CHC NEWS

A newsletter for community health council members and staff

Health and Safety crackdown

The Health and Safety Executive (HSE) has revealed that specialist teams of inspectors are to undertake reviews of risk management in 40 NHS trusts over the next year. Trusts found in breach of regulations could face prosecution. The announcement followed the successful prosecution of Swindon & Marlborough NHS Trust for a failure to lay down guidelines to ensure the safety of staff and patients. HSE inspectors alleged, for example, that the trust had not given staff written guidelines to ensure that clinical waste was properly dealt with. The case broke new ground as it was the first time the HSE has taken a trust to court for a breach of regulations without a specific accident having occurred.

Guardian 14&21 August; Independent 21 August

Waiting lists lengthen

Hospital waiting lists have lengthened in every quarter since the beginning of 1996 and shot up to 136,500 in the quarter to June 1997, a rise of 12.9% over the past year. Despite the Patient's Charter standard that patients must be admitted within 18 months of going on a waiting list, 388 had been waiting for longer than 18 months at 30 June 1997 compared to 9 on 30 June 1996. Numbers waiting over 12 months have risen from 10,400 to 47,000 over the same period.

Commenting on the figures ACHCEW's director, Toby Harris, said that while the extra £1.2 billion for the NHS announced in July's budget was welcome, it would not solve the enormous financial problems faced by the service. Further measures are needed if the government is to meet its promise to treat an extra 100,000 patients.

Guardian, Daily Telegraph 22 August

... and worse to come?

The NHS is gearing itself up for the even greater pressures it will face over the coming winter. Planners can draw on the work of the Emergency Services Action Team (ESAT) which was set up in 1996 to improve the handling of the extra winter demand. ESAT's report detailing experiences of last year and outlining action points for the future has been circulated within the NHS and local authorities along with a letter from the health secretary, Frank Dobson, urging all involved to plan early and cooperate in managing services. In his letter, Mr Dobson sets out three "expectations" he has of the NHS:

- the first priority of health authorities and trusts is to make adequate provision for emergency care;
- hospitals and their A&E departments must not unilaterally close to emergency admissions;
- health authorities must share the risks faced by NHS trusts in meeting unpredictable demand and both must be committed to improving cooperation with other NHS agencies and with social services.

An accompanying letter from the NHS chief executive and the head of the Social Services Inspectorate reminds readers that, whatever the need to prioritise emergency services, the needs of others, including those with long-term needs such as mentally ill people, do not become any less simply because hospitals are full. This letter also recommends that patients, clients and carers receive clear information about what they can expect.

Letter from Frank Dobson 29 August, Report to the chief executive on winter pressures, NHS Executive, August 1997

In this issue:

ISSUE 14, OCTOBER 1997

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES
Earlsmead House, 30 Drayton Park, London N5 1PB. Phone: 0171 609 8405 Fax: 0171 700 1152

Safeguards against sub-standard locums

The government has taken action to ensure that NHS trusts carry out screening of locum doctors in order to identify those who pose a risk to patients. A new code of practice places requirements on the employers of locums and on medical employment agencies both to make checks on prospective locums and to provide reports/references on every locum employed. Reports showing serious shortcomings in the locum doctor's performance should be copied to the GMC. Locums themselves will be required to sign a health declaration and a statement of criminal convictions and criminal proceedings pending. The code provides standardised forms for references and declarations. An Executive Letter (EL(97)48) outlining the main requirements of the code has been sent to CHC offices.

Code of practice in the appointment and employment of HCHS locum doctors, NHS Executive, August 1997

Slow progress on mixed-sex wards

A report on mixed-sex hospital accommodation shows that many health authorities have a long way to go in meeting targets for ending such accommodation, and that a few don't plan to meet them for the next five years. In January, Alan Langlands the NHS chief executive, set out three objectives. The success rates shown in the report are shown below:

- Ensuring that appropriate organisational arrangements are in place to secure good standards of privacy and dignity for hospital patients.
  Achieved by 41% of health authorities.
- Fully achieving the Patient's Charter standard for segregating washing and toilet facilities across the NHS.
  Achieved by 23% of health authorities.
- Providing safe facilities for patients in hospital who are mentally ill, while safeguarding their privacy and dignity.
  Achieved by 43% of health authorities.

Just 21 health authorities had achieved or nearly achieved all three objectives.

The health minister, Baroness Jay, has asked for a further report by Christmas. She has warned that "Any health authority which tells me that it is unable to get rid of mixed-sex accommodation within the next two years will have to have a very good reason."

DoH Press release 6 August
"Summary of health authorities' target dates to secure acceptable standards of segregated hospital accommodation" is available free of charge from Freepost NEA 959, Wetherby, West Yorkshire, LS23 6YY.

Controls on the sale of paracetamol

The government has ordered controls on the sale of paracetamol tablets in an attempt to cut down on suicide attempts and overdoses. Each year paracetamol overdoses account for over 30,000 hospital referrals and over 100 deaths. From September 1998 the following restrictions will apply:

- Packs of paracetamol sold in supermarkets and general stores will contain no more than 16 tablets or capsules.
- Packs of 32 tablets or capsules will be available from pharmacies.
- Pharmacists will be able to supply up to 100 tablets in justifiable circumstances.
- For larger amounts, a doctor's prescription will be required.

The same restrictions will apply to the sale of aspirin to ensure that people do not turn to aspirin as an alternative. The government has decided against including an antidote in all paracetamol tablets. Tablets containing the antidote methionine are available from pharmacies for use where there is a risk of paracetamol misuse.

Times 27 August; DoH press release 26 August

Good (and bad) practice in mental health

At the beginning of this year, the NHS Executive produced the booklet "The Patient's Charter and Mental Health Services" (see *CHC News*, March 1997, page 2). It has followed this up with a 56-page collection of good practice for community mental health services. The publication briefly outlines the Charter standards and gives advice on how to put them into practice. It then gives details of good practice from around the country: very brief notes on 19 innovatory services and more detailed information on focused examples of good practice from ten providers.

It would be an extra bonus if good practice could spread beyond the NHS and into the media. A survey of over 2000 articles carried out by Mind and the Health Education Authority found that almost half the press coverage of mental illness is about crime, harm to others and self harm. Over 40% of articles in tabloid newspapers contained negative words such as "nutter" or "loony, while only 8% of all articles contained advice and guidance. The National Union of Journalists and the Press Complaints Commission are backing calls for more balanced coverage.

The Patient's Charter: Good practice in mental health services, NHS Executive, July 1997; Independent 8 August

Health Divide Widens

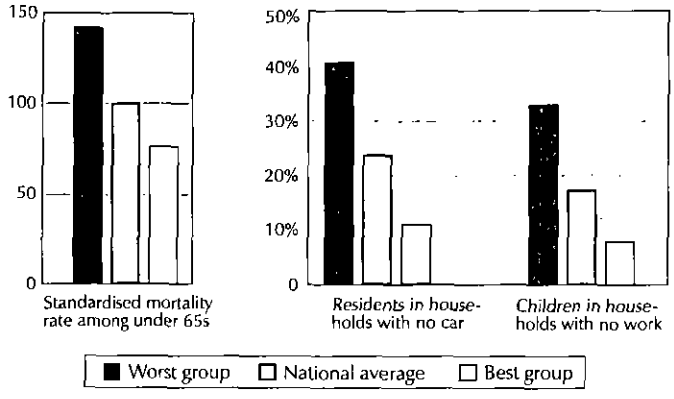
Where you live is more important in assessing your chances of dying in the early 1990s than it has been at any time since World War II. This is one of the conclusions of a Joseph Rowntree Foundation report which looks at the growing health gap between different areas of Britain. In recent years someone living in Glasgow was 66% more likely to die in any given year than someone living in rural Dorset, whereas in the late 1960s the discrepancy was 42%.

Mortality rates have fallen for almost all the population since the 1950s (this study mainly compares data from 1950-53 and 1990-92). However, the improvement has been much less in northern, urban areas than in the south. In Salford, one of the three worst areas in the 1990s, death rates have actually increased by 50% among boys aged between 5 and 14 since 1981.

The geographical inequalities in death rates are also linked to poverty. The graphs on the left show the relationship between health inequality and some poverty indicators based on 1990-92 data. The population of Britain was divided into ten equal groups on the basis of mortality rates among the under-65s. The "worst group" is made up of the tenth of the population living in areas with the worst mortality figures. The "best group" is similarly defined. The graphs show a comparison between the areas.

Changing mortality ratios in local areas of Britain, 1950s-1990s, Joseph Rowntree Foundation, August 1997

Relationship between health inequalities and poverty, 1990-92



What Does The NHS Confederation Want?

Commissioning research from outside bodies always carries a risk that the researchers will not reflect the commissioning body's views. Perhaps this is why two publications published by the NHS Confederation in August present such different attitudes towards CHCs.

In a research paper, *the people's health service*, Anne Barnes a senior lecturer at the Health Services Management Centre, Birmingham, is non-committal about the effectiveness of CHCs and presents reactions of CHCs themselves to the Insight team's recommendations about the CHC role. The paper is concerned with the reasons for public involvement, the different purposes for which it is used and the need to use appropriate methods in the light of these different purposes. She concludes that, among other mechanisms, "independent bodies such as CHCs, user groups and advocacy organisations are an important means of representing views of those who do not want, or are not in a position to, represent their views directly". She briefly discusses the different views CHCs have about their representation role and points out that there is no statutory mechanism through which CHCs can be accountable to local people. One solution, she suggests, might be to consider the idea of CHCs enhancing their capacity to represent the public by themselves becoming accountable to a regional tier of government.

Towards the 21st Century, a consultation paper prepared within the NHS Confederation, is much more outspoken on the question of CHCs and seems to put much less value on their independence from the NHS. It criticises the variable quality of the CHC contribution which, it says, is "not a sufficient foundation on which to rely for ensuring effective and satisfactory dialogue and interaction between those who manage the NHS and those who use it" – as if effective CHCs should absolve NHS managers from their responsibilities for establishing a dialogue with the public themselves.

The Confederation sent the document to CHC offices. It is to be hoped that some CHCs responded to its recommendations for their future:

> Regional offices should continue to be responsible for overseeing the recruitment of CHC members and monitoring their effectiveness, but should take a more vigorous and proactive approach.

> Considerable emphasis should be placed on the training and development of CHC staff and members. The secondment of senior NHS staff to work for CHCs should be encouraged.

> If CHCs are unable and unwilling to improve their performance, then urgent consideration will need to be given to more effective ways of utilising the current resources spent on CHCs.

It's obvious, really

It is a little depressing that it can take "innovations" by NHS staff who have the energy to get things right and the publication of articles in journals to get across messages that are basically common sense. In this case the message is that patients are less likely to complain if a senior nurse on each shift asks every patient in a hospital ward whether staff are "getting it right for them". In late 1995, this system was introduced in the surgical wards of a teaching hospital. As the graph below shows, complaints about nursing care, communication and admission/discharge soon fell markedly. Nurses found that small issues which were worrying patients could be resolved before they grew into major grievances.

Another innovation introduced at the same time was for all patients whose operation was cancelled on the day of admission to receive a personal letter from the chief executive apologising for the fact, explaining the reasons and stressing that the patient now had priority status for admission. The letter is sent on the day of or the day after the cancellation. Although complaints about cancellations did not fall immediately, the authors of this article conclude that without this action complaints would have been higher since there were so many cancelled operations during the winters of 1995/96 and 1996/97.

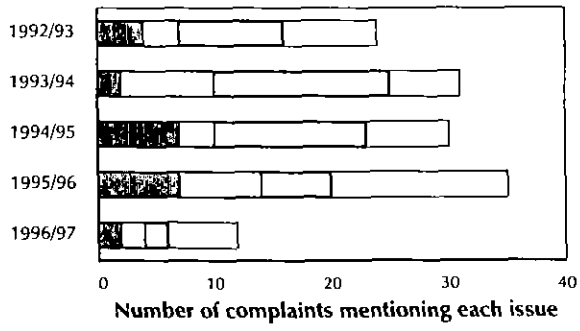
The authors also conclude that recruiting complaints officers at departmental level to visit patients who complain is not productive. They say that it does nothing to encourage other staff to resolve concerns locally and can provide an incentive for them to pass on their problems.

Health Service Journal 21 August

Issues raised in complaints on ward management in five surgical wards

Source: Health Service Journal, 21 August 1997, page 28

Note: Some complaints mentioned more than one issue.



Medical records: accuracy rather than access is the problem

Health Which? reports on a survey of gaining access to medical records. They found that, on the whole, patients had little difficulty in seeing their records within a reasonable time (and all within the 40 days maximum), though a few were put off by unhelpful staff. However, there were significant problems with patients feeling that their records were inaccurate or incomplete.

At the extreme end of the spectrum: a *Which Health?* case study

One woman was horrified to find that very important information had been removed from her records. She had previously seen a doctor's note of allegations she had made about sexual abuse by her father. Some years later she found that this record had disappeared, as well as records of medical problems such as urinary tract infections. The GP was a friend of the family. The woman's father was convicted thanks to evidence from another child he abused, but without the medical records she has little evidence to bring a case of negligence against her GP.

Patients who think that there are inaccuracies or omissions in their medical records can ask their GP to correct them. If a GP decides not to amend the record, s/he must at least add a note of the patient's request. Patients have a right to complain if they disagree with the GP's decision. Deliberate tampering with medical records is illegal.

Health Which? August 1997

Purchasers floundering on public involvement

A survey of purchasers' attitudes towards eight techniques of public involvement produced unpromising results. Purchasers were more involved in informing the public than in eliciting their views. Some used focus groups, but few used existing local groups or user groups. Asked about the success of different approaches to public involvement, questionnaires were rated successful by only 11.4% and focus groups by 7.1% – and these were the top of the "success" list!

Health Service Journal 21 August

Getting To Hospital

Curbing the car

All too many hospitals which once backed on to green fields are now surrounded by tarmac packed to bursting with parked cars and frustrated drivers looking for spaces. Healthy Transport, a network for trusts and health authorities, has been set up by Transport 2000 so that members can swap ideas on how to reduce car trips to health facilities. The network's members, who now number over 100, contribute examples of good practice to the *Healthy Transport Newsletter*. Their initiatives have mainly been aimed at hospital staff – car sharing schemes, subsidised bus passes, cycle facilities and many more. But the network is not afraid of advocating sticks as well as carrots and recommends car park charges as one way of encouraging greener travel.

Some NHS trusts have also laid on alternatives to the car for patients. In Telford, where many patients were not attending out-patient appointments due to transport difficulties, a "Hospital Express" bus service has been set up for staff, patients and visitors and is free of charge to patients. Another minibus service in Bristol is funded entirely out of hospital car parking charges and carries hundreds of people each day.

To find out more contact:

Carey Newson, Healthy Transport Network, Transport 2000, Walkden House, 10 Melton Street, London NW1 2EJ;
phone: 0171 388 8386; fax: 0171 388 2481.

Help with transport costs

The Healthy Transport Network would doubtless be pleased that Manchester Health Authority recommends that patients who are eligible for help with the cost of travelling to hospital should be reimbursed at least 10p a mile if they travel by bicycle. For the most part, though, the Hospital Travel Costs Scheme, is concerned with meeting the cost of travel by public transport, car and, in some cases, by taxi. Manchester HA has produced a guide to the scheme which also outlines current practice and highlights good practice.

In common with the Health Authority, ACHCEW is concerned that the scheme does not cover the costs of travelling to NHS settings other than hospitals. With the growing emphasis on primary care, an increasing proportion of NHS treatment will fall outside the scheme. In a letter to ACHCEW, Tessa Jowell, the minister for public health, indicated that the government does not intend to extend the scheme. We have written to CHC offices asking for information which might show whether ACHCEW should pursue the matter with the Department of Health.

Hospital Travel Costs Scheme: Current Practice and Best Practice Guide

Manchester Health Authority, £10.
For further information contact:
Martin Rathfelder, Welfare Rights Officer,
Manchester Royal Infirmary; phone: 0161 276 4197

How To Work With Your Doctor

Earlier this year, the Royal College of General Practitioners (RCGP) produced five patient information leaflets on using primary health care services (see *CHC News*, March 1997, page 6). The RCGP has now published a report on the development of the leaflets, which involved a literature review, an analysis of over 1000 existing leaflets, a conference and the writing and revision of the leaflets which took several months.

One underlying motive of the project was to reduce inappropriate use of primary care services. Evidence of increased practice workloads is striking: studies indicate that consultations per GP have risen by 22% since 1992 and that there may have been a fivefold increase in out-of-hours calls over the last 25 years. At the same time the report acknowledges that most patients are sensitive to the needs of their GPs and that many feel guilty for using up GP time.

The report reviews evidence of the importance of information for patients. It points out that doctors tend to overestimate how much information they give patients and to underestimate their patients' desire for information. Leaflets have a role in helping to overcome the barriers to communication, although it is stressed that they are not a substitute for face-to-face discussion. One research finding is that most professionals prefer leaflets to be simple and short, while patients prefer detailed information. In the event, the leaflets aimed to provide practical information and, where there were space constraints, to encourage patients to ask for more.

While every effort was made throughout the leaflets to be "on the patient's side", the nature of the project meant that the focus must be on what the patients could do for themselves and for their GP practice. Would it to be too much to hope that the RCGP could move on to a project named "Working with your patients"?

Ten Facts for Health Authorities: Cancer and Acute Services

By Colin Pritchard, Member, Southampton & SW Hants CHC

Like many CHC members, I often meet diligent, courteous, apparently well informed health authority "experts" who seek to explain the vagaries of NHS finance with banks of statistics, which either confuse or leave members ill equipped to ask relevant questions. Recently our CHC was consulted about the HA's purchasing plans for the next five years. The HA staff could not have been more patient or tried harder to explain the thinking behind the proposals, which appeared to be based on:

- a need for the HA to remain within budget;
- levels of previous provision;
- gentle, but strategic, placing of development monies to pursue "socially desirable" objectives, e.g. the laudable enhancement of community care, with hopes of ultimately reducing the proportion of the budget going to acute services.

This seemed eminently sensible, bearing in mind the oft-rehearsed phrase, "there is no bottomless purse".

However we need to ask whether HA plans meet current and future **clinical** needs. If not they will undermine the basic aims of the service - the care and treatment of citizens. This requires a very different set of statistics, such as the following ten FACTS based on the latest figures available, which are relevant to every CHC but may not be on every HA agenda.

1 Between 1981 and 1994 the UK baby population rose by 11%, while maternity beds were reduced by 22%.[1]

2 The numbers of people aged over 75 increased by 30%, yet geriatric beds fell by 25%.[1]

3 While acute beds declined by 22%, episodes of care rose by 29%.[1]

Some may see this as improved efficiency. But consider the issue of acute beds, including those for intensive care. Britain has one of the lowest rates per population in western Europe.[2] Yet improvements to community care can be achieved only by reining in acute services. This is not rational for the following reasons:

4 Cancer deaths are increasingly associated with density of population. England and Wales have the **fifth** highest male and **second** highest female cancer death rates in the western world.[3]

5 Britain is the **fourth** most densely populated country, hence our situation is likely to worsen.[3]

6 The rises in cancer deaths are not **just** linked to longevity, as deaths rose 1% per year over the last 30 years, far exceeding increased longevity.[3]

7 Between 1971 and 1990, there was a 30% rise in **new cases** of cancers in young men (20-34) and a **six-fold** increase in young women. Cases of cancer increased annually by over 6000.[3, 4]

8 Despite this, acute beds **fell** by 44,000 between 1981 and 1994, in the face of the 78,000 cases self-evidently requiring urgent treatment.[1]

The likely HA riposte will reflect Margaret Thatcher's statement with which I TOTALLY agree "We can only have the service we can afford." Who can doubt this? But the question is, *are* we affording what we *can* afford? The answer lies in comparing the proportion of national wealth (GDP) spent by modern health services in other developed countries.

9 The UK has **remained** at the bottom end of the international league table for more than 25 years. Only three developed nations spend less of their GDP on health than Britain.[5]

There is a danger that when CHCs' preferred health priorities fail to gain support, we blame either the HA or the managers. This is unfair. We should indict the public's ignorance, which successive governments have relied on, and the deluge of statistics presented to the public, which obscure rather than illuminate.

10 The present government will broadly maintain previous spending plans[6], which will be the tightest ever since the creation of the NHS.

Is there a way forward? Yes. It is argued that if the UK health expenditure **rose to be 10% LESS than the international average** as a proportion of GDP, in the lifetime of one parliament the NHS budget would increase by 11.7%.[1] This puts the July budget's extra cash for the NHS (equivalent to a 2.3% rise), welcome as it is, into a clearer perspective.

Our CHC is considering inviting local MPs to understand the impact of Britain's low spending on the NHS in comparison with other countries and get their answers to our ten facts.

References

1 Pritchard C, Lang D & Neil Dwyer G (1997) Has efficiency gone too far? Fiscal context for practice. *Southampton Health Journal* in press

2 BMJ (1996) UK reviews intensive care and emergency service. News article. *BMJ* **312**: 665.

3 Pritchard C & Evans B (1997) Population density and cancer mortality in the western world 1963-1993. *Public Health* **111**: 1-6.

4 NSO [OPCS] (1979-1997) *Cancer Registrations in England and Wales 1971-1990.* Series MB 1.23. London, National Statistics Organisation.

5 US Bureau Statistics (1996) *Statistical Abstracts United States: International Comparisons* 115th ed. Washington DC, Department of Commerce Economics and Statistics.

6 DoH & OPCS (1996) *Departmental Report.The Government's Expenditure Plans 1996 to 1998/99.* London, HMSO.

Any gluttons for punishment?

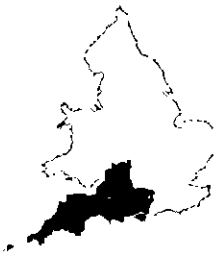
It seems very unlikely that anyone could devote enough time to being a member of two CHCs at one time, but a letter to Salford CHC from the NHS Executive has confirmed that CHC regulations do not prevent this. On the other hand, official guidance (HC(81)15) stating that "No-one should be a member of more than one CHC" still applies, though it has no statutory basis. Are any CHCs aware of this situation cropping up?

Watchdog moves to new kennel

Alan Milburn, the minister for health and Darlington MP, handed over the keys for Darlington & Teesdale CHC's new premises in August. After 23 years in Dickensian offices, the CHC is at last accessible to people with disabilities and staff can speak to people in private. See CHC listings for new contact details.

Reviewing CHC performance

Over the past year or so, CHCs have been making increasing efforts to evaluate their activities systematically, so that they can demonstrate to others, as well as to themselves, the quality of the services they offer to health service users. We have recently received proposals for an evaluation framework from the South & West Regional Association of CHCs and a substantial annual review from North East Lincs which surveyed a range of groups using three different questionnaires in order to get as complete a picture as possible of the general feeling about the CHC.



A performance evaluation framework for community health councils

South & West Association of CHCs

Denise Holden, Howard Lawes and Geoff Poxon, chief officers of East Dorset, Bristol & District and Cornwall CHCs respectively, have developed these proposals for a performance evaluation framework for CHCs. They recognise the need for such a framework to be both flexible, so that the diversity of CHC activity can be encouraged, and robust, so that local people and the NHS Executive can be given clear evidence of achievements and delivery of agreed work programmes. With these requirements in mind, it sets out broad areas in which CHCs can measure their achievements: strategy planning and monitoring; relationships and communications; and organisational arrangements. It then identifies key indicators within each of these areas and a checklist of "deliverables" which CHCs can use and adapt. CHCs are invited to "pick and mix" from various methods of evaluation involving self-assessment, peer review and formal "light touch" management.

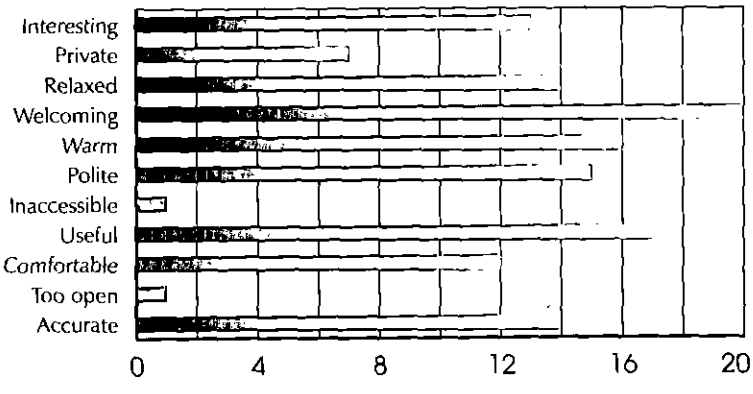
Annual review: The views of key stakeholders on North East Lincolnshire CHC.

North East Lincs can feel justifiably happy with the response to its consumer satisfaction questionnaire which was sent to voluntary sector groups, community workers, the Grimsby College, ex CHC members and members of the public who have used CHC services (see, for example, the graph below). Of course, the CHC was not looking merely for a pat on the back – it also received useful suggestions on how it might develop, some of them general (e.g. a higher public profile and outreach work in neighbouring communities) and some more specific (e.g. advising clients to obtain their medical records *before* meetings with the hospital staff to discuss a complaint). In conclusion, the CHC says that it has already taken many of these comments on board.

"Please tick any of the boxes against words which describe your experience of our services:"

Responses from 31 questionnaires

Source: North East Lincolnshire CHC



The possible responses Slow, Formal, Threatening, Unfriendly, Embarrassing and Inaccurate all scored zero.

AGM follow-up

ACHCEW has been following up on this year's AGM resolutions by writing to various organisations and asking for reactions. So far we have received replies from the Radar, the General Medical Council, the College of Optometrists, the NHS Executive and the Department of Health. It is hardly surprising that these do not show any great shifts in policy. The first three are friendly in tone, while the NHS Executive sets out facts about patient removals from GP lists and the powers of the GMC. It is a little disturbing that the NHS Executive believes that an increase of 4.86% in removals from GP lists over two years suggests that the "year on year increase is not substantial".

One positive development mentioned in the Department of Health letter is that, in response to concerns about patients going hungry in hospital, the Department has sponsored work by the University of Newcastle-upon-Tyne to produce a resource pack for hospital ward staff. It will contain a variety of tools to assist staff in recognising those at risk, looking at organisational factors which may affect nutrition and providing some solutions based on good practice in other places. The pack should be available to NHS trusts this October.

Relaxation on legal aid

The Legal Aid Board has recently changed its guidance to its local officers with responsibility for determining legal aid claims in the area of small (value under £10,000) medical negligence claims.

A letter from ACHCEW's legal officer dated 2 May advised CHC offices in relation to the problems which they may have been experiencing when potential litigants were refused legal aid and told instead to take their case through the NHS complaints procedure.

The new guidance is more flexible. It no longer states "for smaller claims in particular, the Board may require an applicant before legal aid is granted to pursue any available complaints scheme", although it still states "if there is little prima facie evidence of negligence, legal aid may be refused ... on the basis that the appropriate avenue for the applicant to pursue is to use the NHS complaints procedure". The change should have the effect that fewer people are refused legal aid. It is to be hoped that now only appropriate cases will be directed to the NHS complaints procedure.

Action for Victims of Medical Accidents has been monitoring the situation. CHC staff may want to contact AVMA if they have clients who have been refused legal aid or have been inappropriately directed to the NHS complaints procedure.

Personal Medical Services Pilots: consultation with CHCs

Publications from the NHS Executive come with a little stripe across the top telling the reader that the document is about "Good practice", giving "Information" and so on. Lately there has been a rash of documents for "Action" as the new government puts its policies into effect. Among these are guides to setting up Personal Medical Services Pilots, which will test different methods for delivering general medical services (see *CHC Listings* for publication details). The Labour government wants the NHS to take early advantage of legislation which was introduced by the Conservatives enabling pilots to be set up. However, it also wants to make some changes to the process for setting up pilots and, in particular, to impose more specific requirements about local consultation. All this has to be done in a great hurry since the closing date for applications for pilots is 1 November 1997 – and local consultation is supposed to take place before then.

In August, the NHS Executive sent ACHCEW some draft documents relating to this issue and asked for a rapid response. The documents are difficult to interpret since they are written in the legalese of official regulations and a draft of the Directions the health secretary will give on consultation is still with Department of Health lawyers.

The situation appears to be this: The health secretary will require health authorities to consult on each prospective pilot scheme proposal with local medical committees, CHCs and local authorities. The CHC in turn will be required to consider the effect of the proposals on the operation of local health services and advise the health authority accordingly. It is not clear whether consultation will be mandatory in all cases or what provisions there will be if a CHC considers that it has not been consulted adequately. In its response to the documents ACHCEW asked, among other things, that the health secretary's Directions should:

- stipulate the information which should be provided to CHCs in order that they be fully informed as to the possible impact and implication of each pilot scheme;
- specify minimum requirements in terms of time-tabling of consultation exercises;
- require the summary of responses to the consultation to contain sufficient information for the numbers of responses, the identity of the responding bodies and the numbers of submissions made for and against the proposal to be ascertained.