

CHC NEWS

A newsletter for Community Health Council members and staff

National emergency bed register

A national emergency bed register is to be in place by 1 December this year, according to the Department of Health. The register will help clinicians find the nearest appropriate intensive care bed if their own intensive care unit (ICU) is full or cannot provide the necessary care. The central database will phone the 234 hospitals in England which have ICUs three times a day for an update on bed availability. Clinicians will be able to telephone the central database direct for information. The system will also support clinical discussion that is needed before patients are transferred.

The new system is an extension of the Emergency Bed Service in the South East and the Intensive Care Bed Information Service in the North West. It will cover adult and children's intensive care beds in England, but not in Scotland or Wales. The NHS Executive will fund the system for 18 months, after which the running costs (estimated at £100,000 a year) will be passed on to health authorities.

The Royal College of Physicians has welcomed the Department of Health statement, saying that the system will save precious time. It also pointed out that it will provide a clear picture of the demand for intensive care across England.

DoH press release 27 August, Independent 28 August

Planted "patients" to test GPs

Allegedly substandard GPs are to be faced with bogus patients sent into surgeries in an attempt to identify doctors who fail to diagnose common medical conditions. The scheme is to be set up by the General Medical Council under the new powers granted to it by the Medical (Professional Performance) Act which comes into force in September 1997.

The scheme will be used to test only those doctors against whom complaints have been made. These GPs would have an observer monitoring their performance while they treated genuine patients. What the GMC calls "standardised patients" – volunteers or actors feigning conditions such as asthma, heart disease or diabetes – would be interspersed among these genuine patients. The GP would thus know that bogus patients might be expected, but will not know when they would arrive.

Sunday Times 18 August

Stop press

We have just received details of dates by which people must make a claim for problems they believe are caused by silicone implants manufactured by Dow Corning Corporation. For details see CHC Listings which is sent to CHC offices.

ISSUE 4, OCTOBER 1996

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All in a day's work – one doctor responsible for 300,000 patients

Ten health authorities have instructed GPs not to use a private deputising service after it was found that a single doctor had been left on duty responsible for 300,000 patients. Southern Relief Services (SRS) provided out of hours cover for 300 doctors in south London and Kent. On one day in July, four patients with potentially life-threatening conditions had had to wait between three and four-and-a-half hours to see a doctor. One doctor who was supposedly on the deputising rota had been in Germany for five months. The company was bought by a GP, Dr Mohammed Akhtar Ali Shah, on 10 July. Dr Shah complains that he was not given a chance to put the company into good order before Bromley Health Authority advised the other nine health authorities using the service to remove consent for GPs in their areas to use the company.

Sunday Telegraph 18 August

Home from Hospital

Nursing Times and the *Health Service Journal* cover a recent evaluation of 18 Home from Hospital (HfH) projects run by the Red Cross. The HfH scheme aims to provide practical and personal support to people discharged from hospital, usually for a period of up to three to four weeks. The services are funded through contracts with health authorities and/or social services, are managed by paid co-ordinators and make use of trained volunteers. Funding for the 18 projects evaluated amounted to £650,000 last year. The report warns that data on cost-effectiveness will be needed if this funding is to survive: hospitals and social services have generally not carried out formal evaluations of the impact of schemes.

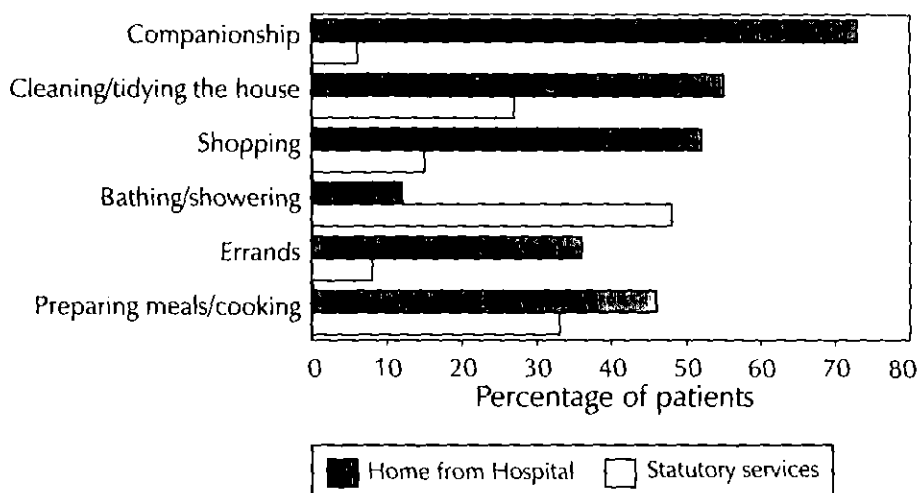
The evaluation, carried out by the Nuffield Institute for Health, found that the service was extremely popular with its mainly elderly clients. Volunteers were doing things that statutory staff carry out only rarely or not at all: walking the dog, cooking breakfast and shopping, for example. The flexibility over what service was offered was welcomed. Three-quarters of clients identified companionship as one of the main benefits. This last point raises one of the problems with HfH: some clients wanted support for longer than four weeks. Some volunteers also felt that certain clients were not well enough for the support to end at this time or, more frequently, that it was not right to withdraw contact. In some cases volunteers continued to visit clients unofficially.

From the point of view of hospitals, the service is welcome since it allows earlier discharge and helps patients to regain their capabilities more quickly. Social services benefit since they might otherwise have to provide services for vulnerable people covered by the scheme. In theory, the scheme is not supposed to be a substitute for statutory services: volunteers are not supposed to engage in "personal care". But the research found that where local authorities had tightened criteria for domiciliary services, HfH volunteers were beginning to fill the gaps.

So far services are overwhelmingly offered to elderly patients in rural areas. Only one of the 18 evaluated was in an inner city area. The Red Cross is trying to provide services in urban and multiracial areas. It would also like to widen the scope to include help for women with young children, for example.

HSJ 22 August, *Nursing Times* 21 August

Help provided by Home from Hospital and by statutory services



Source: *Health Service Journal*, 22 August 1996

HEALTH OF THE NATION

PROGRESS REPORT

The National Audit Office has published a report on progress towards Health of the Nation targets. While there is good progress on some measures and a little progress on others, for three targets the trends are moving away from the target. There is particular concern that smoking is increasing among 11-15 year olds. These figures have prompted the BMA to call once again for an immediate ban on tobacco advertising.

Good progress

coronary heart disease
stroke
breast cancer, 50-69 years
lung cancer, men under 75 years
suicide
gonorrhoea
accidents

Some progress

cigarette smoking, 16 years and over
energy from saturated fat
energy from total fat
cigarette consumption
conceptions under 16 years

No significant change

lung cancer, women under 75 years
drinking, males

Going the wrong way

obesity
drinking, women
smoking, 11-15 years

Too early to say

blood pressure
cervical cancer
skin cancer
giving up smoking in pregnancy

No suitable monitoring data available

mental illness
suicide among severely mentally ill people
drug misusers sharing needles

Health of the Nation: a progress report

National Audit Office
HMSO, £8.95



HEALTH ALLIANCE AWARDS

In 1994 the Government launched the Health Alliance Awards, a scheme designed to recognise and reward the achievements of innovative local partnerships in the community which promote good health in one or more of the Health of the Nation target areas: Coronary heart disease & stroke, Cancers, Mental health, HIV/AIDS & sexual health, and Accidents. There is also a Health of the Young Nation category for partnerships which promote good health to people aged 10-24 years.

A Health Alliance is a partnership between two or more organisations with the common aim of improving health in local communities.

The Health Alliance Awards scheme is free to enter and winners will receive awards and cash prizes.

If you would like to apply for the 1996/97 awards or would like to suggest an alliance which you think deserves a medal, contact Issie Peate on phone: 0171 413 4109; fax: 0171 413 4113.

A DRUG FOR MOTOR NEURONE DISEASE

The Motor Neurone Disease Association has drawn our attention to the UK launch of a new drug, Rilutek. This is the first ever drug treatment to have a demonstrable effect on Motor Neurone Disease (MND), a rapidly progressive and terminal muscle-wasting disease. There is already a debate in some areas concerning the provision of Rilutek. Since it represents the only therapeutic hope for people with MND, the MND Association believes that it should not be denied where there is professional recognition of its clinical benefit (it acknowledges that the drug may not be appropriate for all people with the disease). It calls for everyone with MND to be given accurate and complete information from which they can make well-informed choices. The Association has asked for the help of CHCs and others in working to make the treatment available.

For further information contact:

George Levy, Chief Executive,
Motor Neurone Disease Association, PO Box 246,
Northampton NN1 2PR
phone: 01604 250505, fax: 01604 24726



on CLINICAL AUDIT and EFFECTIVENESS

Definitions

Clinical audit: measuring the success of health care, using mainly medical criteria.

Effective care: care which is provided correctly and safely and where the treatment is based on good practice backed up by research evidence. The evidence should include the effect of treatment from the point of view of patients.

NCCA Clinical Audit Pack

The National Centre for Clinical Audit (NCCA) was established in 1995 by the Clinical Outcomes Group of the Department of Health. The NCCA has produced a clinical audit pack to help in achieving one of its key tasks: to develop criteria for excellence in clinical audits in order to establish a database of good practice. The pack includes:

- an introduction
- a listing of the NCCA criteria for clinical audit
- a summary of selected literature which was used to develop the above criteria
- a form which must be completed for each audit submitted for inclusion in the NCCA Audit Database

The NCCA criteria for clinical audit do not mention involving patients or their representatives – or, indeed, refer to the make up or internal working of audit teams at all. This reflects the fact that existing research studies “do not appear to have examined the process when audit involves different professional groups or patients or their representatives”.

Consumers, CHCs and patient representatives are, however, mentioned in the form which must be submitted for an audit to be included in the NCCA Audit Database, under the section asking who was involved in the audit. It should therefore be possible, as the database is built up, to check how many clinical audits are involving patients, CHCs and other representatives and in what capacity.

The NCCA is seeking comments on its pack over the next six months and is looking for people to undertake a detailed evaluation. A series of eight workshops on how to use the pack is to take place in October 1996.

For further information, contact:
National Centre for Clinical Audit
BMA House
Tavistock Square
London WC1H 9JP
Phone: 0171 383 6451
Fax: 0171 383 6373

Health authorities should involve consumers

CHCs who want a role in clinical audit may find NHS Executive guidance published last year more useful than the NCCA material in negotiating involvement.

Health authorities were made responsible for clinical audit in April 1996, with NHS regional offices responsible for monitoring their performance. *The new health authorities and the clinical audit initiative: outline of planned monitoring arrangements* (EL(95) 103, 4 October 1995) specifically mentions consumer involvement. In addition, Annex B to the letter, on assessing audit, includes “inclusiveness” as a criterion, i.e. that:

“Patients or their representatives are involved in clinical audit activities, including the selection of topics for audit, to improve both local accountability and the effectiveness of clinical audit.”

Clinical Outcomes Group Patient/consumer sub-group

ACHCEW is involved in the patient/consumer sub-group of the Clinical Outcomes Group which gives advice on the development of clinical audit and outcomes work.

The sub-group is shortly to publish a *Promoting user involvement in clinical audit: practical guidance on achieving effective involvement*. It will include references to CHC projects in the field.

For further information contact:
Roselyn Wilkinson at ACHCEW.

CHC involvement

East Dorset: action on menorrhagia

An essential part of clinical audit is that it should produce results in practice. East Dorset CHC is involved with other local NHS services in a project which aims to ensure that women with menorrhagia receive effective treatment and that they have a real role in deciding on the course of their treatment. This is one of a network of local projects set up under the King's Fund programme: *Promoting Action on Clinical Effectiveness*. All the topics chosen for the programme are ones on which there is reliable research-based evidence about the nature of care that should be provided.

Through the project, the CHC is able to work collaboratively with clinical staff from trusts and primary care services to ensure that patient's views are taken into account as part of the development of clinical guidelines.

Leaflets for women are being produced to help them understand their condition and their treatment choices. The leaflets are intended to provide a basis for a dialogue between patients and doctors and will be designed to help women have the confidence to pursue their worries and doubts. One challenge is how to get the leaflets into the hands of patients – beyond leaving a bundle at the local surgery! This is especially important since some women are reluctant to talk about menorrhagia, but instead tolerate it silently. One possibility is to work with local firms with a large female workforce: initial discussions with local managers have been encouraging.

Seminar in Newcastle & North Tyneside

Newcastle and North Tyneside CHCs recently held a forum on the CHC role in clinical audit. The half-day seminar was attended by representatives from clinical audit departments of every trust in the area, both CHCs and the University of Northumbria.

Participants supported user representation on Clinical Audit Committees, but there is much to be done. Speakers and groups identified the need for training, support, team building, defining roles and simple courtesy. Important questions also need to be answered, for example:

- If current or previous users are involved in audit, what will be the implications if they come into contact with individuals delivering their care?
- Are users to give personal opinions as lay people or as representatives of a group? If the latter, will they be allowed the facility to consult?
- At what level will users be involved?
- How many will be recruited to committees?

For a copy of the seminar report, contact Tanya O'Neil, Training & Development Officer, North Tyneside CHC.

Do you have experience of user representation in clinical audit? Would you like to write of your experience in CHC News? If so, please contact ACHCEW.

A screen for screening tests

The Government has set up a National Population Screening Committee which will provide advice on the appropriateness of health screening programmes. The number of screening tests carried out is growing annually, with over £100 million being spent on such tests within the NHS each year and more than this in the private sector. However, some of the tests are of doubtful value, including those which:

- cost a great deal, but identify very few cases (the *Sunday Times* claims that routine tests for syphilis in pregnant women cost £5 million a year, but have picked up only one case in the last 15 years);
- give high false positive rates as in some cancer screening programmes;
- identify conditions which cannot be treated;
- may lead to some people becoming uninsurable (likely to include some genetic and other screening tests which identify untreatable conditions).

The new committee will give advice on whether national screening programmes should be introduced, reviewed, modified or withdrawn in view of evidence of their effectiveness and costs, ethical considerations and the population's health needs.

Department of Health circular, *Sunday Times* 18 August

RECENT PUBLICATIONS

Rationing in the NHS: principles and pragmatism

In this little book Bill New and Julian Le Grand have done an extraordinary job of teasing out the assumptions and principles lying behind attempts at rationing in the NHS and writing about them simply and clearly. They accept that some sort of rationing is inevitable.

Attempts to introduce even modest changes to how the NHS rations its resources have been highly controversial. The authors discuss why explicit, systematic and democratic forms of rationing can produce such an outcry. Explicitness, for example, seems a laudable aim, but it also involves the open acknowledgement that health care may not be available when it is needed. The old system in which patients had been willing to accept a doctor's assurance that "nothing more can be done" had its comforts. But the world has changed, and such assurances no longer carry the weight they did – there is no going back to the situation in which rationing was hidden from public view.

Given this, there is a need to be clear about the principles used in rationing systems: though such clarity does not imply that there are any "grand solutions".

Choosing between services

In a chapter on services which are and/or should be offered by the NHS, the authors analyse what it is that makes health care "special" – something to be provided as a universal public service and not through private markets. They identify three criteria which are necessary for health care to fit into this category:

- **unpredictability** – we do not know when we will fall ill;
- **information imbalance** – we do not generally know the nature of what is wrong or how to return to good health, but have to rely on the medical profession to make judgements for us;
- **fundamental importance** – we feel that it would be wrong to deny someone health care they needed because they could not afford it.

The criteria are illuminating. Car accidents are unpredictable and we are at the mercy of car mechanics in judging how to put a crashed car right. However, we do not have car repair provided by the State, since having a car is not regarded as of fundamental importance. Food is of fundamental importance, but we do not have a "national food service" because the need for food is predictable and on the whole we know what food we need. This chapter goes on to apply the three criteria to elements of the health service, using them to suggest what might be included in and excluded from universal provision. The authors conclude that such a list should be drawn up at a national level.

Choosing between people

The chapter on choosing between people considers characteristics which are related to the needs of patients (e.g. how ill they are) and characteristics unrelated to need (e.g. having dependants, life-style, age). For various reasons, the authors reject the idea of discrimination on the basis of the latter. But even need-related characteristics are not as straightforward as they seem. Using the criterion of a patient's likely benefit from treatment, for example, could lead to discrimination against elderly people, disabled people and poor people.

Anyone who may be involved in discussing rationing at a local level would do well to read this book in order to clarify the principles which they and others are applying and their implications.

Rationing in the NHS: principles & pragmatism

Bill New & Julian Le Grand, King's Fund.

£9.95 from BEBC, PO Box 1496, Poole, Dorset BH12 3YD; phone: 0800 262260.

From the NHS Ethnic Health Unit

Three complementary publications from the Unit:

Good practice and quality indicators in primary health care combines two recent pieces of work – the collection of good practice in commissioning and delivering primary health care for black and minority ethnic people and a project in which quality indicators have been developed for the use of primary health care providers and health authorities. The quality indicators are presented in a section which outlines an agenda for action.

Beyond the boundary is a pack of ten one-sided sheets which give guidance to purchasers on involving black and minority ethnic groups in the assessment, planning and monitoring of health services.

The *Directory 1995/96* gives brief details of projects taking place throughout England with funding support from the NHS Ethnic Health Unit.

NHS Ethnic Health Unit

7 Belmont Grove, Leeds LS2 9NP

Phone: 0113 246 7336; Fax: 0113 246 7273

AROUND THE CHCs

A voice for young people

A shadow CHC of young people is being set up in Basildon and Thurrock, enabling them to give a fresh perspective on general issues and to highlight issues which matter to young people in particular. The idea was thought up by Angela Sharp, Chairwoman of Basildon & Thurrock CHC. Students studying the GNVQ Advanced Course in Health and Social Care at two local colleges will shadow the CHC as part of their coursework projects. They will hold meetings, discussions and consultations and report back to the CHC.

It is hoped that the shadow CHC will be seen as a genuine forum for independent discussion and consultation. The CHC's Deputy Chief Officer will attend bimonthly meetings and, although the CHC may give guidance and ask student-members to reconsider their conclusions, the CHC will not have the power to withhold or censor their views. Where appropriate the shadow CHC's views can be put forward to the health authority, trusts etc.

The idea should be a positive experience for all involved. Young people who may be about to start on a career within the health and social services will gain experiences and skills and will have an opportunity to comment on services which affect them. The CHC will gain knowledge of these young people's concerns and will raise its own profile amongst local young residents. Eventually it may be possible to extend the initiative to younger people through schools.

Nursing home inspection reports should be publicly available

The Health Service Ombudsman has ruled in favour of a person who complained at being denied access to inspection reports on a nursing home. The complainant, supported by Salford CHC, had requested the reports from the Salford and Trafford Health Authority under the Code of Practice on Openness in the NHS. The authority argued that the reports were internal documents and that public disclosure might adversely affect how such reports were written. It also argued that the reports fell outside the Code because the information did not relate directly to the NHS. The Ombudsman rejected both arguments.

Salford CHC believes that the judgement implies that all inspection reports on nursing homes made under the Registered Homes Act 1984 and the Nursing Homes and Mental Nursing Homes Regulations 1984 should be made available on request. This would be of use to CHCs, which have no right to visit nursing homes. CHCs may want to take the matter forward by, among other measures, redrafting leaflets on nursing homes and discussing the issue with health authorities.

How are CHC reports received?

We would like CHC News to give more information on how effective CHC recommendations are in bringing about change in local health services. ACHCEW receives many CHC reports which are listed in CHC Listings or mentioned in this newsletter. We would like to be able to tell readers what happens next: after the reports have been published.

If you have examples of successes in affecting local services – or of recommendations which are rejected or ignored – please let us know.

Assessing CHC performance

South Thames (West) Association of CHCs has been piloting a proposed method of peer review for CHCs. In the pilot three CHCs were reviewed by a team made up of a CHC chairperson, a chief officer and a past chairperson.

The review involved interviews during which CHC representatives answered questions designed to ascertain how each CHC carried out an agreed list of core functions. The questions were sent to CHCs in advance. (The questions were tightened up during the pilot to allow better comparisons between CHCs.) CHCs were also asked to provide a specified range of documents covering their work over the previous year and their structure. Meetings were held with CHCs before the review interview itself to discuss the process. During the course of the pilot it was decided that the review team should also make a follow up visit to discuss the team's report.

The Peer Review Working Group concluded that the method they have piloted is an effective way of judging CHC performance and of enabling CHCs to receive and accept criticism and share good practice. It suggests that in order to ensure consistency, there should be two teams per region and that members of each team should be able to swap places with their opposite number in the other. A three-year cycle of review might be suitable. Regional Offices, the NHS Executive or CHC regional Associations could be made responsible for running review teams – in any case financial support would be required from the NHS to run the scheme.

Proposals for a method of peer review for community health councils

South Thames (West) Association of CHCs

CHC Handbook

All CHC members should by now have received a complimentary copy of the **Handbook for CHC members**, fully updated to take account of changes within the health service and CHCs. We hope you like it – let us know if you have any comments.

Child health

Guidance on **Child health in the community**, has been published by the NHS Executive. ACHCEW commented on a consultative draft of the guide in June 1995. Overall, ACHCEW welcomed the document.

The draft had failed to mention CHCs in the list of groups with which purchasers should collaborate. ACHCEW pointed this out, and the final guidance includes CHCs in the list.

ACHCEW was concerned that the draft advised health authorities to "pay particular regard to the scope for a more selective approach to health screening" in schools. The Association believes that any move away from universal child health screening in the name of efficiency should be based on independent evidence of the effectiveness of targeted programmes and improved health education/promotion. The final version of the guidance says that health authorities should "pay particular regard to the scope for a more *discriminating* approach to health screening" (*italics added*). Whether this change in wording is supposed to reflect any real change in advice is not clear.

Child health in the community: good practice guide
NHS Executive. Copies have been sent to CHCs.

Partnership in medicine taking

ACHCEW has welcomed this consultative document from the Royal Pharmaceutical Society. ACHCEW's response has drawn the attention of the society to CHC research in this area. A welcome aspect of the document is that it refers to "non-adherence" when patients do not follow a recommended treatment regime, rather than the more traditional – and authoritarian – term "non-compliance"

Partnership in medicine taking

Royal Pharmaceutical Society of Great Britain
1 Lambeth High Street, London SE1 7JN
(Final date for responses has passed.)

Elective ventilation

ACHCEW has recently responded to a discussion document on elective ventilation – the use of artificial ventilation in comatose patients close to death in order to preserve their organs for transplantation after death. Elective ventilation is currently unlawful since the procedure is not intended for the benefit of the patient being ventilated. The British Transplantation Society wants the law to be changed to permit the procedure.

ACHCEW's response was based on comments received from 44 CHCs. Of these four were opposed to elective ventilation, 11 were unable to reach a consensus view and 29 gave overall, but sometimes conditional, support. Many were concerned about the possibility of patients who are undergoing elective ventilation blocking beds and staff resources in intensive care units (ICUs). ACHCEW suggests that alternative provision might be more suitable. Provision outside an ICU could be made less stressful for relatives and offer a more dignified death to the patient. The response also suggests that a senior named nurse should be an advocate for a patient on elective ventilation.

Elective ventilation. British Transplantation Society
for the Academy of Medical Royal Colleges,
1 Wimpole Street, London W1M 8AE

Patient partnership

Responding to NHS Executive's **Patient partnership**, ACHCEW has welcomed the commitment to a collaborative strategy, but it feels that there is a very long way to go. In relation to communities' partnership in the development of the NHS, ACHCEW believes that stronger guidelines and regulations are needed, rather than a reliance on the sharing of good practice.

The NHSE document recognises the contribution of CHCs and comments in general terms on the CHC role. However, ACHCEW believes that more specific references to CHCs could have been included. For example, CHCs are not mentioned in the section on "Improving information". The section talks of the need to strengthen local Health Information Services and to promote use of the Internet. ACHCEW comments that CHCs will need to have access to information on the Internet and that other physical locations for information and advice will play an important role.

Patient partnership: building a collaborative strategy
NHS Executive. Copies have been sent to CHCs.
