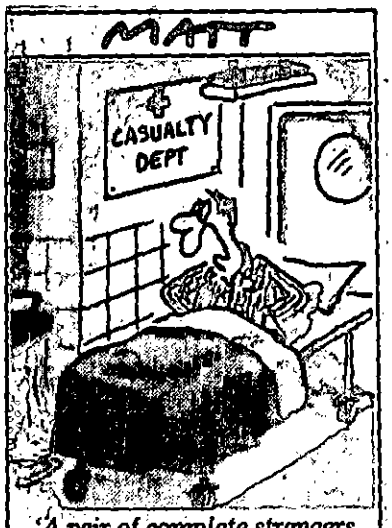
CHC NEWS

A newsletter for community health council members and staff

Casualty Watch

CHCs around the country held a successful Casualty Watch on Monday 26 January, taking a snapshot of waiting times at 194 accident & emergency departments in England, Scotland and Wales. Despite recent talk of a crisis in NHS services, the figures were better than last year. The longest waits were considerably shorter and none of the 17 patients who had been waiting longest was on a chair at the time of the survey.

However, some patients still had to wait for unacceptable times (28 hours 43 minutes for one patient by the time of the survey). The figures also show how vulnerable tightly stretched services are to untoward events. There had been an outbreak of diarrhoea and vomiting at Birmingham Good Hope Hospital, for example, and three wards had been closed. This had a knock on effect at both that hospital and the nearby Birmingham City Hospital. As a result, these two hospitals accounted for three of the four longest waits in the country.



'A pair of complete strangers have met and got married since I've been waiting on this trolley'

Trying to imagine what 26 January must have been like for just one patient at Manchester Royal Infirmary – the 10th longest wait in the list – brings home how distressing such waits must be. A 74 year old woman attended A&E with chest pains at 8:11 p.m. on Sunday evening. At 4:45 a.m. the following morning – i.e. after an 8½ hour wait through the night – a decision was taken that she should be admitted. By the time of Casualty Watch some 11 hours 45 minutes after this decision, she was still waiting on a trolley in A&E.

Casualty Watch has raised a great deal of media interest, and was widely covered in broadcasts on 27 January. Many thanks to all those who took part.

Parliamentary Group gains support

There has been a very encouraging response from MPs to proposals to set up an All Party Parliamentary Group on CHCs. Over 200 MPs from all the English and Welsh parliamentary parties have shown an interest in joining. We are grateful to all the CHCs which have written to their local MPs encouraging them to do so. At the inaugural meeting on 19 February members will agree objectives and elect officers. The draft objectives are for the group:

- to provide a forum for members of both Houses to debate the work and future activities of CHCs (England and Wales), Health Councils (HCs - Scotland) and Health and Social Services Councils (HSSCs - Northern Ireland)
- to develop stronger links between parliamentarians and CHCs, HCs and HSSCs
- to help promote the role played by CHCs, HCs and HSSCs on behalf of the local community.

ACHCEW will act in a secretariat role for the group and provide policy advice and assistance.

In this issue:

ISSUE 27, January/February 1999

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

Setting false options

As reported previously in *CHC News* a consultation process which has been taking place in Wales could have very important implications for CHCs in Wales, and potentially in England as well.

Both ACHCEW and the Association of Welsh CHCs (AWCHC)have responded to *Involving the Public*, a document which places a welcome emphasis on exploring how patients and the NHS can work in partnership. However, although this general goal may be welcome, the outline proposals for CHCs are not. The document lists various alleged weaknesses of CHCs (not backed up with evidence) which centre round a lack of clear focus and overstretched resources. The proposed solution, rather than to increase the CHC resources, is to cut back on CHC activities. CHCs must, the document asserts, focus either on NHS trusts or on health authorities. Both ACHCEW and AWCHC are quite clear in their rejection of this choice. As AWCHC puts it, the focus of the CHC must be the patient and the public in the totality of the new NHS. Both associations firmly oppose the suggestion (under the "health authority focus" option) that CHCs should move away from support for complainants.

ACHCEW readily accepts the need for CHCs to change and improve, but also calls for action from others to help them maximise their contribution. With massive changes under way in the NHS, now is the moment to explore what the CHC contribution could be, rather than prematurely to impose a particular model of activity.

ACHCEW Commission

At a Special General Meeting last year it was agreed that ACHCEW should set up a Commission to consider the future of CHCs and public involvement in the NHS more generally. The Commission, which will be made up of a panel taking evidence from a wide range of organisations, is beginning to take shape. We will keep CHCs informed as details become available.

Choosing new directions

During a year of study leave, Chris Dabbs, now back as chief officer at Salford CHC, has been working on options for the future of CHCs. His summary report, *At the Crossroads*, describes internal and external pressures on CHCs, suggests four options for the future and outlines an organisational framework. Like NHS Wales, Chris believes that CHCs need to narrow their activities, although he does not envisage their ceasing to relate to either health authorities or trusts. Instead, he proposes that they take on one of the four options shown in the diagram below, or possibly two if extra resources are provided. Although the document does not come down in favour of any one of these options, one firm – and controversial – piece of advice is that "providing direct services to individuals with queries and problems [e.g. routine complaints work] is ... no longer viable as a focus or function".

	Function	
	Monitoring/ scrutiny	Facilitating lay involvement
Focus		
Service provision and commissioning (processes, quality, outputs)	Health and social services councils	Citizens' involvement councils
Public health/health improvement (outcomes, effectiveness)	Public health councils	Health improvement councils

A group of chief officers in the South & West Region have also been framing future options. They conclude that CHCs will have to become new organisations with:

- smaller, more tightly focused lay membership, with clear accountability and no formal links to local political, NHS or voluntary bodies
- a professional staff team
- recognised formal links with the Commission for Health Improvement
- a dynamic organisational structure that will enable joint working, formal and informal partnerships, project work with, and secondments from, all local stakeholders
- work programmes that take account of national and key local issues

At the crossroads, Chris Dabbs, Salford CHC
Available at:
http://ourworld.compuserve.com/homepages/chrisdabbs1

Reflecting the public interest
Mike Rolfe, Denise Holden and Howard Lawes
for South & West Regional Association of CHCs

ACHCEW's 1999 AGM/Conference

CHCs: Modern, Dependable, Independent

will be held at
Eastbourne
on
6–8 July 1999

Deadlines

- Receipt of motions from CHCs: **Monday 15 March**
- Amendments to motions: **Thursday 29 April**
- Nominations for the post of Chair and two posts of Vice-Chair: **Thursday 29 April**

Raising ACHCEW's profile

Since taking up her post as ACHCEW director, Donna Covey has been actively raising the Association's media profile – one of the priorities in our current work programme. Over the last couple of months – and before the flurry of activity following Casualty Watch – she has made the following media appearances:

- Today programme, Radio 4, on GP self regulation
- Meridian TV on Doctors
- Late Night Live phone-in, Radio 5, on the doctor/patient relationship
- Living TV discussion "Can women trust their doctors"
- London Broadcasting Company on league tables
- Interview with Radio 5 for a feature on the doctor/patient relationship.

ACHCEW Policy Team

ACHCEW's Information Team has been renamed the Policy Team, a title which better reflects their work.

REGULATING PRIVATE HEALTH CARE

In January, ACHCEW submitted evidence to the House of Commons Health Committee, which is looking into the regulation of private health care.

The submission refers to the White Paper, *Modernising Social Services* in which the government proposes eight regional Commissions for Care Standards in England to take over the role of registering and inspecting private nursing homes and residential care homes (but not private hospitals). At the time of writing the Welsh Office has not set out its proposals.

ACHCEW stresses that CHCs should be given powers and resources to inspect private health care bodies, maintaining a local element to the inspection process. Support and advocacy needed by some complainants could be provided through CHCs, resources permitting.

Day care centres: a gap in the system

Richard Edwards, chief officer of North Hertfordshire CHC, has drawn ACHCEW's attention to a serious gap in registration and inspection legislation, namely the lack of coverage of private day care centres. A statutory body can set out conditions when it places clients at a day care centre, but its only sanction if the conditions are not met is to withdraw the clients. There are no legal requirements for registration or inspection, and apparently no minimum standards of care laid down.

The White Paper says the government has no immediate intention to introduce new regulation for day care for adults. Our submission to the Health Committee quotes North Hertfordshire CHC, saying "these centres will be serving the most vulnerable people in society, including the elderly and mentally ill, who need the full protection that registration and inspection arrangements can offer".

Private hospitals: need for reform

ACHCEW also calls for reforms to the registration and inspection of private hospitals and for effective complaints procedures. Separate evidence has been submitted to the Health Committee by South East Kent CHC, which has been supporting the patients of Rodney Ledward, the gynaecologist who was removed from the medical register last year (see page 7 for Michael Howard MP's endorsement of the CHC's efforts). Among nine main concerns, the CHC stresses the need for:

- nationally recognised clinical audit and clinical governance systems for hospitals, doctors and insurance companies in the private health sector
- clarification of lines of accountability and responsibilities of medical, nursing and managerial staff in the private sector to dissatisfied patients
- nationally recognised and accredited complaints and appeals procedures for private sector patients and access to an independent arbiter.

Responses Received To Resolutions Passed At ACHCEW's 1998 AGM

Resolution	Content	Response from Department of Health/NHS Executive
Emergency motion 2: CHC independence	Called for a revision of CHC regulations about the termination of CHC membership so as to protect the independence of CHCs from regional offices.	There are no plans to revise the regulations. 1998 guidance says that "the process of considering termination of membership should always be conducted with the involvement of the relevant CHC and that its view should be listened to and respected."
Resolution 1: Patient representation at GP interviews	Called for involvement of patient representatives in interviews for new GPs.	There are no plans for change. HAs can, but do not have to, include patient representation on interview panels for single-handed GPs. The letter claims that "it would not be possible for HAs or the DoH to require partnerships to include patient representation in its selection processes". It is ready, however, to put the burden on patients: "it is important ... that patients locally make their GP and HA aware of the quality of services and of any perceived lack of service so that these factors can be taken into account when new appointments are being undertaken." [This resolution and the next one received a particularly warm welcome from the National Childbirth Trust.]
Resolution 2: Removal from GP lists	Called for more information about reasons for removals from GP lists and for an appeal procedure.	Accepts that GPs should *not* be required to give a reason for removals, using a bizarre justification: "In the majority of instances we believe, patients will be fully aware of the background leading to GPs taking removal action. There is therefore no need to require GPs to give reasons in every single case". The letter also opposes an appeals process.
Resolution 3: NHS efficiency savings	Called for the removal of the requirement for efficiency savings in the NHS since there is no slack in the system.	Briefly describes how the new Reference Costs Index will provide a more meaningful measure of performance than the existing Purchaser Efficiency Index.
Resolution 4: Prescription drugs in hospital	Made various points about the handling of medicines brought into hospital by patients.	Deals fully with the various points made in the resolution. Advice on the safe and secure handling of medicines is currently being reviewed. Hospitals have a certain amount of flexibility in drawing up local policies on the handling of such medicines. The final point in the resolution was "This AGM also deplores the practice in some hospitals of returning to the patient only seven days' supply of their own drugs, when they may have brought in, and had confiscated, nearly a month's supply". The NHSE letter comments "These medicines remain the property of the patient and should not therefore be destroyed or otherwise disposed of without the patient's agreement." Destruction may be advisable if, for example, the medication is discontinued. Where medicines are not destroyed they can be returned to the patient on discharge or, with the patient's permission, returned to his/her home by an identified adult.
Resolution 5: Financial assessment of terminally ill patients	Called for means to be found to obviate any need to undertake financial assessment of terminally ill patients on transfer from hospital to nursing homes.	Does not directly address the resolution, but points out the arrangements and funding of a range of services to meet the needs of people who need continuing care, including palliative care. It refers to detailed guidance on NHS responsibilities for palliative care (EL(94)14).
Resolution 6: Data on ambulance response times	Called for a national method of collecting data for ambulance response times on an area basis.	A working party has been set up to re-examine the ambulance returns for England and the first meeting was on 9 December.
Resolution 8: Assistance with travel costs for NHS treatment	Called for people who are entitled to receive financial assistance with travel to hospital to be provided such assistance if in the future they receive NHS treatment in their locality rather than hospital.	Recognises that there are problems and says that the government shall be keeping the matter under review. However, it makes no promises because of the potential administrative burden on GPs and because it questions whether community services will involve users in travel costs they cannot afford.
Resolution 9: Organ transplantation	Called for action on a number of fronts to review what hospitals and health authorities are doing to obtain donors and increase rates of organ transplantation.	Welcomes CHCs' interest and says that the NHSE would very much like to work with ACHCEW and local CHCs to develop work in this area. The UK Transplant Support Service Authority is currently arranging a series of workshops on transplantation issues and would welcome CHC involvement. They would also welcome local involvement in publicity campaigns aimed at the general public and at South Asian communities.
Resolution 12: CHC involvement in the NHS R&D programme	Called for specific CHC representation on the Special Advisory Group on Consumer Involvement (SAGCI) in the NHS R&D Programme and for more attention to be paid to the work of CHCs in this area.	Examples of CHC surveys and research projects have been picked up during a project to construct a database of examples of consumer involvement in research commissioned by SAGCI. Members of SAGCI are appointed to serve the group in a personal capacity and not as representatives of a constituency or interest group. This does not preclude individuals from CHCs or ACHCEW from becoming members of the group, so long as they are willing to serve on a personal basis only.
Resolution 13: CHC visiting rights in non-NHS premises	Called for CHCs to be given a statutory right to visit non-NHS premises where patients are receiving NHS-funded care.	There are no plans to extend the powers of CHCs. However, HAs should arrange for CHCs to have access to NHS patients who are receiving treatment in non-NHS premises.
Resolution 14: Speaking rights of CHC observers	Called for CHC observers at meetings of NHS trust boards and health authorities to be given the statutory right to participate in discussions.	There are no plans to make this a statutory right. However guidance to NHS trusts and health authorities issued in December 1998 (HSC1998/207) states that: "It is good practice for ... a CHC representative to be invited to sit at the board table and be able to participate in discussion (although without voting rights)". It is also good practice to "send agendas and papers for discussion at open session to local CHCs ... in advance of meetings". "CHC representatives ... may attend closed board meetings at the board's discretion".
Resolution 15: CHCs and nursing homes	Called for CHC rights to be extended to cover patients in nursing homes, irrespective of the source of the funding. Also called for an increase in resources to CHCs for this work	There are no plans to extend the role of CHCs to represent the public's interest in non-NHS funded services or care.
Resolution 16: Shortages of nurses	Called on the government to initiate a comprehensive review and develop a plan of action to remedy the shortfall in numbers of nurses.	Does not offer a comprehensive review, but does set out action being encouraged by the government for the period to April 2000: improvements in recruitment and retention; personal development plans for most professional health staff; involving staff in planning and delivery; acceptable food and accommodation standards for on-call staff; review of induction arrangements; health and well-being of staff. Rules out pay as the most important influencing factor.

CHC NEWS, ISSUE 27, JANUARY/FEBRUARY 1999

CHC STAFF AT BREAKING POINT?

By Dan Jakob

Significant staff problems at one in three CHCs in North Thames during 1997-98, coupled with a high staff turnover, were damaging both individuals and the affected CHCs. In response, the Regional Office commissioned a survey to explore the causes of stress and poor performance and to review support arrangements.

The survey report, *Support for Staff in Community Health Councils,* by Dan Jakob, acknowledges that CHC staff strive to do an impossible job well – sometimes at risk to their health and safety. At half the CHCs surveyed at least one member of staff reported that stress levels at work were normally high. Chief officers in London were particularly affected.

Work overload, long hours, uncertain responsibilities and responsibility for the welfare of others were widely perceived as causing stress or poor performance. Work relationship factors, such as poor management and lack of support, were particularly significant at CHCs where stress levels were high. Personnel policies are underdeveloped at many CHCs and there is a lack of clarity about where to go when relationships go wrong.

The risks to the health and safety identified in the report should not be ignored. The Health and Safety Executive has made it clear that employers must act on such knowledge. Concluding that stress can often be prevented by good management, good support systems and the development of a caring culture, the report offers guidance on appropriate action. Specific recommendations include:

- consideration of these issues in discussions about the future remit of CHCs;
- a review of the remit of the Regional Office in the management of CHCs;
- clarification of the roles of staff and members as mutually supportive;
- adequate professional support for chief officers and specialist support for complaints work;
- the development of teamwork arrangements at individual CHCs;
- the allocation of time for all staff to participate in peer support activity.

Dan Jakob's report is available from:
Corporate Services, North Thames Regional Office, 40 Eastbourne Terrace, London W2 3QR.
To discuss taking forward this work, contact Dan Jakob, 110 Tufnell Park Road, London N7 0DU.

Death of Glyn Williams

Readers will be sad to hear of the recent death of Glyn Williams. Glyn was a member of Greenwich CHC for 15 years and in its chair for 12. He was active and successful in campaigns to protect health services in Greenwich and in South East London generally. He played a major role in keeping the regional specialties of Neurosciences and Cardiac Services at the Brook Hospital for 13 years following the original proposals for their closure.

He will be well remembered by those attending ACHCEW AGMs for his sense of humour, zest for life, wonderful Welsh singing voice and nifty footwork on the dance floor. He will be greatly missed.

East Sussex CHC forces reconsideration of service move

Following a referral from East Suffolk CHC, the Secretary of State for Health has told Suffolk Health Authority to reconsider its proposal to move rehabilitation and recovery services from Bartlet Hospital, Felixstowe, to Ipswich Hospital.

The health authority had consulted over the proposed transfer of services, but the consultation had not included the implications of the transfer for the two hospitals in Felixstowe. Frank Dobson had said that before any decision can be made about the transfer, it is essential to know what those implications are. If the health authority believes that the transfer might result in the closure of a hospital, then it would have to carry out a full consultation exercise on this. Anglia & Oxford Regional Office has been instructed to work with Suffolk Health Authority to examine how the proposals would affect Felixstowe's two hospitals.

Mid Essex campaign wins service review

Mid Essex CHC has also scored a success in encouraging its health authority to reconsider cuts. The CHC referred proposals by North Essex Health Authority to close some beds for elderly patients and maternity beds. A consultation exercise showed that the CHC had a great deal of support for its stand among the public, GPs and other health staff. The health authority then contacted the Secretary of State for Health, saying that it wished to review the proposals. It seems that the referral concentrated minds enough for the health authority to realise that "the decisions which are on the minister's desk need to go back to the primary care groups to be considered as part of their plans for the future". Members of the public and the CHC are to be involved in the review.

Around the CHCs ...continued

Hospital reconfigurations

Many CHCs are being faced with proposals to merge acute hospital services on large single sites, with the resultant closure or downgrading of existing hospitals. The Association of West Midlands CHCs has resolved "to support through ACHCEW a national debate on the future of acute general hospital provision – *Big is not necessarily beautiful.*" ACHCEW's Standing Committee is to consider in March how the Association may take this work forward. In the meantime, ACHCEW has circulated two documents to CHCs.

- Notes written by the chair of Barnet CHC of a discussion involving members of the public, four CHCs and two academics. The notes include questions for CHCs to put to health authorities when hospital closures are planned.
- *Our Trust Is Merging* – a document produced by the Royal College of Nursing. It presents a series of checklists to help nurses answer the questions:
  What are the facts?
  What are the issues?
  Is it best for patients?
  Is it best for you?

Huge Fund for Health Grant Programme

A new grant programme has been launched to fund health projects. When Guardian Royal Exchange acquired the PPP Healthcare Group last year, the PPP Healthcare Medical Trust was endowed with a huge amount of money. As a result, the Trust expects to distribute about £17 million annually.

The first grant programmes include some in fields where CHCs have been active. For example:

- initiatives addressing the incidence and impact of mental health problems and/or learning disabilities in children and adolescents;
- initiatives that could defer or prevent the onset of disabling conditions or the need for long-term care or long stays in hospital for older people.

There will also be mid-career awards for healthcare managers and researchers, among others, to enable them to spend 6–24 months undertaking specific work.

For application forms and guidance material, contact:
PPP Healthcare Medical Trust, 13 Cavendish Square, London W1M 9DA, Phone: 0171 307 2622
Email: ppptrust@ppptrust.org.uk
Website: http://www.ppptrust.org

CHCs In Parliament

An authoritative and serious body

Michael Howard MP was generous in his praise of South East Kent CHC, its chair, Paul Watkins, and its chief officer, Jean Howkins, during a parliamentary debate in December. His comments came in a debate he had secured on the case of Mr Rodney Ledward, a consultant gynaecologist whose surgery has damaged several women and left many more worrying about what damage they may have suffered. By the time of the debate, some 418 former patients of Mr Ledward had contacted the local hospital trust or the CHC to express their concerns about their treatment. Describing South East Kent CHC as an authoritative and serious body, Mr Howard backed its call for a public inquiry. In response, the health minister Alan Milburn said that an announcement would be made as soon as possible on how the government intends to proceed.

Hansard, 10 December, cols 581-6

Government urged to grant PCG observer rights to CHCs

Patrick Hall, MP for Bedford, is to convene the first meeting of the All-Party Parliamentary Group on CHCs. In the Queen's Speech debate, he spoke of the role of lay members of primary care groups (PCGs) and the support they will receive. He pointed out that a mechanism for such support already exists in the form of CHCs, and asked whether the health secretary would consider allowing CHCs observer status on PCGs with speaking, but not voting, rights. Mr Hall also welcomed the setting up of the Commission for Health Improvement, commenting that it would enable CHCs and whistleblowers to report suspected problems.

Hansard, 26 November,col 365

Call for LAs to duplicate CHC rights

An interesting remark from Fiona Mactaggart, MP for Slough, indicates the way some MPs' thoughts may be turning on NHS accountability. In a debate on community health services in Berkshire, Ms Mactaggart called on the government to consider giving local councils a formal role in the NHS consultative process, perhaps putting them on a par with CHCs. In his reply, suggestion, the health minister, John Hutton, showed no signs of taking up the suggestion.

Hansard 7 December, col 120

> ... the NHS would not benefit from the imposition of another national Charter.
>
> *Greg Dyke*

In 1997 Greg Dyke, the chair and chief executive of Pearson Television, was asked to take the lead in developing a new NHS Charter "to mark the 50th Anniversary of the NHS in July 1998". There have been some hiccups, and Mr Dyke's report was finally published in November 1998. It has been described as "an important step forward" by health minister, Baroness Hayman. The government now plans to "move forward by consulting the public and the NHS on a new NHS Charter programme over the coming months".

The tone of Mr Dyke's document is very personal, with plenty of suggestions starting "I believe that ..." and so on. While this has the merit of making it clear where the suggestions come from, after a while it also provokes an exasperated "So what?!". Mr Dyke makes it clear that he has gone against the advice of his advisory group in some instances; he says that he has consulted widely, but gives few details; and he lists just four publications in his bibliography.

Priority to local charters

The main thrust of the report is that new charters should be developed locally and include a limited national element. The main justifications for this are that some staff have disagreed with specific process standards in the existing Patient's Charter and that the government wants to encourage local charters. Mr Dyke adds that he "would suspect that [staff and patients] more readily relate to their own local health services and arguably do not have the same overwhelming allegiance to a centralised NHS" – but provides no evidence to back up his "suspicion".

While many organisations, including ACHCEW, support the idea of local charters, few would want a seriously reduced "national element". Mr Dyke suggests an NHS Value Statement, containing the feel-good aspirations one might expect in such a statement, but with little that individual patients could get hold of to use. In addition, some minimum standards would be set at a national level (but fewer than in the existing Patient's Charter) and local bodies would be *required* to set targets in selected areas. Mr Dyke is very anxious to keep as much as possible for local decision, so, for example, standards such as "if the patient wishes, relatives and friends are to be kept up to date on treatment and progress" should be a "common sense decision" to be taken locally. It is not clear why, if it is common sense, it could not be set nationally, saving everyone at the local level the bother of reinventing the wheel. Nor is it clear what a patient should do if his/her local health service fails to show such "common sense".

The priority proposed for local charters has some more serious implications. In particular, Mr Dyke rejects the suggestion that "providing a good standard of clinical treatment and giving the patient the information necessary to make an informed judgement about where to go for their treatment" should form part of an NHS Charter. This is partly because the development of clinical information is being undertaken nationally and should not be "muddled" with locally-defined service and process standards. Yet in King's Fund research, patients and staff alike identified clinical standards as a high priority for a new Charter. Surely, such findings, and not one man's fallible instincts, should be the starting point for shaping a new Charter programme.

Asking the patients and staff

> There is no substitute for a national charter, but local charters can be useful ...
>
> *King's Fund*

The only non-Department of Health publication listed in Mr Dyke's bibliography is *The Patient's Charter: past and future* published by the King's Fund. Based on a literature review, interviews and focus groups, this publication explores the achievements and shortcomings of the Patient's Charter. It also presents the views of patients and staff on what a new charter should contain. Although the preferences of patients and staff differ in emphasis and fine detail, they also have much in common. The authors of the book have combined their suggestions to come up with a list of recommendations for new charters at a national and local level.

The New NHS Charter: a different approach
Greg Dyke
DoH, PO Box 410 Wetherby LS23 7LN or
http://www.doh.gov.uk/charter.htm.
Copies have been sent to CHCs.

The Patient's Charter: past and future
Christine Farrell, Ros Levenson and Dawn Snape
King's Fund, 11-13 Cavendish Square,
London W1M 0AN, £12.95

Note: Items in *CHC News* present the views of contributors and do not necessarily reflect the views of ACHCEW.