CHC NEWS

A newsletter for community health council members and staff

Political parties set out health plans

The three major national political parties used their last conferences before a general election as platforms for promoting their health policies:

Liberal Democrats

New promise

Extra £350m a year for the NHS: £200m for recruiting and retaining staff and £150m to bring maximum waiting time between diagnosis and treatment to 6 months.

How would they pay?

By closing a tax loophole on employers' national insurance contributions on perk payments.

Other commitments

- Three year contracts between purchasers and providers.
- National pay bargaining for nurses.
- Regaining public control of the facts about what is going on in the NHS.
- A halt to bed and hospital closures pending an independent national audit of demand and provision.

Independent 26 September

Labour

New promise

People diagnosed as having cancer would have to wait only a few days for surgery and a maximum of two weeks. The cost of this is estimated at £30-40 million.

How would they pay?

Out of £100 million a year saved by ending the NHS internal market and thus cutting administration costs.

Other commitments

- Restoration of national pay bargaining.
- Ban on tobacco advertising.
- Bringing assets of NHS trusts and health authorities into NHS ownership.
- Inquiry into ways of avoiding patients being discharged from hospital too early.

Guardian 1 October, Health Service Journal 10 October

Conservatives

New promise

Above-inflation increases in NHS funding in each year of a future Conservative Government.

How would they pay?

Not specified.

Other commitments

- Proposals (which have since been published) on developing primary services to allow more local flexibility.
- New plans to help mentally ill people.
- New plans to reform social care for children, disabled people and elderly people.
- A personal pledge from John Major that NHS care will remain free at the point of delivery.

Guardian 12 October, Sunday Times 13 October

ISSUE 5, NOVEMBER 1996

In this issue:

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES
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Mental health: lay panels to lose power to discharge detained patients

Stephen Dorrell, the Health Secretary, has announced that he intends to abolish the power of lay managers' panels to discharge patients detained in hospital under the Mental Health Act. He will act first through guidance in a revised Mental Health Act Code of Practice and will legislate when the opportunity arises.

At present compulsorily detained psychiatric patients can apply for release either to:

- hospital managers who appoint a committee of lay members such as non-executive directors and magistrates, or
- a mental health review tribunal consisting of a lay member, a psychiatrist, a lawyer and a chairperson.

Patients have increasingly applied to managers for discharge, partly because it can take months to get a decision from a review tribunal. The Government is to take steps to reduce these delays.

Mr Dorrell's decision follows the case of a schizophrenic who raped a woman four days after his release from a secure psychiatric unit. Lay managers had gone against medical advice in releasing the patient. A survey carried out by the Mental Health Act Commission found that last year 5% of patients requesting a review were discharged against medical advice.

D. Telegraph 18 September, DoH press release 17 September

Risk ratings for treatments

The Chief Medical Officer, Sir Kenneth Calman, has raised the possibility of issuing risk ratings for surgical procedures and drugs to enable a more accurate understanding of risks of treatments among both patients and doctors. He has proposed six categories to describe risk, ranging from "negligible" (less than one in a million) to "high" (greater than one in a hundred). If people were given and understood this information on risk, they would be better placed to make treatment decisions.

The problems of inadequate understanding of relative risk were highlighted last year during a scare about contraceptive pills. Many women stopped taking the Pill when it was announced that seven brands carried an increased risk of causing blood clots. However the risk of death from a blood clot in these cases was only three in a million. The risk of death from a blood clot in pregnancy is six in a million, and there are other risks associated with pregnancy.

In his annual report Sir Kenneth calls for a public and professional debate on the proposed categories. If they gained widespread acceptance, so that people used the same words to talk about the same level of risk, then they could be attached to new drugs or operations.

Guardian & Times, 26 September

GPs admit to striking off costly patients

Four anonymous doctors have confirmed allegations that GPs are removing expensive patients from their lists, by admitting in a survey undertaken by the journal *Doctor* that they have done so themselves.

The GPs, only one of them a fundholder, said that they had removed patients because their drug treatment was so expensive. GPs have a financial incentive to avoid such patients because of the prescribing scheme introduced by the Government in 1992. Under the scheme doctors who reduce their prescribing budgets within a target range over a year keep half of the savings. GPs can apply for extra funding to cover high-cost patients, but the procedures take time as the GPs have to present an argument to back up their claim.

Senior spokespersons from the BMA, the National Association of Fundholding GPs and the Medical Defence Union have all condemned the behaviour of the four GPs concerned. Their action amounts to serious professional misconduct and (were they identified) could lead to them being struck off from the professional register by the General Medical Council. The BMA recognises that the GPs' admissions could threaten the right of GPs to remove patients from their lists without giving an explanation.

The annual report form the National Association of Citizens Advice Bureaux (NACAB) also provides circumstantial evidence that doctors are turning away expensive patients. The report mentions cases in which GPs have removed patients from lists, without giving a reason, at a time when the patients have needed more expensive treatment.

Doctor 19 September, Times 25 September

Eight-minute response for the most urgent 999 calls

In September *CHC News* reported on the recommendations of a steering group set up by the Department of Health to review standards for ambulance services. The Government has published its response to the recommendations in The Citizen's Charter White Paper. It accepts that emergency calls should be prioritised and states that "From 1997, ambulance trusts will work towards achieving a more challenging standard for immediately life-threatening conditions of reaching the incident within eight minutes of the 999 call. Our aim is to achieve 75 per cent success by 2001 with further progress thereafter." The steering group had recommended that 90% of such cases should receive an appropriate response within 8 minutes, though it had also suggested that achievable interim milestones should be set by Government ministers.

NHS Executive, letter, 19 September 1996

NEWS

Inquiry recommends compulsory insurance for care in old age

An independent inquiry set up by the Joseph Rowntree Foundation has recommended a National Care Insurance scheme in which people with earnings would be required to contribute to an insurance scheme to meet care needs they may have in old age.

The proposals combine two aims: to entitle everyone to a proper standard of care in old age and to oblige individuals to insure themselves if they have the means to do so. As the scheme matured, those on average earnings could expect their insurance cover to meet all their care costs in old age. Those with insufficient cover would have the balance met by their local authority. Earners would be required to contribute a proportion of their earnings (provisionally set at 1.5% of earnings, with upper and lower earnings limits).

The proposals recommend a distinction between the costs of care (non-means tested wherever the care was delivered) and of accommodation (means-tested). Part of a person's contributions would be paid into a personal insurance fund to meet accommodation costs. Those with insufficient cover would be means-tested before their accommodation costs were met. A significant proposal is that the distinction between health and social care should be abolished. Both should be free at the point of delivery without means-testing.

In effect, the inquiry has proposed an income tax increase to meet care costs – not to the taste of either the Labour or Conservative parties, which are vying to be seen as parties of low taxation. Government ministers have dismissed the idea as a "new and unfair tax". The Labour Party has distanced itself from the proposals, while saying that it will study them.

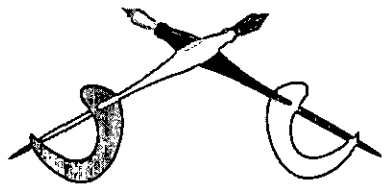
Meeting the costs of continuing care, Joseph Rowntree Foundation, Summary £5; Guardian 16 September

FROM THE JOURNALS

Insurers' access to medical records

The BMJ runs a series of articles headed *Controversies in management*. In a recent issue the controversy concerned the access of insurance companies to patients' medical records when assessing applicants for life insurance, with the head of life insurance at the Association of British Insurers (ABI) arguing for access and a GP arguing against.

The ABI representative says that some people are more clearly at risk of premature death than others and that this must be reflected in premiums. Thus insurance companies need to know of a person's medical history. It is argued that it is best to obtain this from GPs (with the patient's "consent") in part because "For many it may be reassuring to know that their GP, with whom there is an established relationship, is involved in explaining their medical history". Another reason is the cost of insurance companies carrying out their own investigations.



The author says that medical evidence rarely affects an application for life insurance: ABI estimates that about 1% of applicants are declined insurance and a further 4% may have to pay additional premiums. If this is the case one can only wonder at some of the wide-ranging questions the GP says insurers ask, for example:

- Has the daily alcohol consumption been recorded? If so, please advise dates and amounts.
- Has your patient ever sought advice or treatment for any sexually transmitted disease? If so, please give dates and details.

The GP argues that patients have no real choice about giving "consent" to access to their records if, for example, they want a mortgage. S/he believes that patients are inhibited from going to GPs or talking openly to them because they don't want compromising notes on their medical records. People with possible sexually transmitted diseases may go to clinics rather than their GP in order to remain anonymous, and many GPs refer them to such clinics for the same reason. GPs are required to note patients' smoking and drinking habits and are encouraged to be better at detecting depression, yet this information could be used against patients. An awareness of this breaks down the trust between GPs and patients and could compromise good medical care.

The GP argues that insurance companies should conduct their own medical investigations, leaving it open to patients to go to GPs for help in filling out questionnaires if they want to. If an insurance company believed that a patient had lied at the initial application for cover, then the company could seek access to the individual's records through the courts if necessary.

BMJ, 3 August

A MISCELLANY

Toxoplasmosis Awareness Week 1996
25 November – 1 December

Toxoplasmosis is a parasitic infection which can cause damage to an unborn baby if caught by the mother at any stage of her pregnancy. The infection is common and can be passed on from various sources, including undercooked meat, unwashed raw vegetables, cat faeces and unpasteurised goats' milk. The main risks are associated with eating habits and occupation.

The Toxoplasmosis Trust aims to ensure that women get accurate and clear information about the condition. Its Awareness Week this year has two aims:

- to draw attention to pregnant working women and to inform health professionals and women about possible increased risks in the workplace (e.g. in meat packing or agricultural work);
- to promote a leaflet *Toxoplasmosis and your pet cat*, which puts across a reassuring message about pregnancy and cat ownership.

The Toxoplasmosis Trust hopes that CHCs will be able to help them during the Awareness Week. It can provide leaflets, display materials and resource packs.

For further information contact: Rachel Dyke on 0171 713 0663
or write to the Toxoplasmosis Trust, 61 Collier Street, London N1 9BE

The PRODIGY system

The Association of the British Pharmaceutical Industry (ABPI) has written to us about PRODIGY, a computer prescribing trial being undertaken by the Department of Health among selected GPs. Under the system GPs are steered through clinical guidelines to prescribe one of three predetermined treatments once a diagnosis has been made. Interim results of the pilot were published in July, giving public access to the therapeutic information and prescribing recommendations contained in the system for the first time. The final report is due in July 1997.

ABPI has serious reservations about the PRODIGY system, although it says that it recognises the potential role of computers in assisting doctors to come to decisions. The Association points out that "no patient representatives or experts from the pharmaceutical industry were invited to participate in the development of guidelines, the selection of medicines or in the validation process." It also says that apparently no attempt has been made to assess the scheme's impact on treatment outcomes as far as NHS patients are concerned.

ABPI is concerned about the quality and relevance of information contained in the system. For example, it has concerns about the advice presented on the management of high blood pressure. Doctors are not obliged to select a medicine advised by the system, but the difficulty of selecting another medicine may encourage GPs to stick to the choices offered.

For further information contact:
ABPI, 12 Whitehall, London, SW1A 2DY
Phone: 0171 930 3477, Fax: 0171 747 1411

Sexual abuse in psychiatric settings

The Royal College of Psychiatrists has published a report, *Sexual abuse and harassment in psychiatric settings*. It deals with a very difficult area in which fine lines need to be drawn between protection of vulnerable people and the preservation of people's rights to sexual expression, especially since the psychiatric setting may be seen as the person's home.

The report is clear in advocating openness in the prevention of and response to sexual abuse and harassment. For example, the issue of capacity to consent should be clearly addressed in individual care plans. Patient education has an important role in the prevention of inappropriate sexual behaviour and there may be a need for specific sex education. The report recommends that policies on sexual behaviour should be clear and that patients' representatives should be involved in developing them. Education for patients should include information about unit policies. An example is given of a youth treatment centre in Birmingham where rules about intimate behaviour between young people are very explicit and direct. They describe the sort of kissing, cuddling and level of intimacy allowed and what is thought to be acceptable.

It is recommended that patients should have ready access to information about outside agencies able to give help and advice. Outsiders, such as CHCs and women's groups could be involved in regular debates with patients and staff to help raise consciousness and contribute to the development of policies.

Sexual abuse and harassment in psychiatric settings
Royal College of Psychiatrists
Council Report CR52
Details from: Sales Assistant, RCP
17 Belgrave Square, London SW1X 8PG
Phone: 0171 235 2351
Fax: 0171 245 1231

PUBLICATIONS

Alternatives to fundholding

There is a broad consensus from research that fundholders have achieved change for their patients. But why is this so? Advocates of fundholding tend to stress the power of fundholding GPs to withdraw contracts from providers (the "exit" strategy). Critics of fundholding have suggested that the successes of fundholders are due to their greater involvement in health authority purchasing decisions (the "voice" strategy). Most evaluations of fundholding throw little light on which strategy is more effective since they have compared fundholding GPs with old-style GPs who have not joined schemes to influence purchasers ("non-joiners"). This study assesses the relative effectiveness of exit and voice strategies by looking at schemes set up by non-fundholding GPs to influence purchasers and by comparing the achievements of such schemes with those of fundholders.

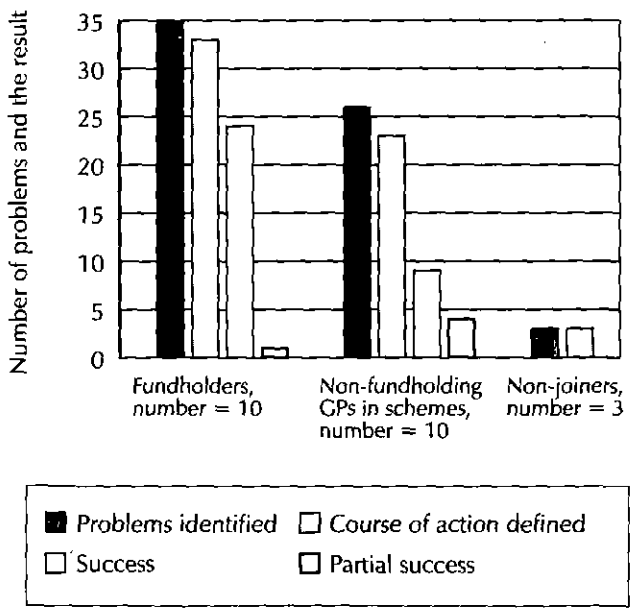
The non-fundholding schemes described are very varied: in size, degree of formality, the areas in which they operate and, crucially, in the co-operation they receive from health authorities (see box). Few had achieved the success they hoped for, though minor changes had been achieved in many cases, and more impressive changes in a few.

A section comparing non-fundholding schemes with fundholders and with "non-joiners", showed that fundholders identified more problems with services than the other two groups. They also defined courses of action and achieved success more often (see graph).

The conclusions stress the diversity of local situations and the varying philosophies of doctors and others involved, which may lead to varied approaches being suitable. Fundholders and locality groups, say the authors, do different things well. Until we know more about their relative effectiveness, fundholding should continue, but GPs who wish to do things differently should have the right to form alternative groupings.

Success of GPs in achieving change

Source: Alternatives to fundholding, Glennerster et al.



Essentials for success in GP involvement

- initial clarification of objectives between GPs and the health commission
- clear representational legitimacy for the groups of GPs who take on the responsibility of being a sounding board
- good mechanisms to tap all non-joiners' views
- clear allocation of responsibilities for purchasing between the scheme and the health commission
- clear lines of accountability back to the health commission
- access to senior managers in the health commission who have responsibility for purchasing choices and budgetary control

Alternatives to fundholding, Glennerster, Cohen and Bovell. Free of charge from Welfare State Programme, The Toyota Centre, LSE, Houghton Street, London WC2A 2AE; phone: 0171 955 6679

Managing volunteers effectively, McSweeney and Alexander. For availability details phone Ashgate Distribution Services on 01252 317707.

Managing volunteers effectively

This book regards volunteers as typically working in an organisation, such as a charity delivering hands-on services to the public, in which they are answerable to a designated manager. The model does not apply easily to CHCs: the roles discussed in the book are not the province of one manager, but are divided between CHC chairs, CHC chief officers, the organisations from which CHC members are drawn and CHC members themselves. Nevertheless, reliance on the efforts of volunteers is of relevance to CHCs, and a CHC might find it useful to go through the book deciding who, in that CHC, is responsible for each of the roles and tasks it covers. Throughout the book, discussion of practicalities and theories is interspersed with examples and exercises designed to get the reader to think about the nature of the organisation s/he works in and to work more effectively.

LOOKING AT HOSPITAL DISCHARGE

Two recent surveys by CHCs looked at patient discharge, one providing detailed information from staff and the other from patients. A third survey, on day case surgery, included discharge as one of the topics for investigation.

In a discharge survey undertaken by Blackburn, Hyndburn & Ribble Valley CHC, staff were asked detailed questions about the process and patients sent a questionnaire. The health authority's written discharge policy specifies the responsibilities of various members of the multi-disciplinary team when a patient is to be discharged. This is reflected in responses from staff, who seemed to be well aware of how procedures should work. Even so, practice varied between wards, particularly in relation to multi-disciplinary involvement. It is not clear whether the differences were arbitrary or a result of clear managerial decisions.

Staff perceptions

It is apparent from the staff responses that awareness of patient perceptions of the process also varies between wards. Thus, for example, there are different comments on difficulties caused by waiting for take-home drugs. Staff on a surgical ward pointed out that parking is difficult and someone collecting a patient cannot always "hang about". Staff on a medical ward appeared to be less aware of practical realities: "No real problems although some patients perceived two hour wait as too long."

Patient perceptions

Shropshire CHC's survey of the experiences of elderly patients discharged from hospital gives a great deal of valuable information thanks to the time that was put into interviewing patients. Trained CHC members held in-depth interviews lasting about 60-90 minutes with 43 patients in their own homes. Questions were asked about: the home situation; discharge arrangements in hospital; the first two days after discharge; and the two to three weeks after discharge. Twelve patients were living alone on their discharge, and of 27 living with a spouse, 9 lived with a disabled, infirm person.

Keeping carers informed

The Shropshire survey clearly shows that relatives and informal carers play a vital role in providing support after discharge. Patients were asked who, apart from those living at home with them, gave assistance in the first two days and in the following two to three weeks. In both cases, friends and neighbours were mentioned most often, followed by sons and daughters. Yet, if the patients' perceptions are correct, the hospitals are still falling down on informing family, relatives and neighbours of a forthcoming discharge. Ten patients said that family/relatives/neighbours were given less than 24 hours notice, and 15 said that family/friends were not involved in the arrangements for their discharge at all.

A survey from Hastings & Rother CHC on day surgery covers, among other things, the discharge arrangements. It must be of concern that 64% of carers were given no information at the time of the patient's discharge. The CHC suggests that (subject to the patient's consent) carers should be given a post-operative care sheet and an oral explanation at the time of discharge.

Did you feel well enough to go home?

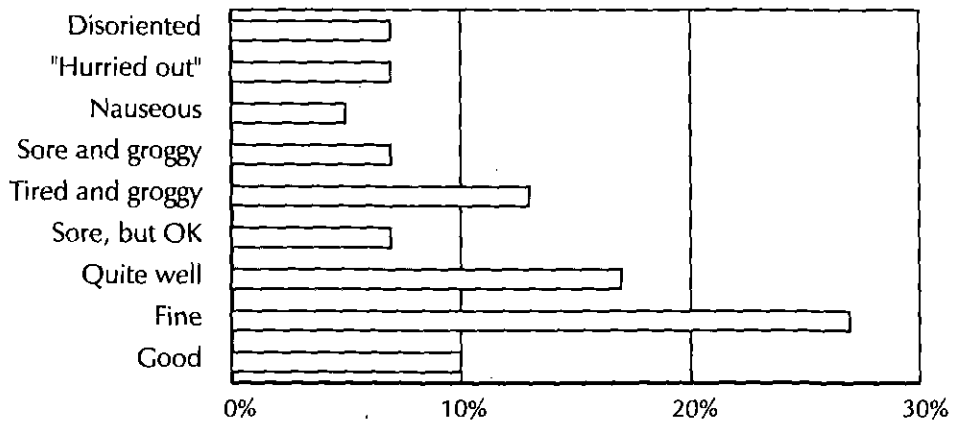
In the Blackburn, Hyndburn and Ribble survey 15% of patients said they had not felt well enough to go home when they were discharged. In the Shropshire survey of elderly patients, the proportion was 27% (12 patients). All 12 felt they needed more treatment and many mentioned other problems. Nine felt they would not be able to manage and 7 of these had no one to help them.

Of 39 patients in the Hastings & Rother survey of day cases, 39% had felt they needed more time to recover from the anaesthetic before being discharged. The graph on the left gives details of how the 39 patients felt at discharge.

How did you feel at the time you were discharged?

Number of respondents = 39

Source: Day case surgery survey: the patients' perspective, Hastings & Rother CHC



AROUND THE CHCs

Two CHCs have recently been working on health issues important for primary school children.

Asthma

A useful survey carried out by the Rhymney Valley Health Watch Groups for Caerphilly CHC looked at asthma policies in schools and has acted as a spur for action on the part of the schools involved. The project was triggered by concerns among a small number of parents of asthmatic children, some of whom were choosing schools some distance from their homes because of how the schools deal with asthmatic attacks.

The CHC was able to take advantage of the local knowledge and involvement of members of its local Health Watch Groups who visited schools to hand over the National Asthma Campaign (NAC) Schools Pack and held follow-up discussion meetings where possible. The CHC was encouraged by the many requests for additional information which it subsequently received from head teachers.

A questionnaire was then sent to 62 schools, of which 40 responded. It was found that, although most schools had a policy of some kind, many policies were inadequate. Over 32% thought that their school policy was very much in line with the NAC draft policy paper, and 80% said that they would consider adopting the NAC model. The greatest problem area was training in the management of asthma. Only 7.5% of schools had been offered training. Although some schools had arranged for training on their own initiative, in 62.5% of schools no teaching staff had received training.

CHC PUBLICATIONS MENTIONED ON PAGES 6 & 7

Findings of a survey of the discharge of patients from Queen's Park Hospital and the Royal Infirmary, Blackburn
Blackburn, Hyndburn and Ribble Valley CHC

Day case surgery: the patients' perspective
Sally Gardhouse for Hastings & Rother CHC

Discharge from hospital: the experience of Shropshire patients
Shropshire CHC

Survey of the dental health of primary school children in Wandsworth
Wandsworth CHC

Asthma campaign primary schools project
Caerphilly CHC

Feedback

Sue Cavanagh has written to thank the 39 CHCs who responded to a questionnaire on *Community Involvement in Primary Health Care Building Planning and Design*, and to ask for any new examples which CHCs could come up with.

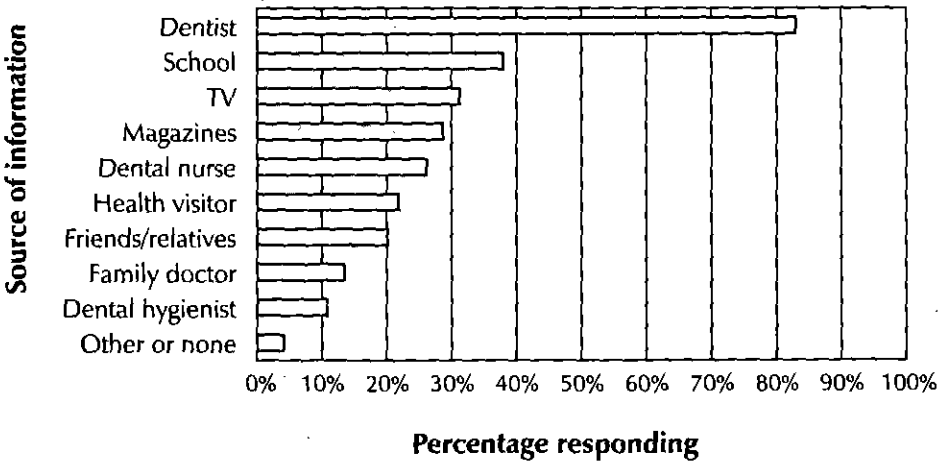
The questionnaire was used to identify 33 projects, of which ten have been selected for further study. An important outcome will be to draw together guidance on community involvement in the planning and design of primary care facilities.

For more information, see *CHC Listings*

Dental health

Wandsworth CHC has undertaken a survey of dental health among primary school children in its area. It found that although parents place a high premium on their children's dental health, they need more information on all aspects of the subject and especially information on diet and nutrition. The CHC was disappointed to find that non-dental health professionals in contact with young families (for example health visitors and doctors) do not seem to be advising parents on dental health and that they are not seen as a source of information on the issue (see graph).

Where do you get information about your child's dental health?
Respondents could give more than one answer
Survey of dental health of primary school children in Wandsworth, Wandsworth CHC



Consultation on Charters: room for improvement

In September ACHCEW submitted a memorandum to the Public Service Committee of the House of Commons on the Citizen's Charter Programme. In the memorandum, ACHCEW drew attention to its own long-standing work on patients' charters and argued for the extension and strengthening of the Government's *Patient's Charter*. ACHCEW made many of the same points to a recent Labour Party "oral hearing" on the Citizen's Charter.

ACHCEW published its own *Patients' Charter* in 1986 – some five years before the Government version. When the official *Patient's Charter* was published ACHCEW was disappointed to find that, despite the Association's detailed proposals submitted to Government ministers, there was nothing in the Charter about strengthening existing arrangements for representing patients' views. Overall, the Charter could be seen as a document *for* patients, but not *by* patients. Again, when the Patient's Charter was revised in 1994, the areas for attention suggested by ACHCEW were not seriously addressed.

This is not to say that all of the *Patient's Charter* standards and rights have been ineffective. Steps taken by central Government in some of these areas may show that the *Patient's Charter* has focused attention on areas needing reform. They may also show that reforms to systems and the imposition of specific targets are of more benefit than general statements of good intentions. Furthermore, the charter areas in which most progress has been made are in secondary care: this should be borne in mind as we move towards a "primary care-led NHS" in which decisions are increasingly being made by independent GPs.

Patient's Agenda

ACHCEW's *Patient's Agenda* is to be launched this November.

The Agenda sets out a range of rights which should be guaranteed to users under the NHS under the headings:

- Access to care and treatment
- Health care regardless of the ability to pay
- Choice and information
- Advocacy, support and appropriate care
- Good quality care in matters of life and death
- Confidentiality and control over personal information
- Redress

ACHCEW's memorandum to the Public Service Committee raises issues of particular interest to CHCs and points out the role of CHCs in helping to ensure that progress is made. In a survey on the *Patient's Charter*, the Association found that the greatest improvement had been made in relation to waiting times in outpatient clinics – the area in which CHCs have been most involved in monitoring. There are also many examples of local progress directly resulting from the Charter, usually where the CHC has been involved from the outset. In ACHCEW's view "Working together, well-resourced CHCs, responsive providers and dedicated purchasers can use the *Patient's Charter* to drive up standards".

Leaflets for pharmacies

David Cook, a member from ACHCEW Standing Committee, would like to hear **as soon as possible,** from any CHCs which have ideas for patient leaflets in pharmacies. He is involved with the Pharmacy Healthcare Scheme, which has recently been awarded a three-year contract by the Department of Health to produce eight patient information leaflets a year.

Campaigns due to be launched soon are:

- Medication and the elderly
- Depression and the elderly
- Safer sex – cover up
- Safer sex – teenagers
- No smoking day

The Pharmacy Healthcare Scheme Steering Committee is looking for ideas about the areas they should be concentrating on in the next two years.

Contact David Cook at Gloucestershire CHC.

Look out for ...

two new ACHCEW *Health Perspectives* on:

- **Accident and Emergency Services**
  Why is A&E under such pressure and will recent proposals benefit patients?
- **The Safety of Medicines**
  Can we rely on the current systems to monitor the safety of the drugs we use?