CHC NEWS

A newsletter for community health council members and staff

New Labour – New NHS

The government's White Paper on the "New NHS" sets out a basis for a ten-year programme to develop the NHS in England. The government promises to bring about more joint planning, to cut bureaucracy, to improve equity and to give more scope to doctors and nurses to make choices. There is a commitment to user involvement, at least at a strategic level – see overleaf. The full document is available through www.official-documents.co.uk or from the Stationery Office.

Working in partnership

Local NHS bodies will have a statutory duty to work together for the common good. The government also intends to require local authorities to promote the economic, social and environmental well being of their areas. These duties should lead to joint planning which will feed into the Health Improvement Plans (HIPs) drawn up by health authorities.

Health authorities

The heart of the health authority's role will be its lead responsibility for improving overall health and reducing health inequalities. HAs must draw up local HIPs in partnership with other NHS agencies, local authorities and the public. HAs will draw up long-term funding agreements (three years or longer) for NHS trust services. They will also have reserve powers to ensure that trusts' major investment decisions are consistent with the HIP. HAs will draw up annual accountability agreements with primary care groups (PCGs – see next column) and will support PCGs in taking on increased responsibility for commissioning services.

Health authorities are expected to streamline their administrative functions, including the sharing of functions between authorities. Fewer authorities covering larger areas will "emerge" as a result of this.

Primary care groups and trusts

Teams of GPs and community nurses will work together in PCGs to shape services for patients. A PCG will be able to take responsibility for a single budget covering most aspects of care for its population (typically 100,000). PCGs will be able to progress through four stages from advising HAs on commissioning to becoming primary care trusts which commission care and provide community health services. Primary care trusts will not be expected to take responsibility for specialised mental health or learning disability services: a more likely model is that primary care trusts will develop strong links with specialist trusts which will co-ordinate service delivery from a wide range of services.

There are to be no more entrants to the fundholding scheme and, subject to legislation, PCGs will replace fundholding from April 1999.

NHS trusts

Trusts should be given more stability through the use of longer term funding agreements with health authorities and, increasingly, PCGs. The government hopes that this will give health professionals more scope to develop services. Further mergers of acute and community trusts will not be encouraged. The government makes various proposals for improving the openness of trusts.

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In this issue:

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Patient and public involvement

The word "choice" appears a few times in the White Paper, but never in relation to individual patient choice. It is always either the NHS as a whole, or GPs and community nurses, who are doing the choosing. There is more mention of involvement of the public, patients and carers at a strategic level and there is a commitment that the NHS Executive will support "the range of initiatives set out in this White Paper" for their greater involvement.

Public involvement at a national level

- Members of the National Institute for Clinical Excellence and the Commission for Health Improvement will include patient representatives.
- The new NHS Charter will be developed in partnership with NHS users and carers.
- The government will introduce a new national survey of patient and user experience.
- The NHS Executive will involve users and carers in its own work programme.
- Representatives of users and carers will be involved in establishing National Service Frameworks.
- Patient representative groups will be involved in measures to strengthen professional self-regulation.

All NHS bodies

- No management information will be classified as 'commercial in confidence' between NHS bodies.

Health authorities and public involvement

- The public must be consulted over the HA's Health Improvement Programme.
- HAs must publish agreed strategies, targets and details of progress against them.
- HAs must participate in the national survey of patient and user experience.

NHS trusts and public involvement

- As previously announced, trusts will be required to open up their board meetings to the public.
- Cost data (which can be compared with national "reference costs") and other data on performance will be made public. (Trusts will have to make their annual operating plans available to HAs and PCGs, but there is no mention of their being made public.)
- Good practice, ideas and innovations should be systematically disseminated.
- Lessons for clinical practice must be systematically learned from complaints made by patients.

Primary care groups and public involvement

- HAs are expected to ensure that PCGs have effective arrangements for public involvement. They are specifically required to ensure this before they allow PCGs to take on increased responsibilities.
- If a PCG becomes a Primary Care Trust, then it *"could* ... include ... lay members" (our emphasis).

CHCs - ambiguous

The sole reference to CHCs is not explicit about their future: "The Government wants a strong public voice in health and healthcare decision-making, recognising the important part played by Community Health Councils in providing information and advice, and in representing the patient's interest."

Quality initiatives

- Evidence-based **National Service Frameworks** will be developed setting out the patterns and levels of service which should be provided for patients with certain conditions.
- A **National Institute for Clinical Excellence** will give a lead on clinical and cost-effectiveness, draw up guidelines and disseminate them through the NHS.
- A new **Commission for Health Improvement** will be established to support and oversee the quality of clinical services at local level, and to tackle shortcomings.
- Explicit quality standards in local **service agreements** between HAs, PCGs and NHS Trusts will reflect national standards and targets.
- A system of **clinical governance** will be introduced in NHS Trusts and primary care to ensure that clinical standards are met.
- There will be measures to strengthen **professional self-regulation.**
- A new **statutory duty** will be placed on trusts for the quality of care they provide.

Patient and user survey

From 1998 there will be a national survey of patient and user experience to be carried out annually at HA level. The results will be published both locally and nationally. ACHCEW has welcomed the announcement of this survey, but has commented that it should be validated by patients' organisations.

Action on waiting lists

The health secretary, Frank Dobson, has appointed a Waiting List Action Team in an attempt to reverse the recent rise in NHS waiting lists. Since May, lists have risen by about 50,000. In the quarter from July to September, they rose by 17,600.

The Action Team will be headed by Stephen Day, the NHS regional director for the West Midlands, who oversaw cuts in waiting lists in his own region. However, whereas the West Midlands success cost £30m, the team is being given only £5m to pilot approaches to cutting lists. Any further money will come from savings made in local budgets. Eight members of the Action Team from the eight English regions will lead regional taskforces to spread good practice. Additional members will be nominated to the team, including members who can provide a patient perspective.

Asked what action is being taken in Wales to cut waiting lists, the Welsh health minister, Win Griffiths, did not mention any specific initiatives, but referred to earlier announcements of extra funds to tackle winter demand and improve cancer services.

Hansard, 5 November, col 236; Independent 19 November; DoH press release 18 November

HAS 2000

From next April a new agency will replace the Health Advisory Service. HAS 2000 will have responsibility for reviewing and advising on services for elderly and mentally ill people. The body is a registered charity. Its joint chief executives are Dr Paul Lelliott, a psychiatrist, and Professor Geoff Shepherd, a psychologist. Other posts, which will be advertised, are expected to be filled by health and social services professionals, service users and carers.

One of HAS 2000's first activities will be to investigate allegations of poor hospital care of elderly patients. Explicit standards against which services can be judged are being developed. Where shortcomings are identified, reviewers will draw up an action plan for use by purchasers and providers of relevant health and social services.

ACHCEW has written to Dr Lelliott saying that CHCs would welcome the opportunity to have an input into HAS 2000's work and, if necessary, to call upon its services. We have asked for his views on how this could be achieved.

Health Service Journal 6 November

News from Wales

NHS Charter for Wales

The Welsh health minister, Win Griffiths, has written to CHC chairs asking for suggestions on how the NHS Charter for Wales could be improved. In particular, he asks how the Charter could:

- give greater emphasis to quality of treatment
- balance users' rights and responsibilities
- ensure better information for patients and the public
- reflect the views of patients and carers
- ensure that standards are deliverable within available resources

Suggestions should be submitted by 23 January 1998.

Guarantee of emergency treatment

Win Griffiths has announced a guarantee that patients in Wales who need emergency medical treatment this winter will get a hospital bed. This guarantee seems to take into account a predicted (though unpredictably large) flu epidemic, but is "subject to the impact of natural events". Health authorities have agreed to admit emergency patients to their own appropriate local hospital, or the nearest hospital with available beds, and to eliminate the practice of referring patients to several hospitals which are closed to admissions.

BMJ 15 November

CHCs challenge validity of "consultation"

The Association of Welsh CHCs is considering a legal change to the validity of NHS Wales's "consultation" document on ambulance services. Earlier this year, the Welsh Ambulance Policy Advisory Group submitted to Win Griffiths a document recommending two options for the reorganisation of ambulance services in Wales, one involving three ambulance trusts and the other only one. In September, Mr Griffiths outlined his decision that a single trust option offered the best way forward. This option alone is presented in the "consultation" document. Full of phrases such as "The new trust will ..." the document is essentially a piece of promotional literature which also provides information on the proposed developments.

The Welsh Association of CHCs says that it is quite clear that a decision has already been made. The association has received advice that this is not legally valid, and the association could take the matter to judicial review. In response to the association's concerns, a Welsh office spokesperson claimed that "It has been our long-established practice that consultation on trust establishments and mergers should be on a single proposal and not on options".

Health Service Journal 20 November, Consultation document from NHS Wales.

More doctors needed

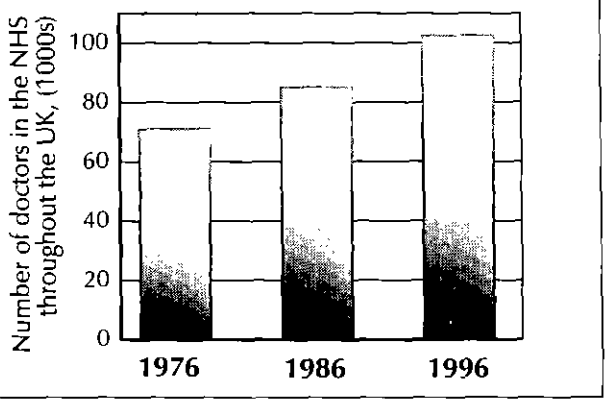
The intake to UK medical schools needs to increase by about 20% (1000 a year) according to the third report of the Medical Workforce Standing Advisory Committee (MWSAC). The Government is concerned that the figure is so high, and has said that it will need "careful examination".

However even the figure of 1000 doctors a year is based on fairly conservative assumptions. At present the annual wastage rate of doctors (due to death, retirement, career breaks etc.) is just over 3.5%; over the last 20 years the number of NHS doctors has increased by an average of 1.8% per year; and the percentage of the profession who were trained in the UK is 76%. The estimated need for 1000 extra doctors a year is based on a wastage rate of 3.3%, an annual growth in demand for doctors of just under 1.7% and the same "home share" (76%).

The committee also calls on medical schools to reduce the number of students who abandon medical courses, and on the NHS to improve staff retention by improving training, career planning and counselling, and more use of flexible working patterns. Another rather unexpected suggestion is that "there is some scope for introducing shorter medical education courses for graduates in other disciplines, to broaden the field from which doctors are recruited".

Rise in the number of doctors in the NHS

Source: Medical Workforce Standing Advisory Committee



DoH press release 28 November, MWSAC report summary

Salaried GPs

An example of the flexibility which could improve the retention of doctors is the recently announced Salaried Doctors Scheme. Under the scheme health authorities will decide where salaried GPs are needed. GPs can then be employed to work within GP practices. Salary rates will not be set nationally, and contracts may be for part-time or temporary work in order to meet a particular need. Salaried GPs will be classified as employees of one of the partners. The government is making £4m available to kick-start the scheme. Further money is expected to come from General Medical Services funds already allocated to health authorities.

DoH press release 24 November

Why delegate?

One factor affecting demand for doctors, mentioned briefly in the summary of the MWSAC report, is the division of tasks between healthcare professionals. An article in *Medeconomics* suggests that there is a good deal of scope for nurses carrying out many GP tasks. One practice in the West Midlands, for example, found that 40% of its GPs' work could be managed by a nurse. The practice put together a single nursing team which could handle a variety of tasks and employed clerical staff to take over some of the nurses' previous duties. It is a little depressing that although various advantages and disadvantages of delegating work are discussed – and not all of the motivations are selfish – someone decided that the article would only attach the reader's attention by placing it under an enormous headline "Free up your time for more income".

Medeconomics November

COMMISSIONING SPECIALISED SERVICES

Since the introduction of the NHS internal market, health authorities have been working towards ways of co-ordinating commissioning of specialised services so as to share financial risks and the work involved. The NHS White Paper has announced new arrangements for planning and commissioning these services. The NHS Executive will work with others to identify which services need to be commissioned for populations larger than those of a health authority but below the national level. It will also co-ordinate discussions on what arrangements may work, drawing on recommendations in the recent Audit Commission report, *Higher purchase: commissioning specialised services in the NHS*. This report looks at the information needed by health authorities, the kind of choices they have to make, and how they may build partnerships with other authorities and specialised hospitals.

Regional offices will be accountable for ensuring that effective arrangements for commissioning these services are established by April 1999. Health authorities and primary care groups will be required to participate in such arrangements.

Higher purchase

Audit Commission, phone: 0800 502030, £20

New guidance on diabetes care

Over 1.4 million people in Britain have been diagnosed as having diabetes, and the British Diabetic Association (BDA) estimates that a further million cases may be undiagnosed. Quite apart from the costs to individuals, the costs to the NHS are enormous: over £4000 a minute, or £2.1 bn annually, according to the BDA. The association says that this bill could be reduced by better education and earlier diagnosis.

New health service guidance *Key Features of a Good Diabetes Service* was published on 14 November – World Diabetes Day. It calls on commissioners of local services to consider action to ensure that services they commission correspond to the document's "key features". The BDA was closely involved in the development of the guidelines and has described them "as a valuable and important document for everyone planning, providing and receiving diabetes care".

The BDA has also prepared a Briefing which outlines the document. It sets out four main objectives:

- a well informed public
- a highly trained and skilled workforce
- a seamless service, working across health sector boundaries which is sensitive and responsive to different needs
- knowledge-based decision making which takes account of international, national and local research

DoH press release, BDA, Independent 14 November

For the BDA Briefing, call the BDA on 0171 323 1531
For the Health Service Guidance (HSG(97)45), call the NHS Responseline on 0541 555 455

Diabetes drug withdrawn

Just two months after it was launched, a drug for diabetes has been withdrawn by Glaxo Wellcome following safety fears. The drug, troglitazone (Romozin), may be responsible for liver damage in 130 patients in the US and Japan. The drug has been prescribed to 5000 patients in the UK. Patients taking the drug are advised to continue doing so, but to consult their doctors to arrange other treatments. Doctors are being advised to carry out liver function tests on patients who have taken the drug.

Independent 2 December

Patients wanting more information can contact the BDA Careline on 0171 636 6112.

CHC survey of diabetes services

Hastings & Rother CHC has recently surveyed the services available for people with diabetes mellitus in the CHC area. In general, the CHC found that a wide range of services was available and that patients were appreciative of the care they received. However, as ever, improvements are needed – both small practical changes and larger changes concerning information, communication and co-ordinating the service across professional boundaries. Some of the recommendations reflect the need for the new NHS guidelines. For example:

- The guidelines stress the need for public education. In Hastings & Rother there had been some attempts to raise public awareness. However of the 23 GPs who responded to the survey (out of 40 approached) about half did not have leaflets and literature available in the surgery. The remaining GPs gave relevant literature to individual patients, but did not display it in the surgery. The CHC calls for such literature to be readily available in GP surgeries.
- Another priority in the guidance is for a seamless service across health sector boundaries. In Hastings & Rother the CHC found that opticians are required to inform GPs and diabetic consultants of relevant information on a patient showing problems, but there seems to be no system for giving feedback to opticians about subsequent treatment. The CHC calls for opticians to be given feedback on referrals.

MENTAL HEALTH SERVICES: POINTERS

An article in the *Health Service Journal* (6 November) describes a project in which users of mental health services interviewed other users who have serious mental health problems. The interviewers were first trained in interviewing and site-visiting and were introduced to the ideas of monitoring and evaluation. Interviewees gave positive feedback, saying that they had been able to have their say about services. Some mental health staff who set up the interviews were very enthusiastic. Others did not want their clients to be interviewed, especially by other users.

The NHS Confederation and the Sainsbury Centre for Mental Health have published a paper, *The way forward for mental health services*, which presents a way forward for integrated mental health services encompassing health, social care and housing. For availability details phone the NHS Confederation on 0121 471 4444.

Ombudsman's report

The Health Service Ombudsman has recently published his report on cases he completed between April and September 1997. During that period his office received 1172 complaints – the most it has ever received. During the same period he concluded 45 full investigations. In a 101 cases a referral back to the NHS body concerned resulted in further action, so that no full investigation was needed. Most of these were complaints about decisions by conveners, and in particular about a failure by the convener to take appropriate clinical advice. We are hoping for a contribution to *CHC News* from the Ombudsman's office in the New Year.

Health Service Commissioner Investigations completed April to September 1997, £11.50. The report is available through http//www.ombudsman.org.uk.

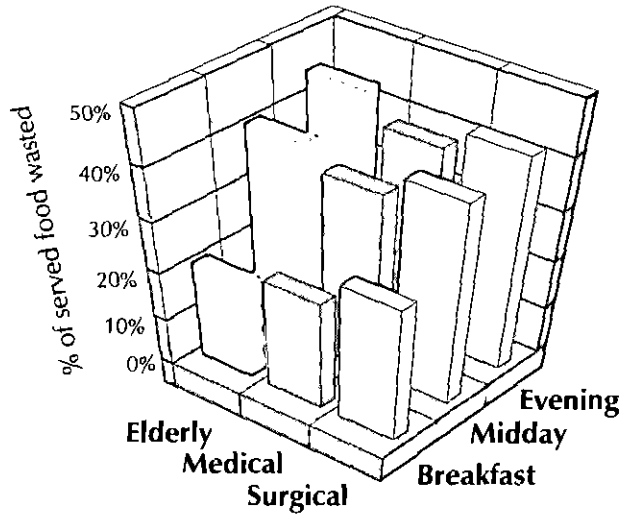
Hospital food going to waste

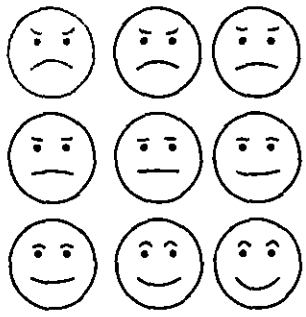
A survey in nine wards at four general hospitals found that almost half of the food served to patients was wasted. This raises worries both about the economic cost of such waste and whether patients are getting the food they need. On average the waste (measured by weight) was highest on wards for elderly patients at the evening meal (see graph). However, the worst individual ward was a surgical one where just over two-thirds of all food was wasted. Where meals were served onto plates in the kitchen, an average of 35% of food was wasted. But even where food was served onto plates in the ward, when staff should be able to respond to patient requests, 28% of the food on plates was wasted. What is more, these wards wasted a further 30% from food which remained unserved on trolleys.

Health Service Journal 13 November

Food wasted in nine hospital wards

Source: Health Service Journal 13 November





Difficult patients: Guidance for GPs and their staff

Nottingham Local Medical Committee and Nottingham Health Authority

This guidance is not as unfriendly as its title – or the high proportion of angry faces on its cover – might suggest. It reminds GPs of the longstanding difficulties which may be caused to patients who are removed from practice lists and points out that some GPs remove patients in response to incidents that other GPs might consider trivial. The guidance was prepared in consultation with Nottingham CHC and Nottinghamshire Police.

The general messages of the booklet are that:

- there are many reasons why patients may display "unreasonable" behaviour
- there is plenty GPs and practice staff can do to help prevent incidents of unreasonable behaviour, including violence
- there are options besides removal from a GP list
- in many cases patients can be formally warned that particular types of behaviour will lead to removal from the GP list
- if a patient is to be removed from the list, a clear explanation of the reasons is likely to lessen ill feeling.

The guidance includes a checklist of questions doctors should ask when dealing with difficult behaviour (or alleged difficult behaviour). It also includes sample letters, a sample conciliation process, procedures for removing a patient from a GP list and guidance on preventing violence.

Know Your Rights

The Public Law Project (PLP) is carrying out a two-year research programme into the NHS, funded by a lottery grant. The *NHS – Know Your Rights* project will look at the operation and effectiveness of the NHS complaints procedure from the perspective of complainants and at users' rights to information about the NHS. As part of the research, the PLP is planning to survey all CHC chief officers in March. The planned questionnaire is long, but ACHCEW hopes that CHCs will respond since it offers a very good opportunity for a national analysis of the NHS complaints procedure.

More information about the survey will appear in the next edition of *CHC News*.

We have received these two updates from David Cook, a member of Gloucestershire CHC:

Pharmacy Healthcare Scheme

Over these last 12 months, this scheme has produced 14 leaflets, and will produce a further six by the end of March 1998. CHCs responded to a request last year for topics which could be included. In response to these requests, a leaflet on *Pregnancy Health* was produced in December and another on *Thrush and Cystitis* is to be published in March.

The Pharmacy Healthcare Scheme is changing its structure to meet new Department of Health requirements. When the details are known and when it is clear how CHCs can contribute to a national information service that is delivered at the local chemist shop, the scheme will ask for your help.

Health & Safety Commission – Health Services Advisory Committee

ACHCEW sits on this committee as the patient's representative to ensure that employers and employees take the needs of patients into account when they agree on safe working practices. Two issues which CHC members should be aware of when visiting are that:

- windows at first floor level and above should only open 5 mm to ensure that patients cannot fall out;
- all hot water taps must be fitted with a temperature control valve to prevent scalding.

In 1966, six health establishments were prosecuted and fined £64,226 for breaches of health & safety regulations. Incidents ranged from water too hot in a bath to a patient falling from a window with unrestricted opening. From January to August 1997 there were seven prosecutions, with fines totalling £79,029. Most were for the scalding of patients, although one concerned lifting and another resulted from a Health & Safety Executive audit of a trust.

CHC members are not health & safety experts, but through listening to patients and staff they can help to ensure that trusts follow the best practice for the safety of patients. Just asking a question is usually enough either to get reassurance or to get things changed.

Salford CHC

Chris Dabbs, the super-busy chief officer at Salford CHC, has been seconded to the new School for Social Entrepreneurs for the whole of 1998. He will be working on the effectiveness of CHCs and undertake two projects with two CHCs in the north west. While he is away, there will be an acting chief officer at Salford CHC. We will give details in *CHC Listings* when they are known.

"Patients aren't bed blockers"

The three Manchester CHCs have got together with many local voluntary organisations to set up a "Homeless in Hospital" group. The group is working to tackle the problems faced by people who have gone into hospital, are medically fit to leave, but are trapped there because social services do not have the funds to pay for their care. These, mainly older, patients do not want to stay in hospital and their families and carers are often desperate to arrange care for them at home or in residential accommodation. But because of inadequate services, the patients have effectively become homeless as a result of falling ill. The group is campaigning for improvements in social services provision and systems, and to ensure that patients who do not need hospital care are not "put on ice" in re-opened hospital wards.

Audit and patient confidentiality

Patient confidentiality is a central tenet of medical practice. Yet confidentiality requirements seem to be breached by the increasingly frequent audit of GP patient files by pharmaceutical and healthcare companies. Roger Coakham, chief officer of South Gwent CHC, raised this matter with the chair of the General Practice Audit Committee for Wales. As a result, a letter has been sent to all GPs in Wales reminding them of the General Medical Council guidelines. The letter states that "patient records must not be disclosed to, or accessed by, a third party from outside the practice such as a nurse, pharmacist or doctor working for a drug company or subsidiary unless the patient has given prior consent, or unless the data have already been anonymised". The issue is to be considered by the General Medical Services Committee and it is hoped that similar letter will be sent to English GPs.

Cancer services in Bristol

The new NHS White Paper proposes the establishment of National Service Frameworks along the lines of the *Calman-Hine Report* on cancer services. This proposal would be welcomed by Bristol & District CHC which comments in its report on cancer services in Bristol that "the NHS nationally would benefit from reproducing similar reviews in other areas of medical care". The CHC has used the *Calman-Hine Report* as a starting point for reviewing the cancer "journey" a patient would take through local NHS services. As a result, it has produced a report, *Ending the Lottery?* which it can offer as a contribution to the development of local cancer services.

NHS Executive puts legal services for CHCs out to tender

Since September 1996 ACHCEW has held a service level agreement (SLA) with the NHS Executive (NHSE) for legal services to CHCs and Marion Chester has been employed as ACHCEW's legal officer. The service has proved extremely popular. In a recent evaluation, 109 CHCs reported that they had used the service. Of these 76% said that they had found the service "very useful" and 21% that it had been "useful"; 98% said that they were "satisfied". Unprompted comments from 33 CHCs included "invaluable", "indispensable", "one of ACHCEW's most useful services" and "How could we do without it?"

It came as a considerable shock, therefore, when ACHCEW was informed by the NHSE that it intends to put the SLA from April 1998 out to tender – and when the NHSE placed an advertisement inviting expressions of interest without drawing ACHCEW's attention to it. A letter from Steve Jolliffe at the NHSE suggests that tendering is the proper way to proceed given that the NHSE must obtain value for money. However, it also seems that regional officers felt that the service had been more than advisory, but had strayed into "policy" issues and advised ACHCEW as a whole on such matters. Marion comments that the vast majority of her time has been spent on individual CHCs' enquiries and that issues arising from their enquiries have been raised through ACHCEW Standing Committee only because of their general concern to CHCs. Many CHCs have expressed the view that this "policy" work has been of most use to them.

ACHCEW will be free to submit a tender for the SLA, but there is a real concern that a commercial law firm may tender at a very low price – offering the service as a "loss leader" in the hope of picking up on medical negligence work which may come through contact with CHCs. If the service is provided through a commercial company then there are concerns about expertise on public law issues, losing the expertise that has already been built up in ACHCEW's legal service and the ability of the service to draw on ACHCEW's materials and expertise. ACHCEW's director, Toby Harris, has written to Steve Jolliffe asking for more information about the criteria used in the tender, the involvement of CHCs in the process, the timetable for tendering and whether solicitors winning the tender would be prevented from acting on medical negligence.

For further details, see letters sent to each CHC office.

Nationwide Casualty Watch

A successful pilot of the nationwide casualty watch was held on 24 November and enabled us to identify some potential problems. ACHCEW is grateful for information received on 126 hospitals from 116 CHCs. We hope that even more CHCs will take part in the "live" exercise. Health councils in Northern Ireland and Scotland will also be taking part. At the end of the exercise, ACHCEW will release results to the media, highlighting the issue of long waits in A&E departments.

Nationwide Casualty Watch
4:30 p.m., 26 January 1998.

Liz Rickarby

Liz Rickarby, ACHCEW's training organiser, has returned from maternity leave. A welcome from us all to baby Olivia, and many thanks to Allison Anthony who looked after the training programme while Liz was away.

Holiday time!

CHC News takes a holiday next month. The next edition will appear in March.

Disputes over visiting patients

In October ACHCEW wrote to the health secretary about the position of patients who are incapable of expressing their wishes about who should be entitled to visit them in hospital. The Chair of ACHCEW had come across a case in which a patient's partner was not allowed to visit due to opposition from the patient's children. ACHCEW has since received a reply from the health minister, Baroness Jay. Although she feels that decisions on admitting visitors are best taken locally, she also comments that it may be useful for trusts to arrange for patients' wishes concerning visitors to be recorded on admission. She also suggests that the matter is considered as the new NHS charter is developed.

A letter to ACHCEW from Hillingdon CHC illustrates just how difficult the situation may be for patients, their potential visitors and health staff. Given the fact that there may be warring parties and the patient may be in a confused frame of mind, it may be appropriate to provide the patient with an advocacy service.

A letter from Salford CHC points out that the issue crops up, perhaps even more, in places such as nursing homes and sometimes results from long-running family disputes. The situation can be particularly difficult for a partner or carer who is not related to the patient, but may have been his or her closest friend for many years.