CHC NEWS

A newsletter for community health council members and staff

Cash crisis in the NHS

The Health Secretary Stephen Dorrell has succeeded in gaining extra funding for the NHS in the annual round of spending bids put in by Government departments. It is reported that Mr Dorrell has won a real increase of £500m – about half what he was seeking – in the face of warnings of a cash crisis in hospitals throughout the country. The Treasury is said to be seeking cuts of about £4bn from the overall £268.2bn spending bill, so any increase in health spending will have to be met by deeper cuts in other departments.

The extra money for the NHS is for the year from April 1997. But there have been warnings of a funding crisis in the meantime which could lead to a winter of ward closures and other cutbacks. NAHAT estimates that English hospitals need £200m to see them through to March. The NHS Trust Federation says that £300m is needed to avoid delays to non-urgent surgery.

NHS trusts

The BMA has warned that several NHS trusts are in deficit, although they have a statutory responsibility to break even. The BMA has a drawn up a list of "hot-spots" including Southampton Hospital, which has a £22m deficit, and the North Durham Acute Hospitals Trust, which has a deficit of £6m. The most recent official figures are for the year 1994/95. At the end of that year 36 trusts had debts totalling £34m. A Department of Health spokesman has said that hospitals must break even year on year and that hospitals in the red "will have to make savings or reductions".

Health authorities

Official figures show that 63 of 99 district health authorities expect deficits in 1996/97 amounting to a total of nearly £118m. Health authorities are not under as much pressure as trusts to break even, but many can be expected to make cuts in services.

Bed cuts

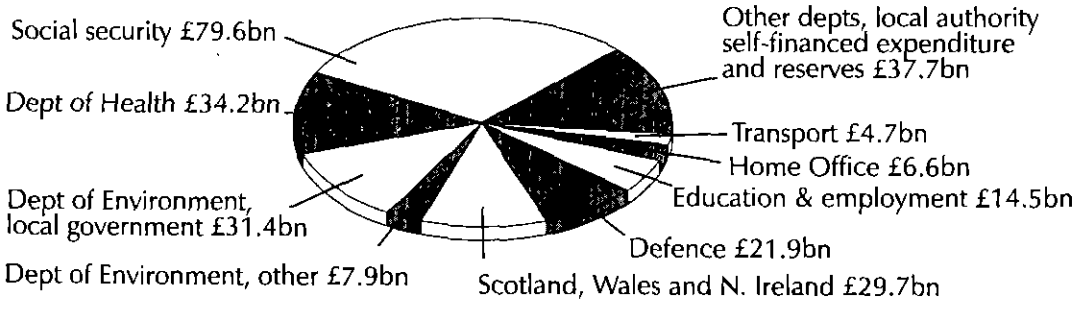
Labour MP Hugh Bayley has been analysing figures on reductions in available hospital beds. Between 1990 and 1994 the number of available beds was cut by an average of 2%. This figure includes a cut of 11% in Barking, east London. Government ministers say that hospitals need fewer beds because they are becoming more efficient.

Guardian 18 October & 5 November, Independent 4 & 5 November

Slicing the cake

Public spending targets for 1997/98 as set out in the 1995 budget

Source: Guardian 5 November 1996



ISSUE 6, DECEMBER 1996

In this issue:

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES
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GPs to refuse patients from nursing homes

The BMA has advised GPs to refuse to take on new elderly patients living in nursing homes unless they are paid extra for doing so. It has said that doctors should continue to care for patients who are already on their lists.

The advice is part of a BMA attempt to define "core services", which GPs are contractually required to provide and "non-core services" for which they should receive extra payments. The association has provided GPs with letters to send to health authorities and care homes outlining duties which they intend to stop carrying out from next April.

Examples of "core services"

- ✔ surgery consultations
- ✔ out of hours care
- ✔ hospital referrals
- ✔ immunisations
- ✔ cervical smear tests
- ✔ maternity services

Examples of "non-core services"

- ✘ care of high dependency patients in nursing homes
- ✘ post-operative care of patients discharged from hospital
- ✘ fertility treatment
- ✘ endoscopy examinations
- ✘ care of drug-dependent patients

The BMA says that the move is necessary since hospitals are increasingly passing responsibility for care to GPs, who have an open-ended contract. The proposals have been condemned by NAHAT, which said that care home residents have the same right as everyone else to register with a GP, and by Age Concern, which said that, yet again, older people are being targeted in arguments over funding problems.

Guardian & Daily Telegraph 7 November

Breaking confidentiality

The Royal College of Psychiatrists has issued advice that permits doctors to pass on information given to them in confidence about some violent patients.

New guidelines say that wherever possible doctors should pass on confidential information only with a patient's consent. However, the guidelines also set out factors which doctors should take into account when they are assessing whether a patient may be violent. If a doctor thinks that passing on information will save someone from a violent attack, then s/he may pass that information on – usually to other health professionals or carers.

A consultant psychiatrist who helped to draw up the guidelines said that concern to protect patients' confidentiality had gone too far and has inhibited the passing on of information to other health professionals or to the potential targets of an attack. Attacks by mentally ill patients cause about 50 deaths a year. However, a spokesman for the Royal College of Psychiatrists also pointed out that the tiny minority of mental patients who behave violently are outnumbered by the number of "normal" people who commit acts of violence.

Daily Telegraph

The domino effect:

Refugee needs put pressure on community care budgets and hospitals

Health authorities in some parts of the country have been warned that places in old people's homes, bed and breakfast accommodation and hostels are being used to house destitute asylum seekers who have had their benefits withdrawn.

The Government withdrew benefits from some groups of asylum-seekers last spring in an attempt to deter "bogus" claims. But local authorities have a responsibility to provide the necessities of life to families seeking asylum under the Children Act. In October, a High Court judge ruled that they also have a responsibility to provide for single destitute adults.

Community care budgets are being used to meet the unexpected costs of supporting refugees. As a result, some local authorities may not be able to provide community care for elderly people ready to be discharged from hospital. If no extra funding is provided, warn the local authorities, they may have to halt arrangements for discharging elderly people from hospital.

In London it is estimated that social services departments are supporting at least 725 families with children and 619 single adults. A survey of 23 London boroughs found that by next Spring the boroughs think they could be supporting 2700 families and 4000 single adults, with costs rising form £32 million this year to £190 million in 1997/98. There are already plans in Hammersmith and Fulham to house refugees in a tented campsite which is currently used by visitors for a few weeks in the summer.

Observer 13 October, Guardian 17 October

Guidance on intimate examinations

The General Medical Council is considering draft guidance to doctors on procedures for carrying out intimate examinations of patients. Currently the GMC advises doctors that they should respect the privacy and dignity of patients, but complaints from patients have led to a feeling that this advice needs strengthening.

The BMA already suggests that GPs invite patients to bring a chaperone if they are due to undergo an intimate examination. However, patients may not be able to do this, and in any case it may not be clear in advance of an appointment that a patient needs an intimate examination. If the patient cannot bring a chaperone, some doctors ask a practice nurse or receptionist to be present during such examinations. But, again, this is not always possible and the patient may object to the presence of someone they do not know.

Guardian 1 November

Choice and opportunity

The Government has issued its White Paper on primary care. The document will be discussed in the December issue of ACHCEW's Health Perspectives series.

NEWS FROM ACHCEW

How reformed is the NHS?

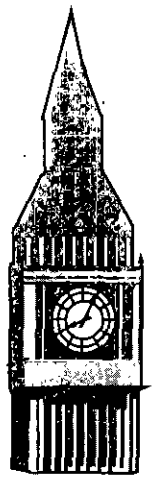
ACHCEW's recent Health News Briefing *How reformed is the NHS?* has received wide coverage in the national press.

The Briefing, which is based on a survey of CHCs, found that there had been changes in the NHS during the early 1990s, but that many of the changes for the better resulted from increased funding and other initiatives, rather than from the purchaser/provider split. It concludes that market forces do not appear to have been strong within the NHS and that, as a result, there is little evidence of effective competitive pressure improving quality or efficiency since the reforms.

The *Health Service Journal*, *The Times* and *The Daily Telegraph* all carried articles highlighting the ACHCEW report.

Nigel Ellis

Nigel Ellis, who has been Research and Information Officer at ACHCEW is leaving to become Head of Branch and Regional Support with the Multiple Sclerosis Society. We wish him well in his new post.

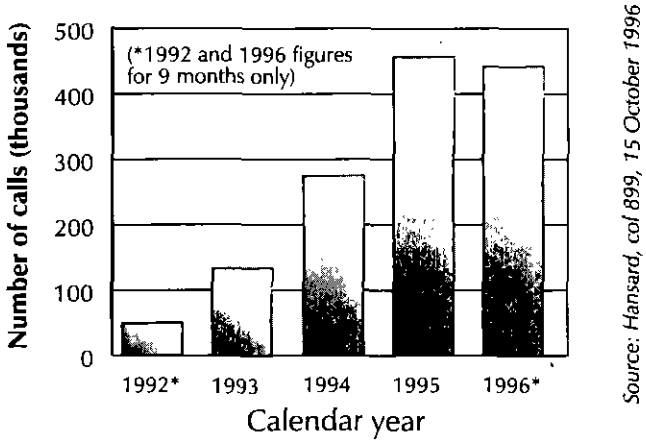


Parliamentary Answers

Health Information Service

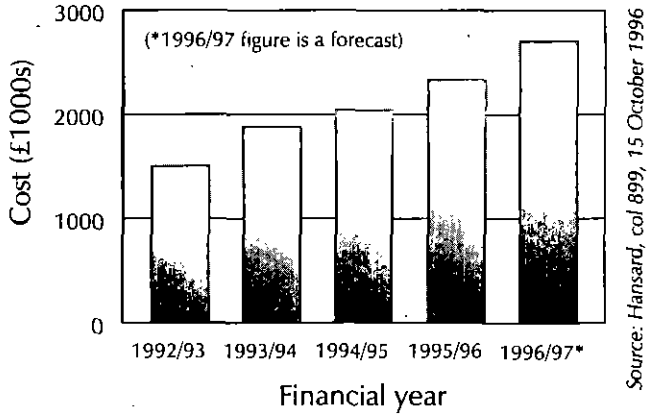
The graphs show information given about the Health Information Service, which was set up in 1992. The figures show that the average cost of a call since that date has been about £6.70.

Calls received by the Health Information Service
April 1992 to September 1996



Source: Hansard, col 899, 15 October 1996

Cost of Health Information Service
From April 1992



Source: Hansard, col 899, 15 October 1996

"No information"

In Parliamentary Answers, Government ministers said that the following information is not collected centrally.

- New hospitals built in (a) London and (b) each health region.
- The number of mixed sex wards in existence.

Hansard, col 900, 18 October 1996

Dorrell sets out social services agenda

In October the Secretary of State for Health, Stephen Dorrell, gave a speech to the Annual Social Services Conference announcing that there would be a White Paper on social services in the new year. He used the speech to indicate what the White Paper will contain.

The Government wants to see a further shift away from local authority (LA) provision of services. Any provision LAs undertake should be a means to achieving their *primary* role as an "enabler and commissioner of services".

Mr Dorrell rejected, at least for the time being, calls for a statutory General Council to enforce professional standards among social services staff. Instead he proposed establishing a unit which would assess and comment on material relating to professional values and obligations. Over time, this might lead to codes of conduct and practice. (Chris Smith, the shadow health spokesman, later told the conference that the Labour Party would arrange for the early introduction of a statutory body.)

Much of Mr Dorrell's speech explained an initial response to a substantial report, *The regulation and inspection of social services*. Mr Dorrell's response represents that of the Department of Health and not the Welsh Office – the regulatory systems in England and Wales are already slightly different.

The report deals with a wide range of activities relating to social services: setting standards, registering providers, inspection and enforcement. It aims to address the main criticisms of the current system: the limited scope of regulation; a lack of even-handedness between providers; weakness in enforcement; and deficiencies in the determination of costs and fee levels. The points on the right mention a few of the conclusions and the Government reaction.

Transcript of Dorrell's speech, Burgner report, Community Care 24-30 October, Guardian 19 October

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The regulation and inspection of social services
By Tom Burgner
Commissioned and published by the Department of Health and the Welsh Office

Proposals for social services regulation

Even-handedness

- The Government has accepted in principle that provision by all sectors should be on the same legal basis. This would mean that all adult and children's homes provided by LAs, and some others currently exempt, should be required to register.
- The author of the report, Tom Burgner, set out options for the structure of regulatory and inspection services. The Government is in favour of keeping the function within LAs (for those services for which they now have a responsibility), but removing it from SSDs. Responsibility could be placed within the Chief Executive's Department or within Trading Standards (this last suggestion went down very badly with delegates). Mr Dorrell rejected the option of an independent inspectorate.

Health and local authority roles

- Currently adult residential homes are regulated by LAs and nursing homes by health authorities. Tom Burgner laid out strong arguments in favour of ending the distinction between the two types of home (providing there is adequate flexibility and choice in a single system). The Government is not convinced by his arguments, but remains open to other views. It seems to be more prepared to move towards a common regulatory regime between the two types of home and is attracted by the idea of joint (LA and NHS) inspection units.

National benchmarking

- The Government has accepted that there should be national benchmarking of service standards from which individual authorities can develop local standards.

Scope of regulation

- The Government has accepted that statutory regulation should be extended to children's homes with fewer than four children.
- Tom Burgner also recommended that regulation should be extended to domiciliary care and day care where a genuine care element is involved. People receiving services in their own homes can be especially vulnerable. Some local authorities operate provider accreditation procedures, but these will not cover people who purchase services directly. There is widespread support for regulation in this area. The need for regulation of day care is seen as less pressing since services users are seen as being at less risk. Although the Government acknowledges there would be merits to extending regulation in these ways, it has placed the proposal to one side in view of the complexity and costs of such a system.

Acting tough

A solicitor writing in *Community Care* advises Social Services Departments (SSDs) to be much more assertive in avoiding costs for continuing care which are being passed from the NHS to local authorities. He says that SSDs often have the law on their side, and can flex their muscles through:

- **Staff training** on rights, e.g. on processes to involve social services in deciding about hospital discharge.
- **Management support** for hospital social workers who refuse to accept responsibility for a discharge.
- **Encouraging complaints from service users,** e.g. if a social worker was not involved in a discharge.
- **Detailed research** on the number of continuing care beds withdrawn by the health authority.
- **Negotiating more strongly** over continuing care criteria.

Most of the article concerns how SSDs could take a stronger negotiating position. In particular, they should challenge the medically-dominated mechanisms by which decisions are made about individual patients. For example, a medical test will be used to decide whether patients require specialist medical or nursing supervision. The author argues that continuing care agreements should have questions on the need for social care. If a patient fails to score as having a social need, the onus should go back to the NHS.

Such suggestions may well help SSDs to avoid picking up the tab for providing continuing care. In the meantime, some service users are likely to be caught in the crossfire. The author recommends that there should be mediation mechanisms to deal with these cases, but this seems to miss the point. Surely we should be able to devise a system which recognises that people have health *and* social needs, not one or the other.

Community Care 17-23 October

Minimising differences

The Government has published its response to the House of Commons Health Select Committee report, *Long-term care: future provision and funding* (see *CHC News* Issue 3).

The committee's report had been very critical of Government policy. However, the response defuses the criticisms by welcoming points of agreement and side-stepping points of disagreement. For example, although the Government accepts that there has been a shift from free NHS care to means-tested nursing home care for some types of patient, it presents this as a positive result of scientific advance and social change.

The committee had reiterated its demand for national eligibility criteria for long-term care. The Government has responded that, over time, the impact of guidance on NHS responsibilities for continuing health care should ensure greater consistency across the country.

The response is available from HMSO, £3.65.

We recommend...

ACHCEW recently attended a seminar on long-term care attended by 19 organisations in the health and social care field. Four recommendations emerged from the day:

- There must be a nationally defined minimum level of provision of long-term care for all, free at the point of delivery.
- Compulsory contributions to a central fund, ring-fenced to provide long-term care for all who need it, is probably the best and possibly the only way to ensure adequate and equitable care for all. Contributions from those who cannot contribute for themselves should be credited to the fund by the Government.
- Pilot studies should be set up to explore whether a shared budget for long-term care could overcome the current problems of agreeing the contributions of health and social services to fund individual care.
- There is an urgent need for assessment of research findings and public opinion to establish what society truly believes should be the role of the State in providing long-term care. This should be conducted independent of Government.

A numbers exercise

The NHS Executive has published a workbook, *Local monitoring of continuing care*, to suggest a joint approach to monitoring between health and local authorities along with others.

The workbook sets out a framework for monitoring people in hospital and in the community. In each case two different models are presented: a simple day census and a more complex "flow" model which determines how many people fit into certain categories over a period.

While the measures will provide useful and standardised quantitative data, there is a great deal they do not tell us. For example, they would show the number of people undergoing an assessment for continuing care, but say nothing about the appropriateness of screening procedures, consistency in assessments or quality of services provided. CHCs should be aware that even if health and local authorities implement this monitoring framework in full, much other monitoring remains to be done.

Workbook available from Health Publications Unit, PO Box 410, Wetherby LS23 7LN.

UKCC: Professional Conduct Complaints

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting has published a report on professional conduct complaints. It briefly describes the system of complaints hearings and sets out issues which have arisen most often from cases which come before the Council. These issues are highlighted in the hope that employers and practitioners will be alerted to situations in which mistakes may occur and that they will develop good practice to avoid the risks.

Procedures

Complaints made to the UKCC are first considered by the Preliminary Proceedings Committee (PPC). The PPC decides whether there is a case to answer by considering two points:

- can the case be proved beyond reasonable doubt?
- is it serious enough to lead to the removal of the practitioner's name from the register in order to protect the public?

At this stage the PPC can:

- close the case, or
- issue a caution in cases where there is mitigation and no risk to the public, or
- forward the complaint for a hearing before the Professional Conduct Committee.

Interim suspension

There have been problems in the past when a practitioner has been dismissed for very serious matters, but could work with other employers pending the outcome of a professional conduct hearing. To overcome these problems the UKCC can impose an "interim suspension" in very serious cases. The interim suspension is reviewed every three months or sooner if the practitioner asks for a review.

Issues arising from professional conduct complaints
UKCC, 23 Portland Place, London W1N 4JT; phone: 0171 637 7181; fax: 0171 436 2924
Free of charge

National Association for Patient Participation

The NAPP has asked us to clear up a confusion that seems to have arisen from a report on NAPP at ACHCEW's 1996 AGM.

NAPP produces two types of information pack:

- A **General Information Pack** which contains two flyers giving information on the NAPP philosophy, aims and objects and a description of how it delivers services to emerging patients' groups, doctors and primary health care teams. A regional organiser contacts groups and health care workers who wish to know more.
- A **PPG Membership Pack,** which acts as an *aide memoire* for groups as they work and develop with the support and input from a NAPP regional organiser.

NAPP has been receiving requests from CHCs for the Membership Pack, but does not supply Membership Packs in this way. As a small charity, it cannot maintain individual correspondence with a large number of CHCs. NAPP is very happy to pass on the General Information Pack to CHCs, who could use it to share information about NAPP's work.

More news on King's Fund Citizens' Juries

Following on from ACHCEW's September 1996 Health Perspective ...

The King's Fund has awarded grants to three health authorities to develop citizens' juries to ask local people about health care. Each has received £12,000 and will randomly select a jury of up to 16 residents. The jury will take evidence from service users and carers and from health care professionals. It will then cross-examine witnesses selected by a local steering group and reach a decision from the options presented, or propose alternatives.

- In Buckinghamshire, the jury will be asked if the health authority should purchase services from osteopaths and chiropractors for people with moderate or severe back pain. (HA contact: Julie Wells on 01296 310091)
- In East Sussex, Brighton & Hove, the jury will be asked where the health authority should purchase gynaecological cancer treatment for its residents. (HA contact: Zoe Nicholson on 01273 699900)
- In Sunderland, the jury will be asked whether it believes that local people would allow health care services currently provided by GPs to be given by nurse practitioners, pharmacists or a doctor in a different setting. (HA contact: Maureen Dale on 0191 565 6256)

For further information about the work of the King's Fund on citizens' juries, contact Alison Forbes, Press and PR Manager on 0171 307 2581.

Will "total, total fundholding" work?
Partners in Health in Wakefield

by Karen Dunwoodie, Chief Officer, Wakefield CHC

CHCs may be interested to know of a pilot project being undertaken in Wakefield district for the first "whole district total fund" in the country, i.e. "total, total fundholding".

Ever since fundholding was conceived, Wakefield CHC members have been extremely concerned about the creation of two tiers of access to treatment. In an attempt to overcome this inequity, Wakefield Health Authority proposed a solution – to set up five localities consisting of a range of between seven and eleven practices covering between 54,000 and 70,000 patients. All local GPs have now signed up to the project – *Partners in Health* in the current jargon. The localities are in the process of agreeing a draft constitution and purchasing intentions for 1997/98.

Each locality will receive a total budget to cover its population and the health authority will no longer have direct purchasing responsibilities. There will be a strategy board comprising a lead GP from each locality and one non-executive and three executive directors from the health authority. This board will attempt to develop a cross-district strategic approach to delivering health care. This year is being used for preparation and the project will go "live" from 1 April 1997.

Pontefract and Wakefield CHCs have been kept fully informed about the proposals from the start. Members have been involved in workshops set up to look at how CHCs could be directly involved with the new scheme. It is thought that the initiative could provide an ideal opportunity for the two CHCs to influence GP thinking for the benefit of patients. Suggestions include:

- liaising directly with the locality groups to identify issues that may be relevant to purchasing plans;
- offering to facilitate the development of patient forums and patient participation groups in individual GP practices;
- having a CHC observer on the strategy board;
- acting as a resource for GP practices by helping with patient satisfaction surveys etc.

Some of these things already happen, but only sporadically. There is still an air of suspicion among many GPs that the CHC's role is one of forwarding complaints.

We are lucky that Wakefield Health Authority tries very hard to involve the two CHCs as much as possible and has declared its intention to assist the process of collaborative working and dialogue between the localities and CHCs.

However the project is still in its embryonic stage and there remain many unanswered questions. Will *Partners in Health* in practice lead to five mini health authorities with five new bureaucracies and five sets of administration, all requiring extra funding that the health service cannot provide? Or will it mean patients have more say and more choice in their health care? Could CHCs at last be more meaningfully involved in the primary care sector? Time will tell. Watch this space to see if "total, total fundholding" is the answer.

Working with MPs

Wandsworth and Merton & Sutton CHCs have linked with local MPs to petition the Secretary of State for Health for additional funding for health services. The CHCs are concerned that the financial crisis facing Merton, Sutton & Wandsworth Health in the coming year will lead to substantial reductions in health care provision. They held a successful meeting with MPs David Mellor, Tom Cox, Lady Olga Maitland and Nigel Foreman to discuss the issues. At the meeting it was unanimously agreed that a cross-party delegation of MPs and other representatives, led by David Mellor, would seek a meeting with Stephen Dorrell as soon as possible to discussion the situation.

CHCs from other London areas facing similar problems will be providing Wandsworth and Merton & Sutton CHCs with details of the cuts in their areas. The two CHCs hope that, in order to provide a united approach across the capital, other London MPs will join the delegation.

For further information contact Lesley Stuart, Chief Officer, Wandsworth CHC.

New look dental charges

Bassetlaw CHC recently asked a local dental practitioner if CHC members could visit his dental practice as part of its regular programme of visits to primary health care premises. The dentist phoned back to ask if the CHC would be willing to pay the practice for the time its staff spent with the visitors.

North Beds CHC in Legal Challenge

Last month North Bedfordshire CHC was granted leave by the High Court to proceed with its application for judicial review against Bedfordshire Health Authority. With the help of the Public Law Project, the CHC is now pursuing the health authority over the authority's failure to enforce CHC monitoring rights in a contract the authority entered into with Health Care UK Ltd.

The dispute centres around two private nursing homes for elderly mentally ill people. The homes, which are owned by Health Care UK Ltd, were both built on NHS hospital sites and accommodate ex-residents of a long-stay psychiatric hospital. The CHC, which wants to monitor the facilities made available to residents, has been denied access to the homes. The health authority has stated that CHC representation on 'stakeholder groups' for the homes offers the CHC monitoring rights. The CHC is adamant that the stakeholder groups do not offer them the independent monitoring rights which CHCs enjoy generally in the NHS.

Rosie Newbigging, the CHC Chief Officer, points out that the CHC originally opposed the proposals to re-accommodate patients for a number of reasons, including concerns about CHC monitoring rights. The contract was awarded three years ago but the CHC was unable to check the wording of the contract relating to CHC monitoring rights until after the publication of the 'Code of Practice on Openness in the NHS' in 1995. It then found that the contract is unambiguous and does require Health Care UK Ltd to give inspection rights to the CHC. However the health authority has since refused to insist that Health Care UK Ltd complies with this term. It is for this reason that the CHC has taken legal action.

CHC members understand that there is a potential risk in terms of individual liability, if the matter proceeds to a full review hearing and if they lose and then if a costs order is made against them. However, there are several options open to members. Together with ACHCEW, North Beds CHC is investigating ways of reducing or eliminating this risk. Possibilities include:

- asking the NHS Executive to indemnify members against such costs orders where the CHC has mounted a legitimate challenge;
- suggesting that the NHS Executive reach agreement with health authorities that they will not seek costs against CHCs;
- asking for donations from other CHCs;
- inviting local authorities or other interested bodies, such as national charities, either to join in the legal proceedings or to subsidise the costs ;
- seeking public financial support;
- legal insurance.

If you or your CHC are interested in hearing more, contact Marion Chester at ACHCEW or Rosie Newbigging at North Beds CHC.

CHC Public Lectures

During the Autumn of 1995 and Spring of 1996 Hull CHC organised a very successful series of free public lectures in conjunction with the local postgraduate medical school and the Royal Hull Hospitals NHS Trust. The first series of lectures proved so popular that another series has been organised for 1996/97.

The aim of the lectures was to provide health promotion and health education to the public and it was decided that some of the subject should cover Health of the Nation targets. In the first series, specialists spoke on osteoporosis, heart disease, breast cancer screening and accidents. The members of the public who attended (about 140 people on each occasion) greatly appreciated both the lectures and the opportunity they were given to ask questions of local specialists.

This year a lecture has already been held on hormone replacement therapy (HRT) and the menopause. At it, Professor Purdie, a local specialist, shared news about studies being undertaken in Hull on a form of HRT which, it is hoped, will actively protect the bones and heart, but not affect the breasts or womb. The three other lectures in this series will be on diabetes, asthma and mental health services.

For further information contact Hull CHC on 01482 324 111.