The cubes can be placed by themselves on a table or can be stacked, either according to a pre-planned grid or in a more random fashion. Three-dimensional objects, such as surgical or laboratory equipment, can be displayed in a similar way to good effect.

Major exhibitions

A do-it-yourself exhibition which suffers from creeping growth may become not so much a major exhibition as a disaster. A major exhibition usually calls for outside professional services and will need to incorporate most, if not all, of the following:

Large photographs for increased impact.

Typesetting.

Imaginative and skilful use of colour.

Very big display boards and panels, or a large number of them.

Complex models.

Surface protection to avoid damage to the boards or panels.

Video or slide-tape machines or special lighting effects.

Specialist services

There are companies throughout the country offering exhibition design and production services. They will write the text, obtain photographs and drawings, have them superbly displayed, and deliver the whole exhibition on display panels to the client. This is easy – and also very expensive.

It is often less expensive if the client does some of the work, particularly at the planning and writing stages, and buys in photographic, design and production services as required. The

regional public relations department will be able to advise on this and may be able to offer practical assistance.

But no matter how much outside help is used, it is up to the client to decide *what* needs to be said and to *whom*. The professional will suggest *how* it is to be said.

Photographs

Using amateurs' photographs seldom saves money. Enlarging them to several times their normal size will show up such faults as camera-shake or bad focusing. Some mistakes can be rectified at the processing stage, but the costs will probably exceed those of hiring a professional photographer or using the medical photography department of the hospital.

Designers

Professional designers are skilled in the use of colour and typefaces, in judging the varying impacts of different sorts of exhibition materials and in matching one aspect of a display with another. They should also be able to provide maps, drawings or other artwork, such as cartoons. It is the designer's job to produce the final artwork from which display panels will be made. Last-minute changes to final artwork can be difficult and expensive to carry out, and it is much better to make alterations in the planning and drafting stages.

Production companies

Most production companies – the people who will make the display panels – also offer their own design services, but there is nothing to stop a client using another designer or producing the designs himself. It helps, however, to know something about the techniques used by the production company. It is possible to save money simply by knowing what is and what is not possible and by having some idea of the most economical but effective ways of presenting a display – for example, by choosing standard colours rather than insisting on relatively exotic shades which are far more expensive.

All display items should be supplied to the exhibition maker at the same time and not in dribs and drabs. Panels for the same exhibition made at different times could have slight colour variations which will not become obvious until they finally go on display together.

It is essential to make sure that the designer and the exhibition maker know exactly what size to make the panels for display. Hospitals which have old but still serviceable display boards made to imperial measure are likely to be disappointed when display panels made to metric equivalents do not fit exactly.

Mobile exhibitions

A mobile exhibition trailer is a major investment which can be right for the needs of one district or group of districts but not for those of another. The following questions need to be considered before making a decision:

What is the mobile display intended to achieve?

What are the major advantages of mobility?

Can an existing vehicle (say, a caravan) be adapted or will one have to be purpose-built?

If one can be adapted, will it be large enough?

Is it to be a mobile office or used simply for storing leaflets and equipment?

Do fire regulations have to be taken into account?

Will it be easy to tow and maintain?

Will an extra member of staff be needed to drive it about?

Are there insurance difficulties?

How often will it be used?

How much will it cost?

Exhibition shells

Shells can be hired at large exhibitions – a nursing career exhibition, for example. A shell is simply a structure consisting of three walls and an opening which faces on to a corridor or walkway. Display panels are fixed to the walls, and a fascia panel provided by the exhibition organisers is placed above the shell facing the corridor or walkway.

Before hiring a shell, the exhibitor should make sure any existing display panels will fit on to the walls, unless new, made-to-measure panels are going to be ordered. He should also bear in mind that although the hire cost often appears to be modest, it may not include important extras. The quoted price is usually for the basic shell only and may not include the provision of an electric point for showing slides, additional lights for display panels, the hire of furniture or storage for leaflets or personal belongings. Sometimes exhibitors are not allowed to provide their own furniture; it has to be hired from an appointed supplier.

To get the full value out of taking space at a large exhibition, it is worth observing these do's and don'ts:

Do organise the display to encourage people to come on to the stand and look around.

Don't block the entrance with tables, chairs or an abundance of pot plants.

Do give people a chance to read at least some of the display before asking if they would like further information or help; people will probably be shy about talking immediately they come on to the stand.

Don't stand intimidatingly at the front of the stand and frighten everyone away.

Do keep the stand tidy: no empty cups, half-eaten sandwiches or ashtrays full of cigarette ends (and, preferably, no ashtrays at all).

Don't keep all the printed material piled in cardboard boxes: use leaflet racks.

Do keep video or slide-tape sequences short: most people will stand and look for only two or three minutes, and a message must be put across to them in that time.

SECTION 6

House journals

House journals or staff newsletters can play an important part in helping communication with staff. They can inform, interest and involve, foster mutual understanding, and create a unity of purpose throughout the organisation.

Examples in the NHS range from low-frequency/high-cost quarterly newspapers such as *Link* and *Norwest*, published by Wessex Regional Health Authority and North West Thames Regional Health Authority, to high-frequency/low-cost journals such as *Gateway News*, produced fortnightly by North Western Regional Health Authority. There are also hundreds of individual district and hospital bulletins and newsletters which fulfil at least some of the functions of a house journal.

Because the various kinds of publication call for different levels of design and production their style and size are generally governed by budget and staffing. A regional newspaper or magazine will pay considerable attention to typography, layout and the balance of photographs and text. A district or service information bulletin will usually be designed and printed commercially, although its format may be simpler. A hospital newsletter will probably be typed and photocopied internally, although it should still look attractive in appearance and content.

Authorities do not face a discrete choice between one or other of these types of house journals, however. A quarterly regional newspaper cannot provide detailed local information, and a weekly A4 newsletter cannot offer background material in depth or coverage of significant regional or national stories. It may be that an authority needs to consider having more than one type of journal if it wishes to develop a comprehensive staff information policy.

All types of house journal do, however, foster a common sense of identity among people working in different parts and at different levels of an organisation. They offer staff a chance to understand and debate the plans, policies and problems of the organisation and often give them the opportunity to 'let off steam' which might otherwise find more disruptive outlets. Above all, they show that the organisation cares about them, needs their support, and recognises and applauds their professional and personal achievements.

House journals can also perform an important role outside the immediate confines of the organisation. They can give news and background information to the media, be a communication channel

to government, MPs and other opinion-formers, and provide information to the public through community health councils, Citizens' Advice Bureaux, public libraries, colleges, schools and other information outlets.

Content

Although the content of house journals will vary according to size, style and local needs, it will normally include some or all of the following:

National, regional and local health service news.

Management information to staff.

Feature articles.

Personnel news – about newcomers, leavers and promotions, for example.

Staff association and trade union news.

Health education items.

Letters from readers.

Competitions.

'For sale' and job vacancy advertisements.

House journals often give staff the opportunity to 'let off steam' which might otherwise find more disruptive outlets

Editorial freedom...

A house journal must have an editor – a single editor. Editing by committee does not work. It gives the journal little chance of attaining an interesting, consistent and attractive style in either writing or appearance, and will often make it subject to editorial delays which inhibit its ability to respond to late news.

Health authorities may wish to nominate a member of the regional public relations staff as editor. More often, however, staff from other disciplines are designated as editors, in which case they should be given at least a basic training in house journal production. This is something regional public relations staff are generally able to provide.

Authorities should resist the temptation to 'vet' all copy (the material to be printed) before publication. They should not regard it as their 'right'. Nor should senior managers, although a responsible editor will often ask them to check stories which are particularly sensitive or complex.

Editors should be given a free hand to try to produce a journal which has credibility with both the authority and its staff by presenting a balanced, accurate picture. It may require courage for an authority to give an editor freedom to print those stories which he believes to be important, even if some are critical of the organisation or its policies, but the alternative is a 'management journal' which may lack general credibility and fail to communicate.

...and responsibility

Editorial freedom carries with it responsibilities beyond ensuring the smooth and efficient production of a house journal in mechanical terms. The editor must ensure that the journal reflects the general aims and direction of the organisation, and that its editorial policies are in line with the organisation's own policies.

Since the primary aim of the journal is to further the aims of the organisation through positive staff relations, editors should actively encourage readers to use the house journal as a forum for discussion and debate. Space should be readily available for readers' views and comments (subject to the normal legal bounds of defamation), while controversial or thought-provoking articles can be included to ensure that the journal does not become too bland.

In particular, editors are responsible for making sure that every part of the organisation feels that it contributes to, and is reflected in, the house journal. Large teaching units, together with doctors and nurses, will generally be considered more 'newsworthy' than, say, domestic staff in a small unit who do a valuable job but who are normally not publicity-minded. Nevertheless, the editor must ensure that no-one is overlooked and apparently forgotten by the organisation.

Many journals will have a definite policy on certain issues, such as smoking or the right of staff to be kept informed of matters which affect them and their jobs. But a policy line must be tempered by objective judgement. For example, a strong line on smoking should be accompanied by a willingness to print staff opinions which may challenge that policy.

Editors are also responsible for monitoring response to the publication and adapting it to meet the changing needs of the organisation and its staff. A tried and tested format or content is not necessarily the best one for the future: organisations evolve, and house journals should do the same.

Finally, an editor is responsible for maintaining standards of publication and should not be afraid to cut or alter any material submitted if necessary. Nor should he feel obliged to refer back to contributors for permission to make changes, unless a prior agreement to so do has been given. An editor takes personal responsibility for what is published, and with that responsibility comes a clear right to edit.

Production arrangements

It is particularly important to get the mechanics of the operation – the inward flow of copy and the design, printing and distribution – running smoothly, otherwise the task of producing a regular publication to strict deadlines, especially on a weekly basis, can take up an inordinate amount of staff time.

People not previously involved in editorial work often have only a limited understanding of what happens to copy after it is handed in, and may fail to appreciate that a fixed publication date means a strict deadline for the delivery of material. Unless it is totally unavoidable – and very few stories will be that important – an editor should never agree to delay publication in order to wait for material. If staff expect a new edition regularly on a Wednesday, it should come out on the Wednesday.

Similarly, a wise editor will set down standards for the submission of material. Copy should not be taken over the telephone, as this can easily lead to errors; nor should it be sent in as scribbled jottings on the backs of envelopes. The accepted standards are that copy is presented in typed form, double-spaced on one side of the paper only, and that it carries the name, department and telephone number of the contributor.

Relatively simple guidance from the editor should also be given on writing style. In general, a story should be clear and concise, free of jargon, and with the basic point of the story in the first paragraph.

Advertising

Only a small proportion of house journals take advertising material

other than personal advertisements from staff. It could be argued that if an organisation wishes to communicate seriously with its staff, it should be prepared to bear the financial consequences. On the other hand, if commercial advertising can be included without restricting the editorial content of the journal and can lower the cost of production, there is in theory no good reason for excluding it.

The real difficulty is practical rather than philosophical. Collecting advertising is very time-consuming. Many advertisers will be committed already to local newspapers; production deadlines for anything other than weekly bulletins can prevent many potential advertisers from displaying special offers arranged at short notice; advertisers may expect the journal to provide a design and artwork service; and the collection of fees can be administratively complicated.

Many health authorities may also impose restrictions on the type of commercial advertising which can be accepted – for example, on tobacco or alcoholic products and medical products. These restrictions will exclude the companies which would most wish to advertise in a journal aimed exclusively at health service staff.

Some of these problems can be overcome by engaging a specialist space-selling agency on a commission basis, but most of these agencies find it difficult to sell enough space to make the job worthwhile.

House journals which do carry advertisements tend to take them from staff only. These are usually best suited to individual unit newsletters or weekly bulletins because the collecting and collating of advertisements on a regional basis is too time-consuming. Some authorities do not charge for advertisements from staff.

This is a useful service, but a distinction needs to be drawn between personal staff advertisements and advertising by companies such as cosmetics wholesalers or local firms which may have made special arrangements with staff associations to sell their goods at discount prices. Editors should think twice before giving free space to commercial advertisers in any publication financed, however modestly, by health service money.

SECTION 7

Public meetings

Arrangements for public meetings will depend on local conditions and the topics to be discussed. A cardinal rule is to make sure in advance that everything, particularly any audio-visual system, works. The following checklist should be helpful.

In advance

Before planning begins, identify the need for the meeting and what its aims should be. Decide who is to be responsible for its organisation and management, whether a single person or a small working group.

Once it is agreed to hold a meeting, decide on the scale of the event. This involves assessing the amount of interest the subject will generate and therefore the number of people who could attend. Do this before questions such as the venue, advertising and organisation are discussed.

Finance

Costs could be incurred for:

Advertising and supporting literature.

Hire of room.

Hire of audio-visual equipment.

Catering.

Speakers' fees and expenses.

Where and when

The venue should be:

Easily accessible to those people who will be most affected by the topic under discussion, preferably with free car parking close by.

Large enough to seat more than the anticipated audience.

The date should be chosen to avoid:

Major televised sporting events.

Election nights.

Meetings of a local authority or community health council.

The time depends on local conditions, but 7.30 pm is normally acceptable.

Chairman and speakers

Before the meeting is announced, choose a chairman. For some controversial subjects it may be wise to have a neutral lay chairman. Decide on and invite the speakers. An outside speaker should be briefed carefully on the local situation.

Publicity

Publicity should start about three weeks before the date of the meeting. Methods include:

Newspaper advertising.

Posters.

House-to-house distribution of notices in the area most likely to be interested (the local residents' association may help here).

News release to newspapers, radio and television.

The venue for the meeting should be easily accessible

Audio-visual aids

Methods available for use before, during or after the meeting include:

Exhibition display.

Video or cine film.

Slide-tape presentation.

Models or diagrams.

If audio-visual aids are to be used, the following should be checked:

Whether equipment is being brought by the speaker or has to be hired.

Availability of power points and extension leads.

Blackout facilities.

Content and suitability for the meeting of audio-visual material not already seen.

On the day

Before the meeting, check the following:

Adequacy of seating.

Heating, ventilation and lighting.

Blackout, projector, slides, screen, plugs and so on for audio-visual aids.

Public address system.

'Reserved' signs for invited guests.

Catering arrangements.

Literature – programmes, agendas, leaflets.

Press table with enough chairs.

Audibility at the back of the hall.

The chairman and speakers should be fully briefed. About half-an-hour before the meeting is due to start at least one person should be positioned at the door to welcome early arrivals, give out literature and check that there will be enough seats.

During the meeting, it is important to:

Start on time.

Keep all the speeches short, especially if there are several speakers. Their part of the evening, including any audio-visual presentations, should be over in about 45 minutes or so.

Allow reasonable time for questions, however lengthy the meeting may become. This is especially important in meetings about controversial issues. People will stay as long as they are interested. Questioners should be asked to identify themselves.

If a question cannot be answered, offer to take the questioner's name and address and undertake to send the answer as soon as possible. Always make a response.

At the end of the meeting, provide tea and coffee if possible and let the speakers talk informally with members of the audience.

Follow-up

If the subject of the meeting is a new scheme, use the occasion to make contact between the promoters of the scheme and the people it will most affect. This contact should be maintained by another public meeting if necessary and by keeping key individuals or groups informed about progress, possibly by a series of information bulletins or occasional letters.

SECTION 8

Royal visits and other ceremonial occasions

A Royal visit or other ceremonial event needs meticulous planning if it is to be what is intended: a memorably happy and successful occasion. From the moment an invitation is extended and accepted, the health service manager given overall responsibility for the arrangements must ensure that no details are missed.

A member of the Royal family invited to open a hospital or visit a special unit with which he or she is associated should be given between six months' and one year's notice of the event. It is advisable to consult in advance the Lord Lieutenant, the Queen's representative in any large town or county. It is through him that a Royal invitation should be made. An exception to this rule is in London where contact should be made directly with the individual Royal person's private secretary.

Obviously, not every invitation is accepted, and once a member of the Royal family has turned down an invitation it is possible that no other Royal person will consider it. In any case, the subsequent invitation must go to a more junior member of the family.

If a member of the Royal family is not thought to be the appropriate person to be invited or is unable to attend, an invitation may be extended to the Secretary of State for Social Services or the Minister for Health.

Regional health authority chairmen will normally deal on behalf of DHAs with formal invitations to members of the Royal family or Ministers. Alternatively, they themselves might be invited to perform ceremonies.

New equipment or small units in hospitals are often obtained through the fund-raising efforts of charities or local organisations. The formal handing-over of equipment, or the opening of a unit, is usually arranged jointly by the health authority and the charity or body which has raised the money. It is important to establish early on who has the leading role; the key to this is usually the proportion contributed to the cost of the project.

A well-known entertainer, sportsman or politician may be invited as guest of honour by the charity concerned. Sometimes a member of the Royal family may attend, particularly if the charity has a Royal patron.

If a ceremony marks the completion of a particular stage in building work, the contractors should be consulted from the start.

They may want their own event; 'topping out' ceremonies, for example, are always a contractor's function, with health service representatives present by invitation only.

Invitations

The number of people to be invited to a ceremony, and whether they are to include their partners, should be decided early on. In drawing up a guest list, close attention should be paid not only to dignitaries and other VIPs but to the people who worked on the scheme.

The welcoming and platform party – the people who will be the immediate hosts of the guest of honour – should be kept to the minimum.

When a new hospital building is being officially opened, the hospital chaplain or a leading local clergyman should be invited to dedicate it. It may be advisable to invite clergy from other denominations to attend as well.

In drawing up a guest list, close attention should be paid not only to dignitaries but to the people who worked on the scheme

Invitation cards or letters should be sent to all guests at least a month before the function to give them plenty of time to reply. It is worth consulting Debrett's *Correct Form* when writing to distinguished people.

The invitation card should include (in order): the host authority, the object of the function, the guest of honour's name, the name of the hospital or unit and its address, the date and the time of the

function, 'RSVP' and details of whom to reply to.

Once an invitation has been accepted, a letter should be sent giving information (including a map) on how to find the hospital and advice on where to park.

Guest list

For a Royal opening, the guest list should as a general rule include:

The Lord Lieutenant, the Mayor, the RHA chairman, the DHA chairman, local MPs, regional and district members, regional and district managers, project team, senior medical and nursing staff, contractors, consultant architects and engineers, unit managers, general practitioners, representatives of interested groups such as the league of friends, fund-raising organisations and the community health council.

Arrangements

Where, in a Royal visit or other major ceremony, there are large numbers of guests, they should be divided into groups and a pass card system used. For example:

Red card (Group A)	admit to	Reception party VIP refreshments in lounge Reserved seat (platform or centre block of seats) Parking space
Blue card (Group B)		VIP refreshments in lounge Reserved seat (left block) Parking space
Green card (Group C)		General refreshments in dining room Reserved seat (right block) No parking space

A road signposting system showing guests the way to the hospital can be supplied by the AA or RAC, provided they are given plenty of notice. Cars would show:

Red sticker	(Group A)	car park one
Blue sticker	(Group B)	car park two

Each pass card should be accompanied by a letter explaining the parking and seating arrangements.

The system will work only with a well-marshalled team of stewards. The head porter and hospital security officer should be involved from the earliest possible stage to liaise with the police over parking and to brief stewards on the pass card system. Arm bands or badges should be used to identify stewards.

The escorts for the guest of honour and reception party should be chosen at an early stage. Other escorts will be needed for the rest of the guests.

Cloakrooms must be provided for guests, with facilities for coats, hats and bags. Umbrella stands should be provided in case it is raining on the day.

Reliable technical advice should be obtained about the public address system. There should be at least two microphones – one for the guest of honour and a second for other speakers. Microphones are not usually needed for an unveiling ceremony because it often takes place in a small room or hallway.

Pot plants and flowers for decoration are often available at long-stay hospitals at reasonable cost. Many local authorities also provide a floral display service. Presentation bouquets should be bought from a local florist. As to who should present the bouquets, a student or pupil nurse in the hospital, or a small child, are always good candidates.

The ceremony

The guest of honour is welcomed by the regional chairman or the chairman of the host authority except in the case of a Royal visitor, Secretary of State or Minister who are welcomed by the Lord Lieutenant or Mayor. The assembled guests are presented to the guest of honour.

The health authority chairman makes a brief speech of welcome (in the case of a private donation, this may be performed by the chairman of the charity) and invites the guest of honour to perform the ceremony.

If a project has been entirely financed by the RHA and not formally delegated to the district, the building is still owned by the RHA and should be formally handed over by the RHA chairman to the DHA chairman before the opening ceremony continues. The regional chairman may introduce this piece of formal business into the welcoming speech.

The guest of honour then performs the ceremony and will probably say a few words. The Secretary of State or a Minister may wish to make a fuller speech.

The building may be dedicated by the chaplain or other clergy. A vote of thanks is made, usually by a senior member of the medical, nursing or paramedical staff.

A brief tour takes place and the function usually ends with refreshments – a buffet for a morning function ending at about lunch-time; tea and cakes for an afternoon function. Whether wine is provided is up to the organisers.

Schedule

A fully detailed schedule for the occasion is essential, particularly for a Royal visit. It will set out every stage of the programme from the minute the day's preparations begin – catering, arranging the flowers, laying out programmes – right through to the moment the helpers are thanked and disperse.

It will say exactly where and when the guest of honour will go during the visit, whom he or she will meet and what he or she will do. This schedule provides an essential source of reference for everyone involved in the organisation and for the police, stewards and news media. It is vital that the programme is not changed unilaterally at the last minute except at the request of the visitor, in which case everyone should be informed immediately.

Brochures

For most occasions it makes sense to produce a brochure which can be used after the function as an information booklet for patients and visitors.

Information in the brochure may cover the planning history of the unit, physical details of the new building (with photographs and drawings), costs, who paid for the scheme and the names of the project team, contractors, architects and medical staff involved. Day-to-day hospital information can also be included and, in the case of a new health centre or clinic, a timetable of daily sessions and facilities provided.

If a photograph of a Royal guest of honour is needed, permission should be sought from the private secretary who will supply a formal portrait at a small cost or provide the names of photographers who have taken official Royal portraits.

The number of brochures to be printed obviously depends on the number of guests and the information to be included, but for major functions involving Royal guests it is advisable to have at least 2,000 copies, not only for the opening day but for use as a handout to visitors and patients after the official opening. To meet the needs of the day, a printed sheet of paper giving the order of proceedings can be slipped into the brochure.

The news media

The best way to gain the interest of the media is through a news release sent to editorial offices at least a week in advance. For small events, a letter to the editors of local newspapers inviting them to the function and providing some background details will be enough.

The media are always interested in Royal visits, and the Royal family like to be seen carrying out their public duties. In some parts of the country, arrangements for media coverage may be undertaken by the Central Office of Information. This would normally be the case where the Royal visitor is the Queen, the Duke of Edinburgh,

the Prince of Wales, the Princess of Wales, the Queen Mother or Princess Margaret.

For visits by other members of the Royal family, or when other eminent people are attending a ceremonial occasion, media arrangements are normally left with the health service and can be dealt with by, or with the assistance of, the regional public relations staff.

Whoever makes the arrangements will need to make early contact with the police, who may offer a liaison officer. It is sometimes useful to invite the media representatives to the hospital or unit a few days before the visit. They can tour the route and meet the liaison officer and any health service staff who will need to recognise them on the day and whose cooperation may be needed for pictures and interviews.

Most media coverage for Royal visits is controlled by a rota party pass system. This means that a restricted number of photographers, television cameramen and reporters, from the local, national or international media, are allocated rota passes for each individual engagement, with approval from Buckingham Palace. The rota is strictly controlled, and those who have passes will make words and pictures available to non-rota colleagues.

Members of the Royal family object to certain pictures being taken – for example, during a meal or when having a drink – and the VIP refreshments area is out of bounds to the media. Individual members of the Royal family may have other dislikes, such as flash equipment going off while they are speaking. Most national press photographers are aware of these restrictions; they have covered many Royal visits and many are known personally to the Royal family.

The reporters and cameramen should be fully briefed about the route, where they can and cannot go, and which parts of the visit will provide them with the best stories and pictures. They should be given all the available written material, including the brochure, schedule, order of proceedings and advance copies of speeches. (Royal speeches will be brought by the private secretary and handed to reporters just before the speech is to be made). The Buckingham Palace press office will attach a note to each rota pass telling the holder exactly where to attend and who will be briefing him.

The media arrangements need particularly careful planning to ensure that cameramen stay one step ahead of a Royal guest and take their pictures from the best vantage points without disruption. Service lifts, side doors and alternative corridors usually provide a convenient route for them. Television crews will discuss and agree with the organisers beforehand the positions where they will be able to get the best uninterrupted views.

Reporters often prefer to be in a separate group, behind the visiting party, so that they can interview people who have met and talked with the Royal visitor. This is usually more convenient from everyone's point of view. Each group should be accompanied and assisted by a fully-briefed member of the local health service staff or of the regional public relations department.

A room should be reserved for the journalists and cameramen to use as a base during the visit. It should be secure, either locked or kept under watch, so that cameras, film equipment, cases and coats can be stored safely. Ideally, it should have telephones; if not, they should be available nearby. Refreshments should be offered, particularly bearing in mind that the VIP refreshments area is out of bounds to the media.

If a distinguished visitor, such as the Secretary of State, is likely to want to say something significant about national or local health service issues, it is important to set aside a few minutes for a press conference towards the end of the visit and to allocate a room for it.

PART 2

RELATIONS WITH THE NEWS MEDIA

SECTION 9

Understanding the media

Most of the contacts which health service managers have with the news media are with local newspapers. They also have dealings with local radio and, less frequently, with television. Occasionally, they deal with news agencies, the national press and specialist magazines.

Some people thrive on this kind of work, and a few become arch-communicators in the media. The reactions of others range from the timid to the paranoid, or to the happy self-satisfaction of the hospital administrator who was reliably quoted as saying: 'I have no problems with the press. I never talk to them.'

The media will never go away and, as long as there is an independent press, the content and style of what appears in newspapers and magazines will be determined by editors and proprietors, not by governments, bureaucracies or other interests. Much the same can be said of television and radio.

A health service manager should remember that the media do not exist to do him and the NHS favours. If he has an understanding of their needs and the way they work, he will be more likely to enlist their cooperation and ensure positive rather than negative or bad publicity. If relations with the media are good, dealing with them can be a rewarding experience; if bad, their stories or programmes can bring nothing but problems.

Local newspapers

Local newspapers serve areas of towns and villages or metropolitan districts. Their quality varies widely, but their aims are the same: to

attract and keep readers and to reflect the life of the community. Their editors are aware of the partisan views, arbitrary statements and sheer emotionalism expressed in much of what they print, but it is their job to reflect what people do and say without bias and as accurately as possible.

Many health service managers and their staff have good relations with the local press. Regular press conferences are held by health authority managers, and sometimes by their chairmen, to review items of interest to the community and discuss matters under consideration ranging from capital developments to changes in policy affecting services to the public. These meetings are valuable and help to foster friendly relations. They and the more informal one-to-one meetings between health service managers and the press – possibly at health authority meetings – help to give a human face to the management side of the service.

National newspapers and magazines

The national press takes little or no interest in local affairs unless they point up some aspect of a national story; and the 'man on the Clapham omnibus' is not interested in the 'man on the Birmingham omnibus' unless he falls off. Innovations which have more than local significance – new approaches to medical treatment, for example – will interest some national newspapers. So will changes in services which appear to hit at vulnerable sections of the community, such as children or old people.

The impact of national newspaper reporters and cameramen covering a story in a normally quiet, unnewsworthy area can be disconcerting, even unnerving, partly because of the siege-like atmosphere which often develops and partly because of the speed and pressure at which the journalists work, sometimes taking short cuts through back doors and complex issues and turning greys into blacks and whites.

In the magazine field, specialist journals offer the best chance for managers and other health service staff to reach a particular professional audience through the news, features or letters columns; and many of them are interested in news photographs featuring members of the profession covered by the journal.

The mass-circulation magazines, with their own writers, advisers and regular contributors, are less accessible to occasional contributors, but should not be ruled out as possible vehicles of information in, for example, such things as preventive medicine and health promotion by contacting the editor or a particular columnist.

News agencies and freelances

News agencies are commercial organisations which provide news as a commodity or a service. They employ journalists to supply news

and features to newspapers, magazines, radio and television.

The biggest agency in the United Kingdom is the Press Association with its head office in London and reporters based in the main metropolitan cities. The PA maintains a constant flow of news, briefings and features to national and local media. Other, smaller agencies scattered throughout the country feed into the national and local media. This news-gathering network is completed by hundreds of self-employed journalists – some of whom specialise in certain fields such as industrial news or health and social service affairs – and by staff employed on local newspapers who act, quite legitimately, as correspondents for national newspapers or other media. This often explains why a story given to the local paper can appear, very thinly disguised, in the national press or on radio or television.

Television

Television has become the dominant form of modern mass media communication. In news and current affairs programmes, it reports on events and issues in much the same way as the press does, but often with greater impact on people's minds than the printed word. A short item in a television programme can convey more than a whole page of newsprint.

Television can work in favour of an organisation with a good story to tell and, properly handled, can do more for public relations than any other medium. The BBC and the ITV companies are always open to suggestions for programmes, but, like newspapers, they are not servants of the health service manager and he will have no control over the cameras or the editing of programmes and news items.

Again like the press, television must always keep the public reaction in mind. The viewer can become easily bored and literally switch off. So, while they may be informative, programmes mostly emphasise the human touch and avoid masses of statistics and detail.

Regional television, which provides viewers with a nightly digest of local topics, is constantly on the look-out for material with human appeal, of the kind found in the health service. It also likes interesting items which can be expounded by an interviewee who can talk with authority and is, in the widest sense of the word, attractive. An interview gives an opportunity to promote initiatives and inform the public. Its impact is greater than a line in a five-minute news bulletin, however valuable that in itself might be.

Radio

Despite the enormous power of television, the impact of radio should never be underestimated. Many people still treasure the ability to get on with something else while being informed!

Radio is a media growth area. The four national networks are being augmented by an increasing number of BBC and independent

local radio stations.

Although national radio recognises the appeal of health topics, it is in local radio that the best opportunities lie. Local radio stations are demonstrably conscious of their community roles and keen to report and discuss local health issues. Their interest is not confined to news bulletins. Health news and information can be introduced into a wide variety of programmes ranging from regular broadcasts on health affairs, through specialist programmes for the disabled to the ubiquitous 'phone-in'.

The editorial process

An understanding of the media requires some understanding of the editorial process.

Most newspaper stories are written in a rush. Many reporters dictate directly from their notes by telephone. But when they put the telephone down, the copy – the words they have composed – is only half way to getting in the paper. In its 'raw' state it will have some ill-constructed sentences, some extra and often useless words, probably a few spelling and punctuation mistakes, and perhaps a factual blunder. It may not always conform to the newspaper's way of writing which can vary from the racy style of the tabloids to the heavier prose of the 'serious' newspapers. All these points are picked up in the next stages.

Many reporters dictate directly from their notes by telephone

In most newspaper offices a reporter's copy goes through the hands of a news editor, part of whose job is to 'taste' the copy and assess how it is to be treated. The copy also goes to the chief sub-editor. As well as sharing in the judgement of a story, he will be aware of other factors.

The chief sub-editor has page plans on his desk which show the layout of the advertising space that has already been sold, and the space remaining for news. He may have pictures which link with the event covered, or he can call up pictures from stock. And he has deadlines which tell him, hour by hour, that some pages must be completed ahead of others.

Taking account of the news editor's advice (and in some cases the editor's views) he will decide which stories go where, and how much space he can give them. To some extent this will be governed by what copy is available as deadlines approach. Major stories arriving late may have to be given less prominent treatment than relatively unimportant stories which were there when needed.

The chief sub-editor will decide on the size of headline and the typeface, how the story will be set out (double or single column, or across several columns), the kind of type (bold, italic, medium or light), the style of type (serif or sans serif) and whether any typographical devices, such as boxes, rules or printing in white out of black, are to be used.

He marks the copy with his instructions and passes it to a sub-editor whose job will be to prune, sharpen and tighten the copy to eliminate slackness. The sub-editor will sometimes re-write the first few sentences of a story to emphasise the 'news point' more strongly. His perception of what is interesting, topical or 'newsy' about a story may override the angle chosen by the reporter. He will check for accuracy, punctuation and spelling, make sure the copy fits the space earmarked for it (by cutting if necessary), and write a headline. The headline must grab the reader's attention and reflect the main point of the story.

It is in the writing of headlines that many difficulties arise. People read newspapers like butterflies visiting flowers: if there are no bright colours they pass them by. So headlines have to be arresting, exciting and terse. They also have to fit the space allowed in the type size required. That is why sub-editors have a vocabulary of short words which turn every disagreement into a row, every refusal into a snub, every investigation into a probe and every confidence into a secret.

Sub-editors like to get feeling into a headline ('Union fury over private beds') or a verb which gives the headline a sense of action ('Minister orders costs probe'), and they like to substitute nicknames for titles ('Health chief snubs watchdog').

Given the limits within which sub-editors have to work, and the chances which exist for a reporter's story to be transformed on its way to the presses, the incidents which give rise to serious complaints of misrepresentation are remarkably few. Nevertheless, the operation is so complex that it is vital for people providing information to the media to make their points clearly and unmistakably in order to avoid misleading reports and headlines – not least when journalists are working on 'a good story'.

A 'good story'

Journalists like to argue that there is a faculty called 'news sense' which media people have and lesser mortals lack. Often it is true that an instinctive feeling about a story makes an editor splash it on page one or hide it on page nine, but there are some clues which might help a health service manager to know what to look for.

Good newspaper stories are often those which create an emotional response, or a lot of people can share in, because they relate to a common experience. Stories which prompt joy, fear, excitement, pity or outrage clearly make 'strong' copy. So do stories which affect a large number of people – even if only to tell them that their rates are going up or that their hospital may close.

The media also have a special relish for anything which makes a public authority look an ass. They love the million-pound gas bill and the hole in the newly-surfaced road, or the letter delivered five years after it was posted.

What bring all these ingredients together more often than not are people. Stories about organisations and policies have their place, but the best stories have 'human interest' as the main ingredient. While the instinct of public servants is often to de-personalise and talk about 'patients' or 'the mentally handicapped' or 'the elderly', the media are constantly looking for stories about people.

Individual babies, children, mothers, grannies, surgeons, nurses and porters can illustrate the quality and achievement of the service – and its shortcomings – much more effectively than facts and figures.

Television and radio treatment

The way news is assessed and evaluated for television and radio is similar to that for newspapers. The main stories will often be the same in newscasts as in newspapers, given that transmission and publication take place at roughly the same time.

What is different is the treatment. The amount of time devoted to any story will usually be dictated, or at least influenced, by how 'visual' a topic is for television and whether it can be told 'from the horse's mouth' in the case of radio. If in television there is time for only one story and there are half a dozen stories of equal news value,

the story chosen for transmission will be the one which is the most interesting visually.

Television news needs to be pictured. Radio news needs, in most cases, the people involved to explain the happening at first hand. The same can be said for the other kinds of current affairs programmes, such as documentaries.

While individual newspaper reporters will often decide which stories to cover, television news reporters rarely do because they have to work with a camera crew. Television news editors decide on assignments, generally after editorial conferences which discuss the events and news of the day and the best use of the available reporters and cameramen. Radio reporters are controlled in a similar way, but to a lesser extent.

A television news reporter is constantly 'fighting the clock', more so than newspaper or radio reporters, because his product is made by a team. Deadlines are now later, however, because television organisations use ENG (electronic news gathering) cameras which, provided there are support facilities, can transmit live or record events on magnetic tape which can be edited very quickly.

Once back in the studio, television reporters usually determine what is used of their story after consultation with the programme editor or news editor. The way in which picture and sound are edited and married together for transmission is the responsibility, firstly, of the film/video editor and, secondly, of the studio director.

The reporter will write a script for his filmed story and, generally, will also write the introduction which is read by the newscaster. The whole script is subject to editing by the programme editor who rules on the shape and content of the entire programme.

Television documentaries are often made on film, and will take anything from days to months to research, shoot, edit and script. In contrast to the news operation, which involves relatively few people, the documentary will have a large production team. This will usually include a researcher, a reporter/interviewer, a film director and a producer. While the researcher, the reporter/interviewer and the director can, and do, influence the content and thrust of the programme, it is usually the producer who plays the dominant role. The script is generally written by the reporter, but his are not the only 'statements' made; vision and background sound make their own contributions.

SECTION 10

Dealing with the media

Publicity in the media is obtained either by reacting to a situation – one which as often as not is unwelcome – or by seeking it positively. Good publicity obtained by taking the initiative encourages the public to take interest and pride in the achievements of the health service.

Achievements and new ideas are to be found in every region and health district. Sometimes, particularly when morale is low, they may appear thin on the ground, but successes do occur and the opportunity to tell the media and the public about them is frequently missed. A conscious, active policy towards media publicity should be adopted rather than a passive one, and health service managers should establish a constructive relationship with journalists.

The manager who treats them with respect will usually be treated in the same way. Frequent dealings with a particular journalist will often lead to mutual trust and a clear recognition of each other's professional role and responsibility. The manager has a reliable outlet for his news and views and the journalist has a source of accurate information.

Journalists should be given information in an understandable form, free of jargon. The manager, faced with an unfavourable story, should give as many of the facts as possible. Saying nothing will lead to ill-informed speculation, which can quickly get out of control. The temptation to mislead is very strong when something goes wrong, but the person who tells a lie or a half-truth is stuck with it. The clever plan, cunning deception or airy dismissal will sooner or later be found out.

Journalists who approach a manager for information or comments are giving him a chance to state his case. If he ducks the chance they will get the information 'through the back door' – perhaps from people who may put distorted interpretations on a situation. Anyone who gives the media inaccurate or misleading information should not be surprised if something is published or broadcast which is untrue or heavily slanted.

Ten key rules

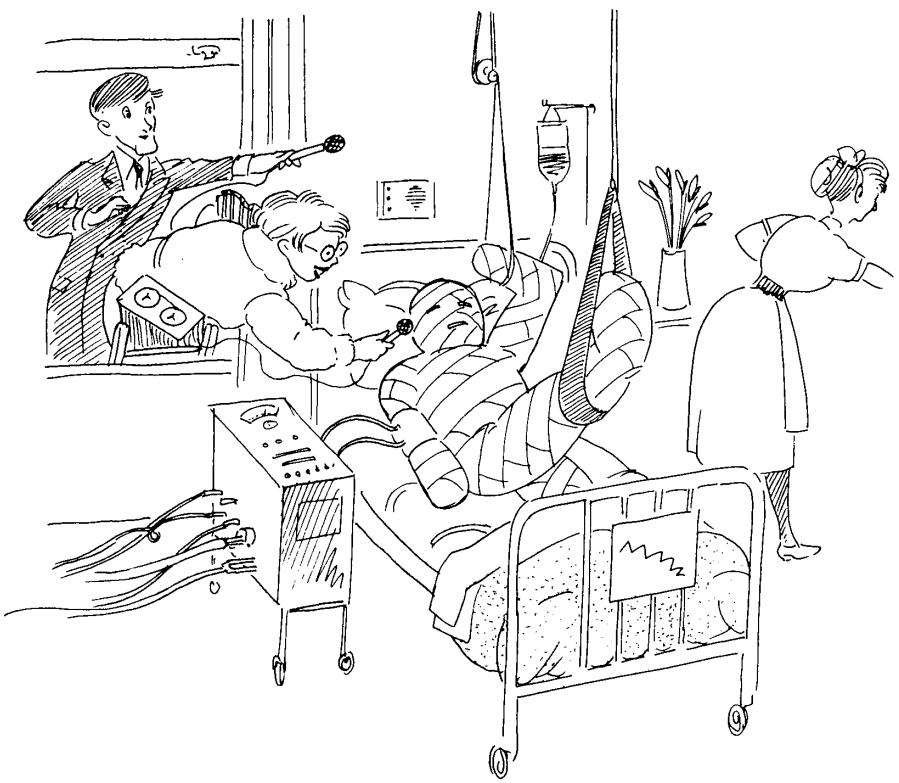
There are ten key rules in developing and maintaining good relations with the media.

Don't be discouraged Be prepared for journalists to 'angle' a story to attract public attention in a way you might not like. The media do not have a duty to print or broadcast whatever you say exactly the way

you say it. Journalists are human beings, so do not be shocked if they make mistakes. Ranting and raving will not put things right. A polite but firm word to the editor might. Do not be put off by one or two bad experiences. The value of the media in communicating with the public cannot be overstated.

Don't resent enquiries from the media The responsibility of the health service to the public and to the media is to provide information about matters in which they have a legitimate concern. The media will take an interest in the health service whether or not they are invited to do so.

Develop the human touch Human stories always make the best publicity because they are the stories people want to read and the ones they remember. Much of the adverse criticism of public bodies is based on stories which make them appear to be lacking in humanity. It is not enough for a decision to be fair – it must look fair to the public. When circumstances make a decision appear unfair the reasons must be clearly explained.



If the manager ducks the chance to state his case, journalists may get the information from people who may put distorted interpretations on the situation

Take the initiative Adopt an active policy, not a passive one. List the achievements and innovations of your organisation and consider whether they would be of interest to the media. If so, give them the facts.

Remember deadlines All the media work to very tight timetables and it is essential to give an answer before a deadline. Otherwise an item of good publicity might cease to be news, or a detrimental story published which could have been made innocuous or turned to your advantage by a prompt reply to a reporter's enquiries.

Respect the 'exclusive' If a reporter, through his own initiative, obtains a good story do not give it to other journalists to get wider publicity. It is regarded as unethical.

Never play favourites Every journalist should be treated on an even footing, whether or not you like their attitude; there should be no discrimination. Favouritism could mean the loss of respect and trust built up in the past.

Never say 'no' When asked for something which seems impossible, it is best to reply on the lines that 'it may be tricky to arrange but we will see what we can do.' When you ring back, the journalist's interest may have waned, but he will appreciate your efforts, especially if you are able to arrange something or even if you have to explain the impossibility of his request.

Strive for accuracy One of the first essentials in building up confidence with the media is to be accurate. A reporter's struggle is often against inaccuracy, for accuracy takes time and time is in short supply to the reporter. The spokesman who constantly helps to achieve accuracy soon becomes an ally.

Try to anticipate trouble If there has been an unfavourable incident which might reach the ears of the media, collect the facts and anticipate all the questions which might be asked.

Coordination

In all dealings with the media, whether positive or reactive, health service managers should make it clear who may or may not talk to journalists and broadly in what circumstances. As a general rule, media relations are the responsibility of senior managers at regional, district and unit level, and the responsibility is written into their job descriptions. Regional public relations officers usually act as spokesmen for RHAs and for the health service generally in their regions.

The designated managers and public relations officers are often the first points of contact for the media. Depending on the nature of the enquiry, they may refer a journalist to colleagues in other disciplines, such as a community physician or nursing officer, who

are in a position to answer the enquiry with knowledge and authority.

The ability to do this with confidence depends to a great extent on the organisation having established procedures for handling enquiries, from questions about conditions of patients to policy matters. It is important to ensure that the arrangements are known and clear to everyone likely to be in a position to be approached by the media. Such arrangements will include the briefing of hospital 'duty officers' about any cases which are attracting, or likely to attract, media interest.

Having arrangements for dealing with the media should not create a bureaucratic straitjacket. The attitude to the media should be one of open-handed helpfulness. In a good organisation it should be possible to point the media in the direction of experts in various parts of the service, and there are occasions, such as a press visit, when all staff should be encouraged to speak to journalists – preferably without their superiors standing threateningly within earshot!

SECTION 11

Ways of communicating

Information may be communicated to the media by person-to-person contact, or through a press conference, press reception, press visit or press briefing. (These functions might more properly be called 'media conference', 'media reception' and so on, but the traditional terminology remains.)

Any of these methods will help journalists to understand the subject and its background, set it in context, and report it accurately in a way which serves the interests of the organisation, the media and the public. They are best used in situations where, for example, the organisation wants to announce and describe a new project, explain controversial changes such as the closing of a hospital, or try to gain or regain an initiative – in an industrial dispute perhaps.

Timing is important. Occasionally it will be dictated by events, but as a normal rule a press function stands a better chance of being covered and reported if it is held early in the week. (It will also stand a better chance of being well attended if it does not clash with another important event.) A Friday afternoon might suit local health service managers or the authority chairman, but will seldom suit the media. Weekly newspapers will have been printed, and the next morning's papers will be concentrating mainly on sports and entertainment. Regional television and local radio will almost certainly not have the time to give to the subject.

Person-to-person contact

This is where a manager, who probably knows a journalist, gives him information for a story either at a meeting between them or on the telephone.

The press conference

A press conference is organised rather like a public meeting, the guests being seated to receive an announcement and ask questions. Hospitality is usually modest – tea or coffee with biscuits. Copies of the announcement should be available in the form of a news release. It is an unpretentious occasion, sometimes called at short notice if the urgency of the news demands it.

Press conferences should not be arranged unless they are necessary. Journalists, like health service managers, are busy people and do not want to waste time listening to boring, unnewsworthy statements of no interest to their readers, listeners or viewers.

When planning a press conference, it should be borne in mind that journalists are trained to ask penetrating questions. It is wise to

anticipate the questions and to be armed in advance with the answers.

Television and radio reporters who attend will almost certainly want separate interviews. A room should be provided nearby where a television crew can set up their equipment and interviews can take place at the end of the press conference.

Journalists are trained to ask penetrating questions. It is wise to be armed in advance with the answers

The press reception

A press reception is much more than an occasion for social drinking. Contrary to popular opinion, journalists attend press receptions and similar functions in search of a good story, not for free food and drink.

A successful formula is reception, initial refreshments, business of meeting and final refreshments. It is wise to divorce the business part of the reception from the eating and drinking. Preferably, guests should be seated to listen to the opening remarks and statements and to pose questions. The speaker who breaks off from drinking to mutter a few ill-chosen words with his back to half the audience is not likely to receive good media coverage.

Only the minimum necessary number of people from the host organisation should be invited; too many may suggest they can be

easily spared from work and also adds to the expense. The hosts should wear badges with their name and job title clearly readable. It makes contact and conversation much easier. Conversation can be especially valuable on such occasions; it gives the hosts and the journalists the chance to discuss the subject of the day in greater depth and often to identify ideas for other stories which might otherwise have been missed.

The press visit

This provides reporters and cameramen with the opportunity to tour a new hospital or department, for example; to attend a treatment session, or to see other aspects of the health service. A press visit is sometimes useful on the eve of a Royal or Ministerial visit, when most of the attention has to be concentrated on the VIPs. The purpose is to bring the media to the story and help them to understand it. The steps to be taken when arranging a press visit are:

Invitation Usually by letter one to two weeks beforehand.

Follow-up Journalists do not always bother to reply to invitations but turn up just the same. Two days before the visit journalists who would be especially welcome should be telephoned, reminded about the invitation and given the final details.

Reception Reporters and cameramen should be welcomed on arrival and shown where to go, where to leave valuable equipment and where there are telephones.

Transport If it is necessary to visit different parts of a site, it is helpful to keep the party together by providing transport.

Refreshments If the visit is in the morning, coffee and biscuits should be provided on arrival. Some journalists may have travelled many miles to attend. If lunch is provided, it offers an opportunity to brief them.

Press notes It is always helpful to provide each reporter with a copy of the programme together with useful background information, including the names and brief biographical details of senior people they are to meet.

Escorts One or two lively people, who know their facts, should be chosen to escort the journalists. This enables everyone to obtain the material they need for their stories.

Television Special arrangements need to be made for television. A reporter usually comes with at least a cameraman, sound and lighting engineers and equipment. Where television can and cannot go during visits should be anticipated and planned, if possible in cooperation with the reporter or one of his colleagues as soon as they arrive. The crew will need to have access to adequate electrical

power points.

Review If there is time it is usually helpful to have a review, by a senior manager, over a cup of tea. This provides an opportunity to underline important points and deal with any outstanding questions.

It is unwise to take round a very big party of journalists. If a large number want to attend, it is best to organise two visits.

The press briefing

This can take various forms:

A meeting at the highest level between, for example, a regional health authority chairman or general manager and a similarly high-level editor or correspondent.

A formal or semi-formal presentation to the media by authoritative representatives of the organisation. This is not very different from a press conference, but is more likely to include off-the-record information.

Information given to a journalist, either face-to-face or on the telephone, as background to help him write a story.

A press briefing should be conducted according to the unwritten rules of what is on the record and off the record (see page 85).

News releases and press statements

Information is also supplied by news releases or press statements, either in conjunction with one of these functions or, more commonly, on their own.

The news release is a useful way of providing information to the media. It should never be regarded as the be-all-and-end-all of communication with the media, but it has the virtue of presenting information in an accurate form.

On the occasions when maximum impact or widespread circulation is wanted a health service manager may find it helpful to ask the regional public relations department to produce the release on his behalf.

A news release should answer all or most of these questions: who, what, where, when, why, how much, how often, and to whom. It should be written in clear, crisp language, as free from jargon as possible. Where jargon or technical words have to be used, they should be explained. The shorter the news release and the shorter the sentences in it, the better the chance of it being used. It should include the following information:

The full name of the organisation issuing the release.

The full address, telephone number and telex number of the organisation.

The date of the release.

RAILTON GENERAL HOSPITAL ①

Bridge Park, Railton, Bromshire RL12 8RN Telephone Railton 99199 ②

NEWS RELEASE 20 May 1985 ③

DUCHESS OF RAILTON TO OPEN ④
NEW MATERNITY WING

The £2.5 million maternity wing at Railton General Hospital will be ⑤ officially opened by the Duchess of Railton on Wednesday 5 June 1985 at 2.30 pm.

The Duchess's twin sons, David and Richard, were born there in the week the first mothers were admitted in January.

To mark the official opening, every mother who has a baby in the new wing on 5 June will be presented with a commemorative medallion by the hospital. ⑥ The medallions are being provided by the hospital's League of Friends.

The 72-bed wing, which combines a personal, relaxed atmosphere with the latest medical equipment and expertise, includes a delivery suite, post-natal ward and special care cots. Building work began in 1981 and was completed last year.

After the opening ceremony the 60 guests - including the Mayor and Mayoress of Railton, Mr and Mrs Tom Foot, and the MP for East Bromshire, Mr William Cunningham - will tour the new wing. They will meet staff and the parents of some of the newly-born babies.

Railton General Hospital's unit manager, Leslie Jameson, said today: "The wing, which brought local maternity facilities under one roof, is already regarded as an outstanding success by mothers. The official opening will give us a chance to say thank-you to everyone who has helped to make it so."

- ends -

For more information please contact

Leslie Jameson ⑦
Unit Manager
Railton General Hospital
Telephone: Railton 99199 (extension 510)

A news release with: ① The name of the organisation issuing the release. ② The full address and telephone number. ③ Date of the release. ④ Heading indicating the contents. ⑤ An introductory paragraph giving the main point of the release, followed by the key facts. ⑥ Double or one-and-a-half spacing. ⑦ The name of the sender or other contact with first name, title of post, telephone number and extension.

Letters of invitation to editors to cover the event can be sent with the news release.

The name of the sender or other contact, including first name, and the title of his or her post, together with telephone number and extension. The sender or contact must make sure to be available to deal with any follow-up enquiries from the media when the news release has reached them.

The release should also have:

A heading to indicate its contents.

An introductory paragraph which gives the main point or essence of what follows.

All relevant facts and as much information as possible about people if they are important to the story, with their names and addresses. First names, not initials, should be used.

News releases should be typed in double or one-and-half spacing and on one side of the paper only, and should normally be sent by first-class post or delivered by hand.

Press statements are mostly used reactively where a hospital or health authority wants to make a concise, definitive statement of its position, without being exposed to interviews or calling a press conference.

It can be either a personal statement – by the chairman, for example – or issued by the authority.

The kind of circumstances in which press statements are issued are when:

A mistake has occurred in hospital involving death or disability to a patient and the health authority wishes to express regret and announce a full inquiry but does not wish to give interviews which might prejudice the inquiry.

There has been criticism on matters of policy and the authority wants to make a definitive statement of its position.

Legal issues are involved – for example, claims of unfair dismissal.

Press statements should be used sparingly. They can distance an authority from the public and reinforce a 'them' and 'us' attitude. It may be that a series of interviews or a meeting with the media at a press conference would be better. Regional public relations officers should be asked to advise on this.

Photographs

Whatever method is used for giving information to the media, it pays to be alert to the potential for pictures.

Photographs supplied to newspapers or magazines should be black and white, glossy and normally measure 10 ins by 8 ins (25.4 cm by 20.3 cm). They should be accompanied by a short typewritten caption of no more than 50 words providing essential information

about the subject of the picture and giving, from left to right, the names (including first names) of people in the picture and their job titles – for example, 'treasurer of the league of friends', 'ward sister', 'project architect'. The sender's name, address and telephone number should be included on the caption.

The photograph may be sent with a news release giving fuller information, but it should still be captioned.

If more than one photograph is being sent, they should be placed with the glossy sides face to face. If they are being posted, they should go in a stiff-backed envelope marked, 'Photographs: please do not bend'.

Photographs can be taken by a specially commissioned commercial photographer or, possibly, by a photographer from the medical illustration department of the nearest large hospital whose staff, as with audio-visual programmes, are often happy to help.

Professional and technical journals usually welcome photographs of professional quality provided they are relevant, interesting and include people. Local newspapers might use a portrait photograph supplied in connection with a new appointment, but for a news story or feature they will probably wish to use their own photographer.

For this purpose, it may be helpful to arrange a 'photo-call'. Whether the pictures are being taken by the press or for the press, it is important to:

Obtain permission from any patients involved and, if necessary, from their relatives. Consult the staff concerned and brief them.

Give the photographers a clear explanation of any restrictions they are working under – for example, if patients are not to be identified or if parts of a hospital are out of bounds for clinical reasons.

Think in advance about the photographers' requirements. (A photographer from the local newspaper, or a commercial photographer, will sometimes be willing to visit a location beforehand and give advice.) Bear in mind the direction of any sunlight and try to arrange things so that photographers do not have to shoot straight into it. Make sure that they have enough space in which to do their job and a clear view of the subject and that if other people are present, as at an official opening, they can get their pictures without either being obstructed or obstructing other people's view.

Check details of what is being photographed. Are the uniforms correct? Do pens, badges or notebooks stuffed into pockets detract from people's appearance? Is there clutter in the background which would give an impression of mess?

Provide enough information for the photographer to understand the reasons for the picture and to write a caption, with the correct names and titles. (Do not suppose that all newspaper photographers have been fully briefed by their picture editors, or that they necessarily work closely with any reporters who may be present.)

Consider the timing of the photo-call, bearing in mind that evening papers – and, indeed, television, to which these guidelines also largely apply – will prefer early in the day.

Television and radio interviews

Before accepting or declining an invitation to give a television interview, it is worth weighing up the advantages and disadvantages of appearing. For a health service manager and his organisation, there are very few occasions which bring no benefits, not least because an interview can give the lie to the image of the 'faceless bureaucrat'. If the manager is known to perform badly on television, he should pass the request to a more skilful colleague.

Many people are deterred from going on television by its apparent mystique. It is a pity to duck the opportunity merely because the prospect is intimidating. It is better to become familiar with the medium.

Some regional health authorities organise television training courses for health service staff. The courses, often conducted by highly experienced television broadcasters, are not designed to produce instant media stars, but they do impart some of the tricks of the trade, help create self-confidence and reduce significantly the trauma of the first appearance on television. The most important trick of all is simply for the interviewee to prepare himself by deciding in advance the points he wants to make. This not only concentrates the mind but improves confidence. It is amazing to find people who will spend hours preparing a talk to the local Rotary Club giving only scant attention to what they are going to say before hundreds of thousands of people on television.

The difference between a 'live' and a recorded interview should also be remembered. Only in the former will the interviewee be sure that what he is saying is actually being heard. Recorded items will almost certainly be edited. Although the interviewee can advise on the relative importance of the various statements he has made, he has no control over what is transmitted. Before a recorded interview, the interviewee might take the precaution of arranging his own recording of the conversation on a small cassette recorder, and refer to it if parts of the interview appear to have been broadcast out of context.

Managers who are keen to appear on television should not sit back and complain at what they regard as lack of interest by the local

television station. They should make a point of contacting the station and telling the news editor about a particular issue they want to see aired. If they are in doubt about its news value they can obtain advice from the regional public relations department. The main thing is to *do* something – to take the initiative, think positively and not to let opportunities slip by.

Much the same applies to radio – in fact, more so. With its strong involvement in the affairs of a defined community, local radio is a particularly valuable medium. Its news bulletins reflect and report a wide variety of issues, and its current affairs programmes are excellent vehicles for the longer, two- or three-person interview.

A BBC training guide describes a radio interview as 'a conversation with an aim' in which the 'interviewer is acting on behalf of the well-informed enquiring listener.' His approach is one of 'informed naivete'. The interviewee should be concise and committed, know what he wants to say and make sure that he says it – even if the interviewer does not ask the 'right questions'. People often explain away missed opportunities by saying, 'The interviewer didn't ask me.' No politician says that: he happily brushes aside inconvenient questions and sticks to his guns!

The interviewer, whether on television or radio, has to elicit the story by asking questions in such a way that the person being interviewed will reply with interesting, possibly provocative, possibly entertaining answers.

When you are giving a television or radio interview, bear in mind that you almost certainly know more about your subject than the interviewer. Say what you want to say clearly and concisely, without padding. Talk positively in a conversational tone, using everyday language which other people can easily understand. Avoid jargon and abbreviations like RAWP and DHA.

Give information in a very simple form; if necessary have some general facts and figures on a piece of paper in front of you, but try not to read from it. Aim to get across two or three points, not nine or ten!

Avoid writing a script or rehearsing your lines; this will almost certainly have a deadening effect and create a poor impression of yourself. Be prepared to deal with questions you would rather not be asked. If you are appearing on television you should:

Sit comfortably and reasonably upright. A 'laid-back' style with outstretched feet and dangling arms may be cool and relaxed, but to the viewer it will look very close to arrogance and disdain.

Do not look at the camera but look at the interviewer.

Keep going, even if the interview seems to be turning out badly

and missing the important points. The interview will never look as bad to the viewer as it feels to you.

Meetings and reports

The media obtain much of their information about the health service from the documents and meetings of health authorities.

Health authorities are subject to the Public Bodies (Admission to Meetings) Act 1960, as amended, and have a legal obligation to conduct the business of their meetings in public. This confers on members of the public and the press the statutory right of admission. The Act states that they can be excluded only by resolution and only when the matters being discussed are considered to be 'detrimental to the public interest'.

They can also be excluded for 'special reasons' stated in a resolution, but, given the public nature of the health service, the number of occasions when this can reasonably be done are, or should be, few and far between.

Authorities should satisfy not only the letter but also the spirit of the law. The 1960 Act requires health authorities to give at least three clear days' public notice of the time and place of their meetings. A notice at the main entrance of the authority's headquarters would satisfy the letter of the Act, but if that notice were stuck on the back door the spirit would, at the very least, be open to question!

The press are able to demand, on the payment of any postage or other necessary charges, copies of the agenda and, if thought fit, copies of any reports or documents supplied to authority members. Reasonable facilities – a table and chairs – have to be provided to enable journalists to do their job, and the provision of a telephone, at the journalists' expense, is also assured by the Act. In practice, few, if any, authorities charge journalists for reports or telephones.

Television and radio have the same rights as newspapers and for this purpose should be regarded as part of 'the press', but the sound recording, on tape or film, of speeches or discussion at meetings is not a right under the Act and can take place only with the consent of the authority. Similarly, visual recordings of the meetings by still or TV cameras may be made only with the authority's agreement.

Embargoes

Embargoes on publication are requests to the media to refrain from publishing a report, news release or other document before a stated time. Except in very rare instances (as in connection with a parliamentary statement), they have no force in law.

Embargoes on long and complicated documents are useful to the media because they give journalists time to 'prepare adequate summaries and considered comment', as the Press Council has put it. They are also used for important speeches or conference papers.

The texts are issued to the media in advance and embargoed until the time of delivery. Because journalists can prepare their reports in advance, the speaker is likely to get better coverage than he would if he relied on reporters making hasty summaries when they hear the speech or conference paper for the first time.

An embargo should give the time and date of publication and any other restriction. The normal wording is: 'Embargo: not for publication or broadcast before 10.00 hours on Wednesday 17 April 1985'. In the case of an official inquiry where the parties have not received advance copies of the report and findings, it may be necessary to add: 'Issued in advance on the strict understanding that no approach is made to any organisation or individual in connection with the following before time of publication'.

In certain circumstances the use of an embargo can be a two-edged sword. The Press Council has held that a newspaper which has obtained information from another source will not have acted improperly by publishing information which is subject to an official embargo. In such circumstances, the net effect of the embargo will be to inhibit official comment while allowing other interested parties the freedom to say what they wish.

The practice of using embargoes in connection with statutory meetings of a health authority varies from authority to authority. Most authorities follow the example of local government, which is largely based on guidance from the Department of the Environment issued in April 1975: 'The normal practice should be to let the press have copies of the documents circulated to council or committee members. These usually reach the press at the same time as they reach members, but if this cannot be done the press should still get them in sufficient time to form a clear understanding of the matters under discussion. There should be no embargo to prevent reports and comments being made in advance of the meeting.'

In confidence

A newspaper or television or radio station which comes into possession of a document issued confidentially to members of an organisation is not bound by the confidence enjoined on the persons to whom it is addressed. This applies to reports of inquiries as it does to meetings of health authorities. The only constraints are those of defamation.

Consideration of certain confidential matters in private at health authority meetings is acceptable in instances where:

Publicity would involve a breach of professional confidence.

Negotiations are in progress concerning financial transactions or contracts.

Disciplinary matters or matters relating to individual officers are being discussed.

On and off the record

In a relationship of mutual trust, a health service manager and a journalist will be able to talk to each other off the record as well as on the record.

A prepared press statement is on the record. So is anything said by the manager which he decides can be quoted word-for-word for publication and can be attributed to him by name. He should think before he talks and choose his words carefully.

There may be times when he prefers to go off the record – that is, to say something or give information which is strictly not for publication. There are two main reasons for going off the record:

Where the information which has been supplied on the record gives an incomplete or misleading account and will prevent the journalist from writing a balanced story. Off-the-record information is in no way attributable to the source, but enables the journalist to gain a full understanding of the issue.

The story into which a journalist is enquiring may be personally or politically sensitive. The manager may wish to explain off the record why he is being awkward or less than cooperative and putting the relationship with the journalist under strain. If they have a good understanding, the journalist may agree to postpone or even, in extreme cases, quash the story once he is put in the picture and accepts the wisdom of doing so. He is very unlikely, however, to fly in the face of what he reasonably considers to be the public interest.

Sometimes the manager and the journalist will agree, after discussing an issue off the record, that an on-the-record comment of some sort can be made.

Before he says anything off the record, the manager must say clearly to the journalist that he wishes to go off the record and gain his agreement to honour the request. A breach of the agreement would be a breach of trust. However, a manager should not abuse the relationship by trying to resort to off-the-record conversations too often. The journalist would not tolerate it for long.

The ability to go off the record depends on the level of mutual trust already established between the manager and the journalist. In dealing with journalists he does not know, including reporters from national newspapers or television networks, it is usually advisable to stay on the record. Most of the journalists would not see the manager as a valuable contact and some may have few qualms about quoting off-the-record information.

SECTION 12

Responding in an emergency

Health service managers and other professionals, including doctors, sometimes have to respond to the media in an emergency or crisis. How they do so will depend partly on the scale and nature of what has happened.

In some instances – after, say, a terrorist attack or a multiple road crash – the police will play a key part in dealing not only with relatives and public but with the media, particularly in the first 24 hours or so. On other occasions the health service managers may be a party to what has happened – for example, a clinical mistake in hospital or a sudden strike by hospital workers.

Health service managers may be party to an emergency – for example, a sudden strike by hospital workers

Major incidents

Hospitals which are designated to take casualties after a major incident have introduced procedures largely based on advice in the health circular HC(77)1. The procedures, which are reviewed regularly in the light of experience, include arrangements for providing information to relatives and friends, and for dealing with large numbers of newspaper, radio and television journalists.

At least one manager, preferably working with regional public relations staff, should be specially assigned to deal with the media, not only in the interests of the journalists but to ensure that the rest of the hospital team are not distracted from their work.

The manager and the public relations staff should make themselves known to journalists and establish an early dialogue with them in order to develop a relationship of mutual help and trust – one in which the hospital and the media recognise the needs and problems of each other.

Journalists must be kept fully informed about the availability of statements and bulletins and told when facilities will be arranged for interviews and pictures. If they are left in the dark about the arrangements or timing of information, or suspect they are being unreasonably obstructed from doing their job, they will try to make their own unofficial arrangements.

Handling the media after a major incident can be divided into three time phases from the moment the first casualties begin to arrive:

Phase one – the first hour.

Phase two – the next two to four hours.

Phase three – one to four days after the event.

Phase 1 – the first hour

The duty manager, on being informed to expect heavy casualties, should:

Contact the regional public relations officer unless other arrangements exist for informing him.

Get to know the senior uniformed police officer sent to the hospital, and the officer in charge of any specialist unit such as an anti-terrorist squad.

Inform the senior uniformed officer that the public relations officer is on his way. This will enable him to get through any police cordon.

A liaison officer may be sent to the hospital by police headquarters to coordinate the activities of police at the hospital. This would happen with Scotland Yard and any London hospital. The liaison officer will have direct contact with his headquarters, with the highest ranking police officer available in the area and with the

casualty switchboard established by the police to deal with calls from relatives.

The police will probably stop anybody except essential personnel from entering the hospital during the first hour. Security will be especially tight if there has been a terrorist attack or if police officers have been injured.

Journalists will be kept outside the hospital for the time being, but should be allowed in as soon as the police agree. A press room should be set up *as near as possible* to the accident and emergency department and hospital reception area. It should be equipped if possible with several telephones.

A press briefing should be arranged. The following information should be collected for use in a press statement to be issued at the briefing:

The time the hospital was alerted.

The number of injured received by the hospital.

The injuries, if only in general terms at first.

A summary of the treatment being given, including the numbers of patients being operated on and the number receiving minor treatment.

No personal details about the patients should be issued until confirmation is given by the police that the next-of-kin have been informed.

The police liaison officer, or a police press officer, may wish to check the statement and to attend the briefing.

The statement should be read to reporters and photographers and repeated in radio and television interviews. The media should be promised a further briefing in one or two hours.

Phase 2 – two to four hours

Information given in the first press briefing should be confirmed and any telephone calls from the media (mainly local newspapers and radio stations asking for details about particular patients from their areas) should be dealt with.

Information about injuries and treatment should be obtained by the manager or public relations officer direct from medical and nursing staff dealing with casualties. This ensures its reliability.

At the second press briefing, details should be given about the names, addresses (if possible) and ages of patients, deaths, injuries, treatment, emergency operations, intensive care cases, numbers of patients sent home.

Times of deaths should be given, together with any information which illustrates the efforts that have gone into fighting for the lives of the victims.

If further developments are likely, briefings should be arranged before either 6 pm or 10 pm to meet television news deadlines. If not, the media should be told. If they know they are being given all reasonable cooperation and are promised a briefing the next day, they will leave.

Phase 3 – one to four days

Journalists will want to interview casualties. They should be allowed to do so unless the doctors, police or the patients themselves object for security, medical or personal reasons. To minimise disruption, a 'press hour' should be arranged when the reporters and cameramen are allowed into the ward.

Patients prepared to talk to the journalists should, if possible, be grouped together in one part of the ward. The staff should also be asked if they would be willing to talk about how they coped with the pressures of the emergency and to give details of injuries and how they are being treated.

Photographers should go in first. A large group of ten or more should be split into two and each group should be allowed at least five minutes to take pictures.

They should be followed by newspaper reporters, for ten to 15 minutes, and then by radio reporters for up to five minutes. In the case of television, only one crew at a time should be allowed into the ward for ten minutes each.

If the patients are feeling tired or distressed by all the questioning and flash bulbs, the TV teams will probably agree to send in only one crew for a single interview and 'pool' the resulting film, or to take in two camera crews and share the reporter. Whatever the situation, they usually try to cooperate as much as possible.

After this 'press hour' the media should not be given further access to the patients unless a patient or his family asks that a particular journalist should be allowed to meet him, or unless a member of the Royal family or other distinguished person makes an official visit. Even then nothing should be arranged which could disrupt the work of the ward and interfere with the recovery of patients.

The Brighton bombing

The arrangements for dealing with the media after a major incident will be tailored to circumstances, as they were after the bombing at the Grand Hotel, Brighton, in October 1984 in the early hours of the last day of the Conservative Party conference. This is how the arrangements worked at the Royal Sussex County Hospital where within an hour of the explosion more than 12 newspaper, radio and television journalists had gathered at the entrance of the accident and emergency department.

As staff came under pressure to answer questions, it was decided

immediately to open a press room – not in another part of the hospital, as the major incident plan stated, but in a clinic room close to the accident and emergency department and within feet of the control point and police liaison office.

This change from the plan was based on the certainty that journalists would congregate at the department anyway and would be easier to control if on-the-spot facilities were provided. As events showed, they were not only more easily controlled but welcomed being 'close to the action' and made no serious attempt to breach security.

By early morning there were 80 journalists at the hospital. Information about the number and identity of casualties was collated by two regional public relations officers and, when time allowed, written out and photocopied for distribution to the journalists. Each statement was read out by the hospital administrator for television and radio.

By mid-morning more medical information was being requested by the waiting journalists. This took longer to gather because patients were in different wards. Statements, which were seen by the police before being released, did not reveal which wards patients were in. Often there was nothing new to say, but simply by announcing that there were no new developments the hospital was able to satisfy the media and reduce the pressure on staff, especially the managers, doctors and nurses.

Telephone calls from the media were dealt with by hospital staff manning the main control room in the hospital's general office. Telephone facilities in the accident and emergency department and the press room were totally inadequate, and two public payphones had been 'taken over' by the media almost as soon as they arrived. British Telecom were called in and provided four emergency lines in the press room by midday.

By the afternoon the hospital began to give condition checks at pre-specified times. There were three a day in the first week and one a day by the third week.

The clinical nurse manager was responsible for passing medical information to the control room, and this was augmented by information about the casualties' hospital life – what they had for breakfast, what visitors they were expecting, and so on.

The demand for interviews with patients was intense, partly because many of them were national figures. Those who were willing and fit enough to be interviewed were approached by one of the public relations officers and, because the media resisted requests to 'pool', they were allowed on to the wards in three groups: first photographers, then newspaper reporters, then television and radio

interviewers. On one occasion, they had to leave because the strain became too much for some of the patients.

During the first three days journalists were at the hospital round-the-clock. They missed nothing; sometimes they knew, before the hospital, of visits by prominent figures and were quick to recognise and make contact with patients' relatives and friends.

The visitors included the Prime Minister and members of the Cabinet. Journalists were not allowed to follow them round the hospital. Instead they were congregated at exit points, where they asked questions and took photographs as the visitors left. They were always flanked by police.

By the fourth day, the number of journalists at the hospital had dropped to about 12, and the press room was closed. A corner of the waiting room was allocated to the remaining reporters whose main concern was not to miss the departure of a patient or the arrival of an important visitor.

Mistakes in hospital

However careful doctors, nurses and other staff may be, and whatever procedures and safeguards may exist, human error can and will occur from time to time.

To maintain public confidence and trust in the health service and its staff, it is essential that the media should be given the fullest possible explanation when mistakes occur.

The most sensational stories are likely to appear when the media suspect that information is being deliberately withheld. Given an explanation and reliable information, the media and the public will usually view the mistake, and judge it, with a sense of reason and proper perspective.

When a mistake has obviously occurred – removal of a wrong limb, for example, or an anaesthetic accident leading to death or brain damage – certain broad rules should be followed when dealing with the media:

Patient confidentiality must be preserved and the name and address of the person involved should not be given without the specific consent or request of the patient or his relatives.

Only basic factual information should be given. Any formal inquiry into the circumstances, which may have to be held later, must not be prejudiced by inaccurate or speculative remarks.

It should be made clear that the matter is being treated seriously by the hospital and health authority, that it is being fully investigated and that any necessary action is being taken to prevent it happening again.

The apologies – or, if more appropriate, the sympathy – of the organisation for the mishap should be conveyed.

Suggestion of a bureaucratic 'cover-up' should be avoided.

A newspaper or radio or television station may get to hear about such a mistake from a number of different sources, but not necessarily (seldom, in fact) from the family directly involved. Health service managers dealing with the initial enquiries will have to tread a very delicate path between giving information which it is reasonable for the journalist to know and overstepping the bounds of patient confidentiality.

An alleged mistake at Bromsgrove Hospital, Worcestershire, in 1980 came to the attention of a local newspaper reporter who had heard that a boy had undergone surgery which should have been carried out on someone else. That was all he knew. He telephoned the public relations department of the West Midlands Regional Health Authority, and a press officer contacted the district administrator to confirm the basic facts and discuss what kind of statement should be issued. It transpired that a seven-year-old boy due to have a minor operation to drain his middle ear had been mistaken for another boy in the same ward of the hospital who was to have an abdominal hernia repair. The mix-up had happened ten days before. Apparently, no harm had been done and an investigation was already underway.

The press officer advised the district administrator to issue as detailed a statement as possible, giving the basic facts and describing the action being undertaken by the hospital and the district management team. This led to the following press statement:

Operation at Bromsgrove General Hospital

On Monday, December 1st, a seven-year-old boy was admitted to Bromsgrove General Hospital for a minor ear operation involving the draining of the middle ear. The operation was scheduled for the following day in a routine ENT theatre session. Unfortunately, owing to a misidentification, he was sent to another operating theatre where a second boy from the same ward in the hospital was due to have a minor abdominal investigation.

The mix-up was not initially spotted and a very small 3cm-long incision was made in the boy's abdomen. As soon as it was realised that a mistake had occurred, the parents were informed immediately. They were told exactly what had happened in the theatre and were given a full apology. The boy was released from hospital on the Wednesday (December 3rd).

Although the boy suffered no harmful effects from the minor surgical procedure, the Bromsgrove and Redditch District Management Team is concerned that the reasons for the error of identification should be swiftly and fully established. It is especially important to ascertain whether

procedures need to be reviewed and tightened up as a result.

The District Management Team has been conducting a detailed, fact-finding investigation and statements are being taken from all the staff involved. This exercise should be completed tomorrow (Friday December 12th) and a report will be considered by the DMT next week, when it will be decided whether to refer the issue to the Hereford and Worcester AHA and to call for a formal inquiry.

The hospital very much regrets what occurred and has already apologised to the parents, who were offered the option of having the ear operation carried out on their son at another hospital, probably the Ear, Nose and Throat Hospital in Birmingham. However, they have chosen to allow him to return to Bromsgrove General Hospital in January.

The statement refers deliberately to the 3cm-long incision made during the operation. Without minimising the seriousness of what had happened, this had the effect of dispelling any suspicions that major surgery had been carried out on the wrong person.

The statement explains how the parents had been quickly informed and an investigation set up, and it includes a public apology. (A private apology had already been given to the parents.)

It adds that they were offered the opportunity of having him transferred to another hospital for treatment on his ear but had chosen to let him return to Bromsgrove Hospital.

The hospital received bad publicity, but the press coverage was generally accurate and based on correct information. A formal inquiry into the case was later carried out by health authority members, and their report was published in full. There was little or no 'sensationalising' in the media because full information had always been made available.

The names of the boys were not disclosed. The parents were specifically asked whether they wanted the names to be released, but they declined. However, the press eventually managed to track them down.

Restoring public confidence

Some 'emergencies' are self-inflicted. Managers at a psychiatric hospital in Essex, who discussed with nursing staff representatives the possibility of admitting patients from maximum security hospitals, did not explain adequately that the patients were ready for rehabilitation in an open hospital.

Unable to get clear answers to their questions, the nurses sent a deputation to the main local weekly newspaper, told the editor of the breakdown in communication with management and expressed anxiety that dangerous 'rapists and murderers' might be coming to the hospital.

The newspaper led a hue-and-cry, taken up by three other local

papers which embellished the story with more quotes from anonymous staff 'spokesmen'. The hospital management's attitude was: 'Don't worry. It will all go away.' It did not.

Eventually, it was decided at district level that the only way to counter the bad publicity was to encourage journalists to visit the hospital and see, not dangerous rapists and murderers, but unaggressive men and women being rehabilitated.

The confidence of the nurses had to be secured. The managers held informal meetings with nurses and other staff from which emerged a measure of goodwill in the knowledge that the story had become exaggerated out of all proportion.

A press conference was arranged. Journalists' questions inevitably included, 'Where are the straitjackets?', 'What about ECT?', 'Where are the padded cells?'. The management were able to show that there were no straitjackets and no padded cells, and the journalists were invited to see a modern ECT suite, which certainly was not the horror chamber many had expected to see.

After this there were other press visits leading to illustrated articles appearing in all four local papers, describing different aspects of the hospital and its work. There were also follow-up articles on patients who, thanks to their rehabilitation, had been discharged and were earning a living in the community.

The exercise culminated in a massive 'open day' covered by BBC Television which also followed two patients through rehabilitation and into the community.

Industrial action

It is not unknown for a health service manager to learn of a lightning strike by hospital workers from a journalist who tells him that all his hospitals are threatened with imminent shut-down.

Before he responds, he should check the facts. He will probably find that a few dozen workers have walked out of one or two hospitals and that the vast majority of staff are still at work.

What he says to the journalist, and how he says it, will have a bearing on staff attitudes and often on the future course of action, particularly when emotions are running high and there is resentment about management conduct. Whatever is said to the media by management must leave as little room for misunderstanding as possible to avoid misinterpretation during later negotiations.

On the other hand, it can be a mistake to try to cover up the effects of industrial action; the workers' response may be to step up the action until the effects cannot be ignored. The important thing is to recognise the urgency of the situation presented both by the situation itself and the pressures exerted by the media. The manager has to act quickly; decision by committee at this stage is irrelevant.

Staying silent will give the initiative to the strikers and the public will get a one-sided story. Management must respond, if only with a 'holding' statement which, at the very least, indicates their active concern.

A management statement must be reasonably acceptable to the media; otherwise it stands little or no chance of being included in stories about the dispute. It may have to be brief for political or tactical reasons, but if a bridge of confidence has been established between a manager and journalists in his district he should be able to discuss some of the issues with them in confidence so that they can keep them in perspective when preparing their stories.

SECTION 13

Doctors, patients and the media

A physician lecturing to medical students in 1907 warned them to beware 'the Delilah of the press'. There were times, he said, when she could be courted with satisfaction, but sooner or later she played the harlot and had 'left many a man shorn of his strength – the confidence of his professional brethren.'

Today, doctors' representative bodies positively encourage them to embrace Delilah. The Royal College of Physicians believes every doctor should be willing to 'collaborate with the media in public education about what medicine has to offer in prevention and cause of disease'. The British Medical Association says that doctors able to help the public with information should 'regard talking to the media as an extension of their medical practice'.

Doctors must not publicly discuss their own abilities in a way which could imply that their methods are better than other doctors' and so attract more patients, but professional anonymity when dealing with the media is not always necessary or even desirable.

A physician warned medical students to beware the 'Delilah of the press'

Guidelines from the BMA say it is acceptable for the doctor's identity to be revealed when it does not add to his professional stature, when it is in the public interest, when he is speaking on behalf of an identifiable section of the profession, or when using media primarily aimed at doctors.

As an example, a named surgeon complaining publicly about the dilapidated condition of an obstetrics and gynaecological department would be:

adding to his professional stature if he said to the public and the media that he could do even better work if the unit were not so run-down;

speaking in the public interest if, after fruitless protests through official channels, he were to complain that the conditions were unsuitable for patients and staff and called for improvements;

speaking on behalf of an identifiable section of the profession if he was the spokesman for the obstetricians and gynaecologists in the department, or secretary or press officer of the local branch of their professional body;

using media primarily aimed at doctors if in a professional journal he called for greater investment in obstetric and gynaecological services, citing as an example the frustrations he was experiencing in his own work as a result of his department's shortcomings.

A doctor may use his own name in connection with a subject other than medicine. When discussing a medical subject, he may be named only if he confines himself to general terms, avoiding discussion of individual cases.

In the field of general health education the name and relevant qualifications of the doctor may be given to lend added authority.

Doctors making statements on behalf of known organisations may be named when this is in the public interest. However, a doctor must not exploit the media to promote any organisation in which he has a financial interest.

Situations in which doctors' names might be used include:

A major incident needing authoritative statements by doctors on the scale and nature of casualties.

Discussion of important ethical issues such as brain death and data protection which pose particular dilemmas for the public.

Publicity exercises to promote health and prevent illness or accident.

Circumstances in which a doctor's name should not be used include:

Publicity about a health centre where he holds surgeries.

Discussion of a patient's illness – in the case of a well-known personality, for example.

A local radio phone-in programme covering the area in which he practises.

Publicity about the success rate for his treatment of a particular disease or condition.

Any fund-raising for a project – such as a NHS clinic – where he might treat private patients.

If they are in doubt doctors should consult their professional bodies. The BMA has divisional press officers who have been trained in media techniques and will give guidance. A divisional BMA secretary or press officer will sometimes speak on behalf of a doctor and his colleagues if they are reluctant for professional reasons to talk to the media.

Patient confidentiality

The media may sometimes take the view that the 'public interest' overrides all other considerations, but illness is a private matter, and confidentiality between doctor and patient must be safeguarded. In practice it is not always possible to observe the rule to the letter and there has to be a compromise.

The circular from the Ministry of Health, HM(56)58, Information to the Press about the Condition of Patients (Appendix 1), gives guidance to health service staff on dealing with the media, and is still relevant. It defines two groups of patients – sickness cases and accident cases.

The only information which should be given to the media about a sickness case is confirmation that a person named by the enquirer is a patient, and even this should not be given if it acts to the patient's disadvantage. It means that the media can be told a person is a patient unless the hospital is of a specialist kind, such as a psychiatric hospital, which would indicate the diagnosis. Any other information – for example, the nature of the illness or the patient's progress – should not be given without the consent of the patient, the doctor or a close relative.

In cases of accident, a distinction is drawn in the circular between individual cases and multiple cases.

The name and address of an individual patient and an indication of his or her condition, but not a diagnosis, can be given to the media in response to enquiries. Relatives should also be informed, but if they have not, the media must be told. Other information should not be given without the consent of the patient or a relative.

In multiple cases – after a major incident, for example – early publication of names and addresses will help to dispel the anxieties of relatives of other people who might have been involved (see page 87 for hospital arrangements after a major incident). Normally, the media obtain names and addresses of casualties from the police. Since the police do not release the information until relatives have been told, hospital staff receiving enquiries from the media can be reasonably satisfied that, if the enquirer has the patients' names and addresses, then the relatives already know. If a journalist seeks other information, staff should give it only if and when authorised.

Some cases do not fit neatly into the guidelines of the circular:

A man on a serious charge collapses in court and is taken to hospital. Since he is ill, the hospital (according to the circular) can only confirm he is a patient. The media will, however, persist in their enquiries because his condition is clearly a matter of public interest. The patient may refuse consent for further information to be given and this refusal must be complied with.

The father of a murdered girl has a heart attack and is very ill in hospital. Local journalists know he has had a heart attack, but do not know where he is. They also want a confirmation of the diagnosis. The name of the hospital can be given, but nothing else without his consent.

A leading actress collapses on stage during a performance and is dead on arrival at the hospital. The media will be told almost immediately, either by the theatre management or by a contact in the ambulance service, and will call the hospital to confirm she is dead. According to the rules, this is a diagnosis which cannot be released without consent. However, the Ministry's circular makes a specific reference to people who are well known and this appears to give some latitude to the doctor. An attempt should be made to contact a relative before a statement is made, but commonsense may override this.

A former champion motorcyclist is killed in a road accident. His nearest relatives are too distressed to be helpful, and his agent has telephoned to say that no statement should be made until he – the agent – arrives. The media should be told that a statement will be made at a certain time, and this promise must be kept. Meanwhile, because he was involved in an accident, it is in order to confirm that the man is dead.

In all cases, the patient, or a close relative, and the doctor involved should be consulted as soon as the media are interested. The approach is best made by a hospital manager. If consent is not given,

no statement should be made apart from what is permitted in the absence of consent. In cases of continued uncertainty or difficulty the manager may find it helpful to consult the regional public relations department.

A patient who is willing for information, such as diagnosis and condition, to be supplied may also be prepared to give interviews and be photographed, in which case the hospital should make facilities available.

SECTION 14

Criteria for press conduct

Possibly the best criteria for what is and what is not acceptable conduct by the press are to be found in the adjudications of the Press Council, a body established in 1953 and composed of professional and lay members.

The Council considers complaints of breaches of the unwritten ethical code of press practice, whether they are due to the publication or non-publication of statements or pictures or the conduct of press representatives. (The procedures for making complaints to the Press Council, and to the Broadcasting Complaints Commission, are set out in Appendix 2. They include the Press Council's 'fast track' procedure, introduced in 1984, for the speedy correction of significant errors or inaccuracies published in newspapers or magazines.)

Complaints to the Press Council should not be made lightly. The Council will not begin an investigation unless the editor of the publication concerned has had a reasonable opportunity to deal with it.

The four principal aims of the Council are:

To preserve the established freedom of the British press.

To maintain the character of the British press in accordance with the highest professional and commercial standards.

To consider complaints about the conduct of the press or the conduct of persons and organisations towards the press; to deal with these complaints in whatever manner might seem practical and appropriate, and record resultant action.

To keep under review developments likely to restrict the supply of information of public interest and importance.

A number of important adjudications made by the Council in recent years are of interest and relevance to the health service.

Journalists must make themselves known

In January 1981, the Press Council upheld a complaint against the *Daily Mail* from the authorities at Manor Park Hospital, Bristol, that two journalists failed to make themselves known to a senior officer when seeking an interview with a hospital patient or volunteer their identities to a nurse who asked who they were. The newspaper also failed to give a satisfactory explanation or apology to the hospital.

The sector administrator had protested to the editor that neither the patient nor her doctor wished to give interviews. The

administrator had provided a statement for the press and it was made clear there would be no interviews. After the interview appeared in the *Daily Mail*, other media representatives complained about the hospital's lack of fairness.

The editor said the reporters were invited to the hospital by the patient's son. Nobody on the *Daily Mail* knew of the sector administrator's statement or of the ban on interviews. There was no subterfuge and the interviews were conducted with the patient's permission.

The Council reiterated a previous view that 'when pressmen enter a hospital for the purposes of their work they should make themselves known to a responsible officer of the hospital.' It added, however, that there could be 'occasions when newspapers might rightly disregard this obligation and courtesy.' These were when information which should be disclosed in the public interest could not be obtained in any other way.

Such an occasion was the subject of a Press Council adjudication a year later, in February 1982. The Council rejected a complaint by Liverpool Area Health Authority that a reporter and a photographer

Journalists should make themselves known to a responsible officer of the hospital

from the *Daily Mirror* entered two hospitals without authority when they were investigating the effects on the NHS of government cut-backs.

The Council again repeated its ruling that journalists entering a hospital on an assignment should make themselves known to a responsible officer, but concluded that because of Liverpool AHA's general attitude towards the press and the reporter concerned it was reasonable for him to believe he would not be given free access if he approached the authority.

The *Daily Mirror* 'performed a service by publicising disturbing facts about two Liverpool hospitals which it was in the public interest to make known,' said the Council.

Relieving pressure on people in a crisis

Upholding a complaint that the *Daily Mail* harassed the family of a heart transplant donor, the Press Council emphasised in January 1981 that newspapers should cooperate in arrangements to relieve the cumulative effect of their enquiries on people already suffering severe personal grief. The Council did not uphold a complaint that a reporter attempted to obtain information without disclosing she was a journalist.

The Council said the newspaper should have known that repeated attempts by its writer to contact the family on instructions from her office would, however courteously made, contribute to the harassment of the donor's grief-stricken family.

The media generally should be aware that persistent enquiries, even if they were in the public interest, could contribute to the distress of people in a state of severe personal grief.

The Council pointed out that hospital authorities were frequently well placed to make arrangements to shield individuals by arranging timely press conferences and the issue of statements.

Newspapers justifiably wanted opportunities to put questions to medical or scientific experts, or to obtain the reactions of people at the centre of a human story.

'Where, however, proper arrangements could be made to spare individuals under stress or grief the strain of repeated enquiries, newspapers, press and broadcasting organisations should be prepared to cooperate in them – even where what emerges is a firm statement from those who might otherwise be harassed that they wish to say nothing.'

A similar view had been expressed by the Council in February 1980 after an inquiry into issues raised by the Birmingham City Coroner at the inquest on Professor Henry Bedson, head of the Medical Microbiology Department at Birmingham University, who had killed himself after an outbreak of smallpox.

The Council said a man already under stress as the central figure in a crisis of acute public concern should not be left vulnerable to the heavy pressure of public, press, television and radio enquiries as well.

None of the media had acted improperly or inconsiderately towards Professor Bedson or his family, but his organisation should have provided other spokesmen to deal with enquiries and, possibly, hold press conferences.

Tragically, Professor Bedson had been so anxious that enquiries, particularly those raising technical matters, should be answered accurately that, for the best of motives, he had decided to take the calls himself.

The Council commented: 'The likelihood is that no-one, including the newspaper and news organisations, the University and the health authorities, appreciated the volume of pressure there would be.'

Importance of prompt corrections

Newspapers which publish significantly inaccurate and misleading reports should correct them promptly, said the council in June 1981 upholding a complaint from Sandwell Area Health Authority. After publishing an inaccurate report about perinatal mortality, the *Sandwell Evening Mail* failed to publish promptly a statement by the health authority which would have dispelled distress among the public.

The newspaper had said that a confidential report from borough health chiefs suggested that pregnant women living near chemical factories were more likely to lose their babies. The area administrator sent the editor a statement which denied any association between residence near chemical or engineering plants and perinatal mortality. The report had not been confidential (as suggested by the newspaper), but had in fact been widely publicised.

Three weeks later the administrator complained to the editor that the statement had not been published. The editor replied that holidays and sickness were prolonging his enquiries.

A corrective article was published seven weeks after the administrator's statement. The Council said that, despite extenuating circumstances, the delay in correcting an inaccurate report which was likely to cause serious public concern and distress was inexcusable. 'There was a particular duty on the newspaper to relieve that concern and distress as promptly as possible.'

The case for sensational treatment

A complaint by the City of Liverpool that the *Daily Mirror* published sensational and unbalanced reports which did nothing to ease communal tension was rejected by the Press Council in April 1983. The City Council objected to sensational articles about a Toxteth

school which referred to 'mini-mobsters' and an extortion racket following riots in the area.

The Press Council decided that the events which led to the temporary closure of the school were themselves sensational, shocking and a case for serious local and national concern. 'Newspapers would have done no service by concealing them. The *Daily Mirror's* coverage of them was vivid and justifiably sensational. There has been no suggestion that it was inaccurate.'

Conflict over use of confidential information

A psychologist who talked to a reporter about bomb-disposal men failed to satisfy the Press Council in September 1982 that he had made clear which part of the information was not for use. The Council rejected a complaint that the magazine, *Titbits*, published information given to the reporter in confidence.

During a telephone conversation with the reporter, the psychologist told him of a study of bomb-disposal men, but said that for obvious reasons the research was secret. He gave this information in trust, but told the reporter he could describe a non-confidential survey of firemen and generalise its findings to bomb-disposal men. He claimed that his confidence was betrayed.

The reporter said the psychologist volunteered the information about his survey without a warning or a request for a promise not to use it. When the conversation was going off the record the reporter had drawn a line on his notebook, and the psychologist then gave four sentences of background which he did not use.

The psychologist realised he should not have mentioned the survey, but presumed that because he said it was confidential even its existence would not be referred to.

The Press Council said the psychologist, who was experienced at giving interviews, had acknowledged to the Council that it was foolish of him to disclose confidential information on a sensitive subject to a reporter.

The need for adequate enquiries

The Press Council came to the defence of maligned public servants when it criticised the *Sunday Independent*, Plymouth, for failing to make adequate enquiries before publishing a story about an injured decorator's invalidity benefit being stopped.

The paper's John Blunt column asked: 'Who are these faceless buffoons with their index-linked pensions who we pay to make decisions a child of ten could see were ludicrous?' Anonymity, it said, protected them as usual.

The Western Region information officer of the Department of Health and Social Security said two doctors had examined the man and decided he was capable of working. The columnist was not at the

tribunal hearing, which was open to the press, and had not contacted the Department.

The editor asked for the name of the officer who had weighed the evidence and a copy of what she told the tribunal. The Department named the officer and offered to send copies of her evidence if the decorator agreed, as it contained personal medical details. He did not agree but said he was willing to speak to the editor on the telephone.

Upholding the complaint, the Press Council said it 'supports the activity of the press in scrutinising the way decisions of this nature are taken and in making the processes of Government and administration more open. The newspaper in this case, however, did a disservice to campaigning journalism. It failed to make adequate enquiries with the result that the comment it published was inaccurate, incomplete and unfair.'

Appendix 1

INFORMATION TO THE PRESS ABOUT THE CONDITION OF PATIENTS – *HM (56) 58*

Recommended routine procedure at hospitals

As approved by the Conference of Representatives of the Medical Profession and the Press, 16th May, 1956

Introduction

1 The following recommendations are put forward as guiding principles which hospitals could reasonably adopt.

Sickness cases

2 Information should not be divulged to the press without the consent of the patient beyond the statement that the person named in an enquiry is a patient. Where, however, even this statement would be deleterious to the patient's interests, his presence in the hospital should not be disclosed without his consent. For example, in certain special hospitals, such as mental hospitals and sanatoria, where the mere admission of the patient implies the nature of the diagnosis, no information should be given to the press without the patient's consent, and that of the doctor in charge, who should satisfy himself that to give the information would not be prejudicial to the patient's interests.

3 In the case of well-known people (and subject always to the patient's consent), a brief indication of progress may be given, in terms authorised by the doctor in charge.

4 In the circumstances referred to under 2 and 3, where the patient is too ill to give his consent, or is a minor, the consent of the nearest competent relative should be obtained.

Accident cases

5 (a) *Individual cases.* The press should be given, on enquiry only and at the time of the enquiry or as soon as possible afterwards, the name and address of the patient and a general indication of his condition but not necessarily a diagnosis. The patient's relatives should, if possible, be informed before any statement is given to the press; but if it has not been possible to do so, this should be made clear to the press. Further information should be given only with the patient's consent. Where the patient is too ill to give his consent, or is a minor, the consent of the nearest competent relative should be obtained.

(b) *Multiple cases.* In accidents involving a number of people (for example, a railway or air accident) all reasonable steps should be taken to ensure that relatives of the injured have been informed

before the publication of names, bearing in mind the necessity of early publication to dispel the anxiety of the next-of-kin of all other persons who were, or might have been, involved in the accident. Further information should be given only with the patient's consent. Where the patient is too ill to give his consent, or is a minor, the consent of the nearest competent relative should be obtained.

6 Hospitals admitting accident cases should maintain a casualty book or other similar records by reference to which enquiries may be answered.

General

7 All hospitals should ensure that a sufficiently experienced and responsible officer of the hospital is at all times available, whether in person or by telephone, to answer press enquiries, and should nominate an officer or officers for this purpose.

8 When dealing with representatives of the press, broadcasting or television authorities who call at hospitals and are unknown to them, such hospital officers are advised to ask to see evidence of accreditation in the form of a document issued by the representative's newspaper, news agency, photographic news agency, or other authority, or a membership card of the Institute of Journalists or the National Union of Journalists. Telephone enquirers not known to the officer receiving the call can, if necessary, be asked to give a number which can be rung back for the purpose of checking.

9 Satisfactory cooperation between hospitals and the press will depend on the observance of conduct that will promote mutual confidence and good personal relations. Difficulties and misunderstandings should be taken up between the hospitals or board [authority] concerned and the national or local press.

Appendix 2

PROCEDURE FOR MAKING COMPLAINTS TO THE PRESS COUNCIL

The following guidance has been given by the Press Council on making complaints to the Council:

How to make a complaint

If you have a complaint you may prefer to write direct to the editor of the publication concerned in the first place. The simplest and quickest way of seeking a prompt correction of an inaccuracy is to write direct to the editor.

Alternatively you may prefer to send full particulars of your complaint (including a copy of any relevant published material) to the director of the Press Council. He will acknowledge your letter and forward a copy of it to the editor without making any comment about the matter. This gives editors the chance to take any action they think fit including responding directly to you if they wish.

Keep copies of all letters you send to the newspaper or periodical and all those you receive from it.

If you are not satisfied with the editor's response or if you do not receive any response within a reasonable time – say a fortnight – and you want to pursue your complaint through the Council write again to the director sending him:

(a) a statement of your complaint saying what you think was improper on the part of the newspaper, periodical or journal and why you think it was wrong;

(b) copies of all letters sent to the editor or those acting for him or her;

(c) all letters from the editor or those acting for him or her;

(d) the page of the newspaper or periodical containing the matter about which you are complaining if the complaint is about something which has been published.

(*Note:* Any document you submit to the Council in presenting your complaint will be retained in the Council's case records and submission of documents is taken as evidence that you accept this rule.)

In certain cases it is helpful if you forward signed and dated statements by witnesses in support of your complaint. If you do this, please supply the names and addresses of witnesses. You may decide to do this on your own initiative, but the director will tell you if he thinks such statements would be helpful.

Where a complaint concerns someone other than the complainants (for example, a person referred to in the item complained of) the Council may require the complainant to seek that person's views before the complaint goes forward for adjudication, or the Council itself may seek their views.

Conciliation procedure

Some complaints can be remedied promptly by the publication of a correction, explanation or apology. The Council's conciliation procedure is designed to achieve speedy results in such cases and in others where mediation between a complainant and an editor might be helpful. The conciliator can act informally to try to help them reach agreement.

If you think your complaint is one which might be settled by mediation, you can ask that the conciliator try this. (An editor against whom a complaint is made can similarly ask for an attempt to be made to resolve it by conciliation.) If the conciliator agrees that the complaint is a suitable one, he will approach the other side and try to help both to reach agreement.

Conciliation is only tried if both parties consent to it, and its failure does not prejudice the position of either party if it proves necessary for the case to go forward formally for adjudication by the Council. Correspondence and conversations about the complaint between the parties and the conciliator during an attempt at conciliation are treated as confidential and not reported to the Council or its complaints committee if the case goes forward formally. If conciliation fails, the further investigation of the complaint is not done by the conciliator but by members of the complaints department led by the Council's assistant director.

If you think that conciliation might usefully be tried in your case, please let the Council have a telephone number at which you can be reached if possible. At any stage in the handling of a complaint, the director can suggest to the parties that it should be referred to the conciliator in an attempt to resolve it.

Investigation

If conciliation is not tried or fails to resolve the complaint, the assistant director and his staff investigate on behalf of the Council. They do this first by correspondence with the complainant, sometimes asking for further information, and clarification of the offence against ethical press standards that is alleged. They often ask the complainant to help draft a concise statement of the complaint usually in one or two short sentences.

If the complainant shows there are grounds for thinking that there have been breaches of recognised standards of press conduct, the Council puts the complaint and the evidence which has been

collected to the editor concerned for him or her to answer. The editor is also asked to put the matter to any journalist involved.

A dossier of all the relevant evidence is compiled for the complaints committee, which consists of equal numbers of press and public members. The committee may:

(a) halt the inquiry if it finds there is no case to answer;

(b) call for further evidence including oral evidence if necessary;

(c) recommend a finding to the Council;

(d) take other appropriate action.

In most cases the complaints committee reaches a decision on the basis of the written evidence from both sides put before it in the dossier.

Oral hearings

Editors and journalists involved – as the people accused by the complainant – have a right to appear before the committee and give oral evidence if they wish. If they do, the complainant, too, is invited to attend and give oral evidence. The Council, committee or the director on their behalf may decide that the attendance of the parties and witnesses is necessary in particular cases.

Oral hearings by the complaints committee are informal. Complainants and respondents are not legally represented, but a complainant or a journalist may bring with him or her a friend to act as an adviser – though not to present the case on their behalf.

Lack of means is not an obstacle. In cases of hardship the Council may pay attendance expenses.

If it is decided that a complaint you make should be the subject of an oral hearing, you can get advice about how the hearing will be conducted from the director.

Adjudications

After the complaints committee has considered a complaint, its recommended finding, the dossier of evidence and a report of the oral hearing if there has been one are considered by the Council.

Any adjudication on which the Council decides is sent by post to the parties shortly before being released, in the great majority of cases, to the press for publication. The general remedy offered by the Council to complainants is the publication of the adjudication on a complaint, but there are exceptional cases where a complainant may have substantial reasons for wanting to avoid further publicity whether his or her complaint is upheld or rejected. If there are such reasons in your case, you should tell the director as soon as possible and the Council will consider whether it can agree to deal with your complaint without giving publicity to the result.

Canvassing and confidentiality

Parties to complaints must not canvass, correspond with, or approach individual members of the Council about complaints which are pending before the Council or its committees.

The Council requires parties, their advisers and witnesses to complaints to treat as confidential all the proceedings including all correspondence and what takes place at the oral hearing (if any) until the Press Council has published its findings on the complaint.

In the event of any breach of the foregoing rules the Council may reject a complaint outright or censure a complainant or respondent (as the case may be).

Warning about delays

Delay in making a complaint can seriously hamper its investigation and the effectiveness of any remedy. Please, therefore, present any complaint promptly.

The Council refuses to deal with complaints where there has been unreasonable delay in submitting them or following them up. Generally it regards a delay of more than two months in the submission of a complaint as unacceptable unless there are unusual and substantial reasons for it.

The Council also expects editors to respond promptly, and the director can impose time-limits for the production of their replies to complaints put to them by the Council.

Alternative redress

If a complainant asks the Press Council to investigate and adjudicate on a complaint, he or she is expected to wait for that adjudication before taking any alternative steps to seek redress. The possibility of legal action being taken is dealt with in the next paragraph.

Legal action

The Council is a body concerned with ethics not law. It does not seek to take the place of the courts, but there are some matters which could equally be the subject of legal action or a complaint to the Council. Where legal action has been threatened – or is considered a possibility – the Council will not adjudicate unless the complainant signs a waiver. This is an agreement not to take legal action if the editor agrees to cooperate in the investigation and to publish the Council's adjudication.

'Fast track' procedure

The 'fast track' procedure is concerned only with complaints of factual inaccuracies made by people or organisations who are named or clearly identified in the published item concerned.

The following timetable applies for daily newspapers, with slight modifications for weekly and Sunday newspapers and more flexible arrangements to fit the production schedules of periodicals:

Within three working days of publication the complainant's request for a correction must be submitted to the editor, making

clear that it is under the Press Council correction procedure, with a copy of the request and of the item concerned to Press Council. Complainants may suggest appropriate wording for a correction but are not bound to do so.

Editor to publish correction or to reply to complainant (copy to Press Council) within three working days.

Failing publication of an agreed correction, or the reaching of agreement, the complainant should inform the Press Council within two days of receiving the editor's reply or of the expiration of the second three-day period.

A Press Council panel to rule within three days. The panel will usually comprise the chairman of the Press Council and a press member (or a vice-chairman and a public member) and the director or his designated deputy.

If the panel rules that a correction should be published it is to be published at the earliest opportunity. If the panel rules against publication of a correction the complainant may in effect appeal against the ruling by complaining in the customary way through a complaints committee to the Press Council.

An editor may take the issue to Press Council level by failing to act on a panel decision that a correction should be published. In these circumstances the complaints committee and Press Council will take account of the panel's decision, and the reaction to it, in their adjudication.

A panel decision for or against publication must be unanimous. Failing unanimity, or if the panel so decides, the Press Council will consider the matter.

The director has authority to rule out use of the 'fast track' for complaints where it is inappropriate. He has authority to extend its time limits in special circumstances.

Address The Press Council is at 1 Salisbury Square, London, EC4Y 8AE. Telephone 01–353 1248.

BROADCASTING COMPLAINTS COMMISSION

What is it? The Broadcasting Complaints Commission was set up by the Home Secretary on 1 June 1981 under Part IV of the Broadcasting Act 1980, to consider and adjudicate upon complaints about radio or television programmes, advertisements or teletext transmissions broadcast by the BBC or the IBA after that date. Part IV of the Act was replaced on 1 January 1982 by Part III of the Broadcasting Act 1981, which consolidated broadcasting legislation.

How it works

The Commission can investigate complaints only if they fall into one of the following two categories:

(a) *Unjust or unfair treatment* in the programme actually broadcast. This includes treatment which is unjust or unfair because of the way in which material included in a programme has been selected or arranged. A complaint can only be made by a person affected, that is anyone who was a participant in the programme in question and was the subject of that treatment or anyone who had a direct interest in the subject matter of that treatment.

(b) *Unwarranted infringement of privacy.* A complaint can only be made by a person affected, that is anyone whose privacy was infringed in, or in connection with the obtaining of material included in, the programme actually broadcast.

The Commission cannot consider a complaint if it appears to them that the matter complained of is the subject of court proceedings; or if it appears to them that the person affected has a remedy in a court of law and that in the particular circumstances it is not appropriate for the Commission to consider the complaint; or if it appears to them that the complaint is frivolous or for any other reasons inappropriate for them to consider it.

Complaints about the quality of broadcasting services and programme content generally are not matters for the Broadcasting Complaints Commission and should be sent to the BBC or IBA as appropriate.

Who can complain?

The Commission may consider a complaint from an individual or a body of persons or by a person authorised by the person (or body) affected to complain on his behalf. The Commission can also consider a complaint made on behalf of a deceased person by a personal representative or relative provided that the programme was broadcast within five years after the death of the person affected.

Procedure

Complaints should be made in writing and within a 'reasonable time' of the broadcast. The Commission will consider the complaint and if necessary invite the complainant to see them. This would be in private.

When the Commission have adjudicated upon a complaint they can require the broadcasting body concerned to publish a summary of the complaint and the Commission's findings.

Address

The Broadcasting Complaints Commission is at 20 Albert Embankment, London, SE1 7TL. Telephone 01–211 8465.

Recommended reading

You May Quote Me	by Knowles Mitchell and Winston Tayler. Institute of Health Services Management, 75 Portland Place, London, W1N 4AN.
The Hospital Shop Window	by Susan D Jones. Institute of Health Services Management, 75 Portland Place, London, W1N 4AN.
Manual of Public Relations	by Pat Bowman and Nigel Ellis. Heinemann.
You're on Next!	by Michael Bland. Kogan Page Ltd, 120 Pentonville Road, London, N1.
Getting Through	Report of a working party on health education, marketing and the mass media. South East Thames Regional Health Authority, Collington Avenue, Bexhill-on-Sea, East Sussex, TN39 3NQ.

Index

This is the first comprehensive guide for health service managers and other senior staff on all aspects of good public relations practice, including dealings with press, radio and television. Public relations is *not*, the book points out, about 'ducking and weaving against journalists, silencing abrasive pressure groups and covering up embarrassing mistakes. It *is* about communicating effectively, fostering goodwill and creating mutual understanding and confidence.'

The contributors are experienced press and public relations officers in regional health authorities. The editor is Roger Silver, regional press and public relations officer for the South East Thames Regional Health Authority. He was public relations officer from 1972 for the authority's predecessor, the South East Metropolitan Regional Hospital Board, after working as a journalist on weekly and daily newspapers, including *The Guardian*. He has devised and presented programmes about health and the health service for local radio and takes a special interest in communication techniques in health promotion. He is chairman of the training and education group of the National Association of Health Service Public Relations Officers.

0 19 724628 1