

CHC NEWS

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

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NEWS

Rising child psychiatric admissions

The number of children admitted to psychiatric hospitals has been rising over a period when adult admissions have been falling. Admission of children aged 10–14 rose from 38 per 100,000 in 1985 to 63 per 100,000 in 1990, a rise of 65%. There was a 21% rise in the 15–19 year old age group and 42% rise among the under-10s. According to child psychiatrists, increasing psychological pressure, a reflection of poverty and unemployment, is partly to blame. They also say that spending cuts have led to closures of children's homes and special schools and reductions in child guidance clinics and specialised therapy. As a result children with difficult behaviour, rather than specific psychiatric illnesses, are being "dumped" in hospital.

In hospital, children do not have the legal rights that they have in children's homes and visiting arrangements for families are often very limited. Furthermore, children can be admitted to hospital as "voluntary" patients without their consent if parents (or the local authority for children in care) agree to the admission. In such cases, they cannot appeal to the Mental Health Tribunal as adults can.

Independent 4 April

Limits on adoption by smokers

New guidelines from the British Agencies for Adoption and Fostering say that children under two should not be placed for fostering or adoption with people who smoke unless there are exceptional circumstances. This is because young children and those with respiratory illnesses are particularly at risk from passive smoking. The junior health minister, Tim Yeo, has urged caution in applying the guidelines, saying that the lifestyle of potential adopters and fosterers is only one of the factors to consider: "Each case must be judged on its merits using common sense and compassion". However, the BAAF have pointed out that there are many more suitable applicants than there are babies needing new families. They suggest that prospective parents should be told at an early stage that smoking habits will be considered during assessment, and that smokers should be treated sensitively and offered help to give up.

Guardian 25 March

Incentives to cut drugs bill

All GPs, including non-fundholders, are to be offered cash incentives to spend less on prescribed medicines. The cost of GP prescriptions has risen by 25% since 1990, and has risen considerably more in non-fundholding than fundholding practices. Regions are being asked to submit plans for pilot incentive schemes. There are fears in some quarters that incentive schemes may tempt doctors to allow cost to bias their clinical judgement. The deputy chairman of the GPs' committee of the BMA, Dr John Chisholm, has called for the medical profession to be involved in the design of schemes to ensure that they are voluntary and ethical.

Guardian 12 March

RHAs try to claw back GP budgets

More general incentives for GP fundholders are being limited by regional health authorities. Individual RHAs are setting a ceiling on the savings practices can make, in a bid to prevent them from building up and retaining massive surpluses (see *CHC News* No 79). NE Thames RHA, for example, is attempting to stop fundholders from retaining more than 4% of their budgets. South Western RHA plans to claw back savings and review practice budgets. At the same time it has said that "only in exceptional circumstances will continuing recognition be given to an overspending practice". Many fundholders, predictably, are not amused.

Pulse 10 April

Confidentiality warning

Hospitals and health authorities have been warned by the Data Protection Registrar that they are wide open to challenge under the Data Protection Act. Hospitals and DHAs hold and swap computer-based information on patients in the form of "contract minimum data sets" for billing and monitoring purposes. Among the items that have caused concern are those recording marital status and ethnic origin. The registrar is also concerned that the new NHS number, being issued to every patient, may be developed as a national identity number used by all Government departments.

Guardian 15 April

Legal Aid cuts

The Law Society is seeking judicial review of the decision by the Lord Chancellor, Lord Mackay, to cut Legal Aid. The society claims that 14 million people will be affected by the cuts, a claim dismissed by Lord Mackay as "absurd".

ACHCEW is concerned that the cuts will exclude many patients from legal recourse, either because they will no longer be eligible for Legal Aid or because they will not be able to afford the required contribution to costs. Toby Harris has written to the Lord Chancellor pointing out that a high percentage of medical and personal injury cases are successful, and the costs end up being paid by the opponents. This form of litigation is not, therefore, a great drain on the Legal Aid fund and achieves a high level of positive results. Long-term plans need to be agreed through formal consultation; in the meantime the Association supports an alternative short-term package developed by the Law Society in consultation with professional and consumer organisations.

Times 6 April

AZT disappointment

Preliminary results from the largest study undertaken of the anti-AIDS drug AZT (also called zidovudine and Retrovir) show that it does not delay the onset of AIDS if taken by healthy HIV-positive people. The drug is supplied to about 200,000 people worldwide. The study, involving more than 1700 participants, was funded by the British and French governments. After three years in the double-blind trial, 92% of the AZT group were still alive compared to 93% of the placebo group. In both groups 18% had gone on to develop AIDS. Side-effects were significantly more common in the AZT group. The results do not affect the benefit of giving AZT to people who already have AIDS symptoms. It is still believed that it can extend their lives by an average of about nine months.

A smaller trial in the USA had suggested that AZT might delay the onset of AIDS. However, the trial was halted sooner than planned because early results suggested that it would be unethical to continue treating subjects with the placebo rather than the drug. The British-French study had shown a short-term benefit at early stages, but the effect did not last.

Wellcome, the manufacturer of the drug, has objected to the conclusions of the study.

Independent 2 April

NHS complaints

Publications on NHS complaints systems from NAHAT and the Consumers' Association are described in *General Publications*. A *Which?* survey sheds further light on the CA's approach, and GPs have been voicing their concerns.

Survey at Chase Farm: *Which?* followed up the 127 people who had complained to Chase Farm Hospital in the year to April 1992. The basic message was that complainants want to be taken seriously. Three-quarters wanted improvements to services for others, over half wanted recognition of the problems they had experienced, some wanted an apology and only a quarter wanted staff to be disciplined. The main point of dissatisfaction was that people were not given information on follow-up action. Of 32 files investigated in detail, only 10 complainants were told that action had been taken. Of four case studies presented, only one complainant was satisfied with the outcome: she was the one who had been given a detailed reply to her catalogue of complaints, which responded to every point, apologised, and explained who had made each error and how it had been corrected.

Which? April

GPs reject GMSC proposals: The consensus NAHAT has called for seems to be some way off. Proposals from the General Medical Services Committee of the BMA, which are broadly in line with NAHAT's proposals, have been overwhelmingly rejected by local medical committees. The GMSC recommended that complaints should be heard by independent regional committees, with the FHSA acting on behalf of the complainant, and that records should be kept of informal complaints. Of 86 (out of 117) LMCs who responded to a survey, over 90% objected to the proposals, particularly to the proposed advocacy role for FHSAs.

Doctor/Health Service Journal 8 April

... and object to appeals delays: GPs are also unhappy with delays in complaints appeals. It is not unusual for cases to take two years to reach appeals panels and six months for a verdict to be announced; the complaint may already have been in the pipeline for up to two years. Of course, long delays are upsetting for patients as well and are in nobody's interests.

In 1991, success rates at appeal were 19% for both complainants and GPs.

Pulse 10 April

D-DAY FOR COMMUNITY CARE

Rule change for owner occupiers

Not everyone is aware of a rule change which comes in with the Community Care system. It will affect many elderly people entering residential care. Under previous arrangements, owner occupiers who entered care could claim income support if they could show that they had tried to realise the value of their property. The Department of Social Security had no powers to claw back the benefit already paid when the property was sold. Now, however, a local authority may recover the cost of care out of the proceeds of an eventual house sale.

Independent 24 March

The homes business

An article in the *Independent* examines the growth of the private residential and nursing home sector over recent years. The sector had no significant role in the care of elderly people and highly dependent patients 20 years ago, but today accounts for two-thirds of nursing home beds and more than half of residential home places. Since 1980, the number of private beds has been rising at 16% a year. Four reasons are identified for the expansion: a growing number of elderly people; the introduction in 1983 of supplementary benefits for those needing long term care; the unblocking of long-stay beds in the NHS; and the improved quality of homes which has made them a more acceptable option.

The Community Care Act has important implications for the sector. The trend towards contracting out to private providers will be boosted by the withdrawal of eligibility to income support for residents of local authority-run homes. However, it seems likely that smaller operators will be under pressure as local authorities demand ever greater value for money and improving standards of care. Big companies are in a good position to step in if smaller operators do find the new regime too demanding. Takare, the largest company in the industry, with 4285 beds, has a further 720 beds. The second biggest, Westminster Health care, with 3100 beds, is building another 629.

The judgement that some homes are at risk of closure even if the sector as a whole is likely to expand is shared by Laing & Buisson. In their annual survey of the elderly care market, the analysts conclude that, if councils are to stay

within budget, fewer applicants will receive help with fees than in previous years. They say that homes operating in low-cost areas, such as the Midlands and the North, will be most at risk as national income support limits are replaced by local price deals.

Independent 24 March

A gulf in perceptions

Surveys published in *Community Care* and its sister title *Doctor* reveal a yawning gap between the perceptions of GPs and social services departments (SSDs) as to what preparations have been made for the new Community Care system. GPs will need to refer patients to SSDs which will then arrange and pay for the services the patients need. Despite the avalanche of information, 20% of the 341 GPs surveyed say they are unaware of the reforms. It is a little difficult to reconcile this figure with the 93% of GP respondents who believe that it will be GPs not social services who will have to care for people being cared for in the community.

SSDs believe that they have fulfilled their end of the bargain as far as preparing GPs is concerned. GPs think otherwise:

Consultation. 32% of GPs say that consultation has taken place between themselves and SSDs whereas 100% of SSDs say it has taken place.

Assessment. 17% of GPs say an assessment process has been agreed, whereas 79% of SSDs say they have made assessment arrangement jointly with GPs.

Named social worker. Only 15% of GPs have a named social worker, although 38% of SSDs say they have made arrangements for a named social worker to liaise with practices.

Referral. Only 20% of GPs say that referral forms are ready for the new system. 52% of GPs say that SSDs are asking for more than a basic medical history with referrals. (The General Medical Services Committee has advised that GPs' responsibilities begin and end with the provision of basic medical information.) 51% of GPs are not satisfied with previous referrals to SSDs.

Payment. 79% of SSDs believe GPs should do assessments for nothing. *Doctor* takes this as evidence that SSD managers have "failed to discover the basic conditions [GPs] work under".

Doctor 1 April

FOCUS ON COMPLEMENTARY THERAPIES

Policies in the NHS

There is widespread acceptance among purchasers in the NHS of a role for complementary therapies, but few policies on their provision.

A survey carried out by the National Association of Health Authorities and Trusts found that about two-thirds of FHSAs, GP fundholders and DHAs could see a place for such therapies, with only 14% of respondents believing that they should not be available freely on the NHS. Only 15% of FHSAs and a third of DHAs had policies on complementary treatments, though many were already purchasing them. A quarter of DHAs planned to purchase such treatments in the future. DHAs tend to fund treatments on a one-off basis through extra-contractual referrals. About a third of the fundholders were offering complementary treatments, most of them through members of the primary health care team. Note, though, that the response rate was only 43% among fundholders.

Complementary therapy and the NHS is available from NAHAT, Birmingham Research Park, Vincent Drive, Birmingham B15 2SQ; £6 members/£8 non-members.

BMJ 10 April

Call for regulation

Psychologists have called for legislation to regulate the profession in an attempt to stamp out unethical sexual relations between therapists and their clients. In a survey of 588 clinical psychologists, 4% reported having had a sexual relationship with a client. Unlike doctors, psychologists (and other unregulated therapists and counsellors) cannot be struck off the register for serious professional misconduct. Membership of the British Psychological Society can be revoked, but this does not make it illegal for the therapist to practise. The BPS has sent details of cases to the Department of Health in a bid for statutory regulation.

Independent 5 April

Guidelines for therapists

Other complementary therapists are also seeking to put their house in order. The three

alternative medicine associations (the British Complementary Medicine Association, the Council for Complementary and Alternative Medicine and the Institute of Complementary Medicine) are jointly producing a code of conduct which is to cover training, patient handling and ethics. The work is being funded by the Department Of Employment. The code is to embrace well-established disciplines (e.g. homeopathy) and fringe therapies (e.g. crystal healing). The latter group is particularly in need of safeguards – the number of alternative healers has doubled in the last five years, the fastest growth being among unregulated fringe therapies. Among the expected guidelines is a minimum of one year's training for all therapists. The associations hope that their voluntary standards will forestall possible moves by the European Commission to ban alternative healers from diagnosing and treating medical conditions.

Observer 21 March

Perceptions of therapy

A *Daily Telegraph* survey provides information on users of complementary therapies. Of those who had used such a therapy, 52% had decided to use it because orthodox treatment was not helping (68% had tried orthodox treatment first); 35% were using it because it had been of benefit before. Ninety-four per cent found the treatment very or quite helpful and the same percentage would use it again. Musculo-skeletal problems were the most common condition for which alternative therapy was used. Homeopathy was the most commonly used treatment, followed by osteopathy and acupuncture.

An overwhelming majority of respondents thought regulation very important, with regulation by the therapy organisations rated more important than legislation.

Few people had been recommended a therapist by a GP, although 67% had told their GP of the therapy. Only 33% were aware that a GP could "delegate" patients to be treated by alternative therapists. Even fewer knew that fundholders could purchase such treatment (18%) or that non-fundholders could apply to the FHSA to fund it (11%).

Daily Telegraph 6 April

FROM THE JOURNALS

New queues for old

The relationships between treatment rates, demand for treatment and waiting lists are complex. The NHS reforms influence both how (and whether) patients enter waiting lists and how they are then selected for treatment. As a result, the nature of waiting lists is changing.

Whether a patient is placed on a waiting lists depends on contracts between purchasers and providers and on extra-contractual referrals (ECRs). To the extent that a hospital is judged by waiting times or the length of its lists, it has an incentive to refuse to add a patient to a waiting list if its contract with a purchaser has already been fulfilled. It may even decline an initial referral. Anecdotal evidence of such practices exists, but there is no requirement to collect statistics of refused cases. Waiting lists may therefore decrease, not because of additional treatments, but because patients are not allowed to join them. This becomes increasingly likely as hospitals shift from block contracts with DHAs to cost-and-volume contracts.

ECRs represent a potentially uncontrolled drain on DHA referrals. In response, most DHAs have placed elaborate controls on them, resulting in many reports of refused ECRs. This could in turn mean that patients are not put on waiting lists, or not as soon as they would be otherwise. A similar situation may arise with GP fundholders holding back referrals, in effect holding their own non-recorded waiting lists.

The treatment of patients already on waiting lists is also affected. Under the old system, a consultant had a single waiting list from which patients were selected for treatment on the grounds of medical priority, time on the list, case mix and consultant preference. Now each consultant is faced with a series of queues, each "owned" by a different purchaser. People in the queue can be treated only if the purchaser pays for treatment. It is financially irrational to treat patients with high clinical priority if the purchaser will not pay for it (for example because the contract for that year has already been fulfilled) or to refuse low priority treatments for which there is an ECR.

The outcome of all these influences may be an administrative reduction in demand, with fewer patients obtaining treatment, but with those that do so having shorter waits.

Health Matters, Winter 1992/93

Health inequalities: new concerns about the children of single mothers

When relating childhood mortality to socioeconomic classification, the Office of Population Censuses and Surveys excludes from its analysis children whose parents are classified as "unoccupied". The authors of this paper, Ken Judge and Michaela Benzeval of the King's Fund Institute, argue that this produces a misleading picture of health inequalities and an underestimate of the effects of poverty.

The childhood death rate among those classified as "unoccupied" is 68.8 per 100,000 compared to 48.8 for social class V and 22.8 for social class I. Accidents and external causes of injury account for 60% of deaths among children in the "unoccupied" group, twice the proportion in the rest of the population. However, the OPCS excludes the group from its analysis of health inequalities, mainly because the label "unoccupied" may have a different meaning to those registering deaths and those recording population statistics in the census. It is therefore argued that it is not safe to use the figures to calculate mortality rates for the population.

The authors take a different view. They provide evidence which suggests that the discrepancy between classifications in death registrations and the census is relatively small. In both cases, most parents classified as "unoccupied" are lone mothers who are not earning (estimated here as 89% of the group). Most children in these families will almost certainly be living in poverty. Inclusion of these figures in the analysis of links between deprivation and mortality has two effects. It reinforces the link between health status and socioeconomic grouping, a link which, the authors argue, is underestimated in the *Health of the Nation White Paper*. In particular it undermines the common supposition that the discrepancy in mortality between social classes declines as children get older: 10-15 year olds have much higher mortality in the "unoccupied" than other social groupings.

BMJ 13 March

NHS internal market 1991-2: towards a balance sheet

This paper questions claims that the internal market in the NHS has resulted in increased efficiency. The author examines evidence from tax relief on private health insurance for the over 60s, GP fundholding, and implementation and transaction costs. He concludes that some improvements are due to increased funding rather than the reforms and that some changes are in fact reducing efficiency.

In 1991-2, in-patient numbers rose by 3.5%, day cases by 31% and out-patient attendances by 3.2%. How are these improvements to be explained? There had been virtual zero real growth in NHS funding during the 1980s, but in 1990-1 and 1991-2 NHS spending rose by 2.8% and 4.1% respectively. This increased funding should be included in any explanation of increased activity. Similarly, the elimination of two year waits is the culmination of a centrally coordinated initiative which started in 1986 and has cost £156m. This indicates the efficacy of "the power of a key ministerial priority and targeted additional funding" rather than the internal market.

The author then argues that tax relief on private health insurance, far from fostering efficiency, instead distorts the market. It is estimated that it cost the treasury £60m in 1991-2 and has not been offset by any gain in total expenditure on health care.

Budget-setting in the GP fundholding scheme also fails to address inefficiency. Fundholders were given budgets on an historic basis, allowing them to maintain pre-existing activity and referral patterns. Wide variations in per capita budgets have been identified nationally. A study of 15 practices in London and the home counties showed a 400% variation in drug budgets, over 300% in hospital in-patient treatment budgets and 150% overall. Given that it seems unlikely that the variations will prove to be correlated with need or deprivation, the author concludes that higher spending practices have been rewarded for inefficiency and the more efficient penalised by lower budget allocations.

There is also the cost of implementation of the internal market to be taken into account, and the on-going costs of market transactions (which require much more information than has previously been used). Estimates of these costs vary: one estimate in a *BMJ* article puts implementation costs at £2bn and recurring

costs at £500m annually. Officially implementation costs came to £786m in the three years from May 1989 to April 1992 (plus £12.5m for the fundholding scheme and £11m for the capital assets register). The salary bill for senior management, while difficult to interpret, is also suggestive: up from £25.7m in 1987 to £251.5m in 1991. It remains to be seen whether these costs, substantial and largely unrecognised, will be offset by corresponding gains.

BMJ 13 March

Charting progress

Andrew Cole assesses the Patient's Charter one year on and finds grounds for cautious optimism. He is interested in the Charter mainly as it relates to nurses. There are estimates that the named-nurse initiative is being operated by 80% of the profession, though in some cases they may be paying no more than lip-service to the idea. Where it is applied properly, it is reported to make a big difference, especially to long-stay patients and their relatives. Waiting times for operations is another area of achievement.

The Charter for Accident and Emergency Departments is causing concern. The charter states that patients should be seen immediately for assessment. Most A&E Departments do not adhere to this strictly: instead they assess patients after registration. It is difficult to devise protocols by which nurses assess patients before registration. Gary Jones, Chair of the RCN A&E Forum comments that "you could end up with quite a queue outside the door".

There are two more general concerns about the Charter. One is that the focus on Charter Standards could lead to other priorities being neglected. For example, it may not be an overall benefit for waiting lists to be reduced if that is achieved at the expense of the time people wait to see a consultant in the first place. The other is that standards are being laid down to benefit patients, but they are having to be achieved by staff who are under pressure and operating within limited resources. The National Association for Staff Support has called for a parallel Staff Charter in the belief that looking after staff will also benefit patients in the long term. The author concludes that, until support for a Staff Charter is forthcoming from the Government, health staff will remain sceptical of the efficacy of the Patient's Charter.

Nursing Times 7 April

NEWS FROM ACHCEW

Former Chair, Rita Lewis, has been appointed a lay member of the newly constituted United Kingdom Central Council for Nursing, Midwifery and Health Visitors.

Heather Wood has resigned as ACHCEW's Vice Chair on her appointment as Director of Quality for the Isle of Wight Commissioning Authority. ACHCEW's Standing Committee has elected Jennifer Elliot from the Northern Region of CHCs as Vice Chair until the AGM.

Dr Brian Mawhinney, Minister for Health, will be speaking at ACHCEW's AGM/Conference in UMIST in July. This is the first time the Minister for Health has attended an ACHCEW conference since 1986.

ACHCEW is holding a day seminar on "Rationing health care: should CHCs help?". This will take place on Tuesday 25 May 1993. CHC Chief Officers have the booking forms. An ACHCEW Health News Briefing on the same subject has also been circulated to CHCs in the last few weeks.

Bargains

Three hoods for sound-proofing printers, going free. Must arrange collection. One Fujitsu printer in good working order for sale. Price negotiable. Enquiries to Chye Choo at ACHCEW.

CHC PUBLICATIONS

Review of Oxfordshire community hospitals 1992/93

Oxfordshire CHC, 18 pages

This timely report into community hospitals in Oxfordshire assesses the services they offer; their capacity to meet increasing demand; their shortfalls; and their plans and aspirations. The county is fortunate in having maintained these hospitals at a time when many other districts were closing theirs. They now are seen as having an important role, but are in danger of being swamped from two directions.

Both the Community Care Act and the internal market in the NHS are increasing the load on community hospitals. The focus on community care is increasing their volume of rehabilitation and respite care work. At the same time, acute hospitals, anxious to increase their throughput and to reduce readmissions, are looking to discharge more people into the community hospitals. To cope with these pressures, the hospitals need to establish and maintain good links with both acute hospitals and the network of services in the community (which themselves need to be adequately staffed). It is very important for trust to be built up between the parties.

The reorientation towards community care creates another difficulty. There is a gap between public expectations, especially among people who have generously supported their local community hospital over the years, and the

inability of the service to offer long-term care. None of the hospitals were offering long-stay beds to new patients. Expectations are gradually changing. Yet it would undermine the role of community hospitals if the limits on stays were to become too strict. People in the hospitals are often having to come to terms with many changes in their lives: perhaps the sale of their home and family tensions, perhaps a recognition of limitations and increasing dependency. An acceptance of these changes takes time. An over-emphasis on throughput may rob community hospitals of their ability to fulfil the vital function of helping people manage transition. Furthermore, unless the hospitals can offer a flexible response to people's varying needs, the rhetoric of choice will remain merely rhetoric.

The CHC found many examples of good practice among the hospitals they visited, and there is clearly potential for their important role to be developed. But this will not happen without a strategy framed in the context of health and social care developments across the county. The CHC makes recommendations for such a strategy, recognising that there are funding implications if the health authority is to take advantage of this valuable resource.

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Health related self help groups in Leeds
Leeds CHC
28 pages

Directory listing 146 local (or where there are none, national) groups which can provide information, help and support on a wide range of issues.

Hospital discharge survey November 1992
East Herts CHC
31 pages

Investigates effects of changes to discharge procedures introduced in Sept 1992. Improvements had been made since a survey in April 1992: the dissatisfaction rate was down from 44% to 20%. More checks were being made on home facilities, though many staff continued to assume that patients with regular visitors would have had arrangements made for them.

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The younger disabled people's project

Vivienne Foy for Lancaster CHC, 22 pages

Survey of disabled people in the 16-65 year age group with a wide range of disabilities. A questionnaire (63 respondents) was supplemented by in-depth interviews with people with disabilities and their carers.

An unexpected finding was that people with disabilities did not make particularly heavy use of the health services. Nevertheless, a number of improvements to access are required for when people do want to use the services. The interviews revealed a wide range of needs and perceptions, though again the common theme of difficulties of access emerged. As in many other surveys, there was a severe shortage of speech therapy and a lack of services for people with acquired brain damage. Despite general good will on the part of NHS staff as indicated by their willingness to be interviewed, there is a perceived lack of disability awareness among some of them.

CHC: information epicentre!

David Dredge for Bradford CHC, 58 pages

A report resulting from an information consultancy at Bradford CHC and involving other CHCs in the Region. Drawing on visits and analysis of CHC work, the author presents some theoretical background and practical suggestions on information handling. He believes that unnecessary duplication of work is taking place; to overcome this he recommends a regionally-based organisation with specific functions devolved to local level for centralised collection, indexing and dissemination. He discusses the HEALTHBOX initiative as a way of taking this forward.

If you want to obtain copies of any CHC publications, could you please contact the relevant CHC direct (see directory for phone numbers) and not ACHCEW.

OFFICIAL PUBLICATIONS

An assessment of health and related needs of physically handicapped young adults

Anne Chamberlain, Sally Guthrie, Melvyn Kettle and Janet Stowe for the Department of Health
Available free of charge from: Central Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ

RHAs have been asked to include services for people with a physical disability in their 1993-94 corporate contracts. This report sets out issues to be addressed by NHS purchasers in specifying services for young adults with disabilities that are primarily physical. It concentrates on the needs of people aged 16-30 as they make the transition into adulthood. At this stage in their lives they are faced with four major challenges: consolidating their identity, achieving independence, establishing adult relationships and finding a vocation. Failure to help disabled young people in these tasks will have heavy costs in terms of unfulfilled potential, a heavy burden of disability and many years of dependency for the young people and their ageing families.

The nature of people's disabilities and their needs are complex and varied. Yet purchasers can be guided by some common targets aimed at promoting health and quality of life. These are to take appropriate action on any underlying disease, to maximise the potential for work, to give attention to the needs of carers and to enhance autonomy.

A chapter of the report attempts to estimate the scale of needs, looking at individual conditions as well as the overall picture. However, estimates are variable and local information is crucial to purchasing decisions. The report goes on to draw out implications for services. The needs of people with particular disabilities, experiences of current provision and examples of good practice are discussed. The evidence is also viewed from the perspective of the skills young people need to

develop as they move into adulthood. It is clear that models for interventions will come from several sources: medical, therapy, education and social work. Purchasers must be alive to this and welcome and evaluate innovations from all these fields.

There are chapters on Legislation and guidelines, Models of care, Measurement of outcomes, Targets and Research, and seven appendices giving further details. An important overall recommendation is that a dedicated community-based team should be set up with specific responsibility for young disabled people. The team should include both health and social service professionals and should provide full assessment, treatment and access to specialist services. For this to be achieved, clear agreement will be needed between authorities at the planning, funding and operational levels.

GENERAL PUBLICATIONS

Initiatives in user and carer involvement: a survey of local authorities

Office for Public Management, Occasional Paper No 4

OPM, 252a Gray's Inn Road, London WC1X 8JT; phone: 071 837 9600; fax: 071 837 6581

£10, 52 pages. 4-page summary briefing available at £1.60 for 10 copies.

The survey on which this report is based was carried out as a baseline for the *Margin to Mainstream Programme* funded by the Joseph Rowntree Foundation. The programme aims to support good practice in user-centred community care.

Questionnaires were sent to all social services authorities in England and Wales: just 42 replies were received, a response which indicates that user and carer involvement is still undeveloped in many authorities. While no local authorities involved users and carers comprehensively, there had been progress in some areas. Many respondents are involving people in decisions about individual care, but few are involving users and carers in management of facilities or service quality and very few involve them in allocation of budgets.

For many authorities, the process of involvement is just beginning. Small changes to details of provision are still more common than major ones. There may be resistance to change from staff who are used to acting as advocates on behalf of users and working within systems which support institutions rather than people. It is encouraging to note, though, that those authorities which have longer experience in

user and carer involvement are more optimistic than those which have just started.

The report notes many practical activities listed as achievements by the responding authorities. The report and summary briefing give a list of problems encountered, a checklist for managers (both "foundation activities" and "further initiatives") and lessons for the future.

Consumers Congress Checklist

The Consumer Congress has produced a "Consumer representation checklist" as a contribution to the debate about best practice for consumer organisations. It suggests that organisations fill in the checklist as a group exercise in order to assess how well they represent consumers. The checklist is available in large type, in braille and on tape.

Copies available from: Consumer Congress, 20 Grosvenor Gardens, London W1W 0DH; phone: 071 730 3469; fax: 071 730 0191.

NHS complaints procedures: the way forward

*Consumers' Association. Available from: CA, PO Box 44, Hertford X, SG14 1SH; phone 0800 252100
£10, 27 pages*

Complaints do matter: a consultative paper on future NHS complaints arrangements

*NAHAT. Available from: The Publications Department, NAHAT, Birmingham Research Park,
Vincent Drive, Birmingham B15 2SQ; fax: 021 414 1120*

£6 members, £8 non-members, 48 pages. NAHAT have said they will send a copy to all CHCs

These two reports start from the same premise: good organisations have systems for dealing quickly and effectively with complaints and make use of the information gained to improve services. They agree, too, that the systems in the NHS are too complex, take too long, are off-putting to complainants, are often over-defensive and too often fail to give a satisfactory explanation of conclusions to complainants.

Both reports outline current procedures, the CA publication in somewhat more detail. The CA sets out the strengths and weaknesses of these systems very clearly. The criteria it uses provide a useful checklist: visibility, accessibility, flexibility, transparency, speed/time limits, impartiality, effectiveness, appeals and monitoring. An important change both organisations would like to see is a shift to a more investigative and less adversarial approach. This is partly in recognition of the fact that many complainants want explanations, apologies and assurance of improvements rather than proof of fault. They stress the importance of communications and a readiness to acknowledge errors as soon as they become apparent.

There are differences in approach between the two documents, however. The CA is more determined to see systems from the complainant's perspective. A consequence of this is that its proposed system has more uniform procedures for different types of complaint: the complainant, after all, is not generally particularly concerned with how the NHS chooses to classify complaints. For example, under present arrangements FHSA service panels can hear complaints only if there is a possible breach of terms of service. The hearing thus becomes a scrutiny of the relationship between the FHSA and the practitioner rather than a forum in which the complainant's concerns can be addressed. The CA, therefore, believes formal procedures should be extended to cover non-terms-of-service issues. NAHAT, on the other hand, would retain the distinction. In non-terms-of-service cases NAHAT recommends an offer of conciliation, with an option of an investigation by a "patient satisfaction officer"

(PSO) if the complainant does not agree or remains dissatisfied. In the case of hospitals, too, the CA makes less distinction than NAHAT between complaints concerning clinical judgement and others. Both, however, propose that the various systems should be more alike and call for uniformity across the country.

Both would like to see a separation between complaints handling and disciplinary action/compensation, though NAHAT recognises that this is not wholly achievable.

Neither organisation recommends an external independent body to investigate complaints. However, they do see an increased role for more arms-length overview. NAHAT recommends that independent service panels should be organised to cover several FHSAs or provider units, possibly at a regional level (though they would be held locally). PSOs, however, would be employed at FHSA and provider unit level. The CA goes a step further. It would prefer the whole system to be run at Regional level, with "complaints officers" operating locally but under RHA administration.

There are additional points of detail which will be of interest to CHCs. The CA wants the ban on legal representation for complainants to FHSAs to be lifted. NAHAT recommends that complaints to FHSA should be made within 13 weeks of the date on which the cause for complaint first came to the complainant's notice (not from the event itself). PSOs should be able to override this time limit if there is good reason. The CA also recommends that a practitioner should not be able to veto the investigation of a late complaint. NAHAT recommends that CHCs should have an input into the audit of complaints at provider units and FHSAs. They should receive adequate resources for this and for training in their complaints role. NAHAT also recommends that complaints arrangements should cover all NHS-initiated care, whoever provides it.

ACHCEW will be responding to both these documents. Comments from CHCs on any aspects of NHS complaints systems, or copies of their responses, would be very welcome.

The right to take risks

*Counsel and Care, Twyman House, 16
Bonny Street, London NW1 9PG
phone: 071 485 1550; fax: 071 267 6877
£5 (£4 on orders of 10 copies or more),
35 pages*

A pack containing model policies, staff guidance and training material on restraint and risk taking in residential care and nursing homes of old people. Includes sections on "A classification of restraint"; "Policies and guidelines", (on principles, care plans, residents with particular needs, and communications) and "Training material".

People not parcels

*Counsel and Care, as above. Available free
with large stamped addressed envelope.*

7 page discussion document on the use of electronic tagging on older people in residential care and nursing homes.

Countdown to community care

*Richard Gutch and Doreen Cope for
Arthritis Care, 18 Stephenson Way,
London NW1 2HD;
phone: 071 916 1500; fax 071 916 1505
£5, 32 pages*

Report assessing the implications of the community care reforms for people with arthritis – some 10 million people in the UK. It challenges the adequacy of community care plans, which tend to emphasise nursing and residential care at the expense of a more comprehensive approach. Section four sets an agenda for action.

Doctors and their patients

*Martin Rathfelder for the North Western
RHA and Greater Manchester Welfare
Rights Advisors Group.
20 pages, available in printed or electronic
form. Contact Martin Rathfelder, Welfare
Rights Officer, Manchester Royal Infirmary,
Oxford Road, Manchester M13 9WL;
phone: 061 276 4197.*

Pamphlet for doctors who want to advise patients on how to obtain social security benefits (related to medical conditions). Can be used to help patients who are not aware of their entitlement or do not know how to make a claim. Slightly out of date (June 1992), but it could easily be updated and adapted for use in another area.

Winterton Action Pack

*The National Childbirth Trust
Alexandra House, Oldham Terrace, London
W3 6NH, phone: 081 992 8637
£5, 45 pages*

A pack aimed mainly at NCT branches outlining practical steps for ensuring the voices of the users of maternity services are heard by those planning and purchasing the services. Written to help achieve the standard of care and service advocated in the Winterton Report (see CHC News No 71).

Ultrasound ??? Unsound

*Beverley Lawrence Beech and Jean Robinson
in AIMS Journal: Association for
Improvements in the Maternity Services, Vol
5, No 1, Spring 1993
Available from The Publications Secretary,
Goose Green Barn, Much Hoole, Preston,
Lancs PR4 4DT
£5.75 (inc p&p), 30 pages*

A special issue which raises doubts about ultrasound exposure in the womb. Includes 16 articles reviewing the current state of knowledge and calling for safeguards and better evaluation.

Training for lay participation in health: Token voices or champions of the people?

The Patients Association

72 pages, free of charge from: The Patients Association, 18 Victoria Park, Bethnal Green, London E2 9PF;
phone: 081 981 5676/5695; fax: 081 981 6709

This report, based on interviews, questionnaires and a literature review, seeks to identify key areas in which training is needed if lay representatives are to be effective in their role. Most of the report is on the common needs of lay representatives: there have been studies of specific areas, such as CHCs, but too often different groups of representatives work in isolation and are unaware of developments in other areas. As well as being of general interest, the findings should be of specific interest to CHCs: of the 190 completed questionnaires, 46 were from CHC members.

Part A looks at current definitions of lay people and why their work should be valued. In contrast to the negative official definition of a lay person, it defines lay people as providing "a means of listening to what the patient or consumer wants and needs and ensuring that services are developed to meet those needs". By taking this view, the positive contribution lay representatives can make becomes clearer. It also follows that training should not be used as a way of removing differences between the professional and the lay view, but rather as one way of fostering mutual understanding. This section also stresses that training by itself is not enough: it must be linked to other developments such as clarifying feedback processes, establishing contact with under-represented groups, providing adequate resources for lay representatives and making structures more responsive.

Part B concentrates on the training and support needs of lay people. It includes a sub-section on CHCs and identifies a wide range of motivation and experience among CHC members. Expectations of CHCs are high and CHCs are having to deal with a large volume of complex work; both staff and members need considerable support if they are to live up to expectations. The PA identified the following areas of training need for CHCs:

- ♦ Verbal and written communication and listening skills.
- ♦ Assessing when consultation is and isn't helpful, how to go about it and creating effective community networks.
- ♦ Skills associated with meetings.
- ♦ Keeping up to date with changes and their implications.
- ♦ Stress management and assertiveness.
- ♦ Building bridges with professionals, joint seminars.

There are sub-sections on other specific groups and a summary of common training needs.

The final section looks at current training provision, which again includes a section on CHCs. A large number of training initiatives are already under way. The authors conclude that simply making existing resources more widely available would produce immediate benefits. The funding required for lay people to access training is not necessarily very high, but such training is often beyond the means of small self-help groups and voluntary organisations.

INFORMATION WANTED

Basildon and Thurrock CHC believe that GPs may be under pressure to reduce the number of sickness certificates that they issue. The CHC would like to hear from other CHCs which have any information or comments.

Pontefract and District CHC would be very interested to hear from any CHC which has been successful in opposing a hospital closure to the extent that the Minister has overturned a health authority's closure decision.

Winchester and Central Hampshire District CHC has learned that its local district general hospital is "rationalising" weekend rotas: some specialties are alternating emergency admissions at weekends with a neighbouring hospital, the main reason given being problems with junior doctors' hours. The CHC would be interested to hear from any other CHCs which have come across this or similar practices.

Deadline: If you have any items for the next issue of *CHC News* could you please get them to ACHCEW by 12 May.

FORTHCOMING EVENTS

Consent and the reproductive technologies

- ♦ one-day conference
- ♦ organised by the Social Science Research Unit, Institute of Education
- ♦ on 22 June 1993
- ♦ at Institute of Education, Bedford Way, London WC1
- ♦ £25/£5 unwaged

Further info from:

Consent Conference Secretary
Social Science Research Unit
Institute of Education
18 Woburn Square
London WC1H 0NS
Phone: 071 612 6397/6391

Listening, informing and influencing

- ♦ a seminar following up the Local Voices DoH publication
- ♦ suggested as useful for CHC secretaries and members
- ♦ organised by IHSM
- ♦ at London
- ♦ on 4 June 1993
- ♦ £120 + VAT members/ £130 + VAT non-members

Booking forms from:

Michelle Teer
Conference Secretary – Seminars
IHSM
75 Portland Place
London W1N 4AN
Phone: 071 580 5041; Fax: 071 255 1289

Mental health in the countryside: rural needs, rural services

- ♦ one-day conference
- ♦ organised by Good Practices in Mental Health as part of its Rural Initiative
- ♦ on 21 May 1993
- ♦ at Somerset County Cricket Ground, Taunton
- ♦ £65 (some free places available for unwaged service users)

Further info/booking forms from:

Jan Sherlock/Liz Wyatt
GPMH
380-4 Harrow Road
London W9 2HU
Phones: 071 289 2034/3060

Evaluating quality

- ♦ two-day conference on evaluating services for people with disabilities and elderly people
- ♦ organised by the Rehabilitation Resource Centre, City University, London
- ♦ on 18-19 May 1993
- ♦ at 336 Brixton Road, London SW9
- ♦ £150 (some free places available for service users)

Further info from:

Margaret Mullany
The Conference Administrator
Rehabilitation Resource Centre
City University
Northampton Square
London EC1V 0HB
Phone: 071 477 8378
Fax: 071 477 8579

Release: one-day training courses

- ♦ **The Criminal Justice Act 1991**
- ♦ 23 June, Plummer Court, Newcastle, £40
- ♦ **Giving telephone drug advice**
- ♦ 12 May, Plummer Court, Newcastle, £40
- ♦ 20 May, Charing Cross Centre, Norwich, £45
- ♦ 25 May, Cheshire Drug Training, Northwich, £45
- ♦ **Children, drugs and the law**
- ♦ 24 June, Plummer Court, Newcastle, £40
- ♦ **Drugs and the law**
- ♦ 13 May, Plummer Court, Newcastle, £40
- ♦ 21 May, Charing Cross Centre, Norwich, £45
- ♦ 26 May, CDTIC Theatre Court, Northwich, £45

Further info from:

Alasdair Cant
388 Old Street
London EC1V 9LT
Phone: 071 729 5255
Fax: 071 729 2599

or (for Newcastle courses)

Dave Hicks
Plummer Court
Carlisle Place
Newcastle upon Tyne
Phone: 091 230 1300

User and carer involvement in community care: kick starting process

- ◆ series of one-day programmes organised by Office for Public Management
- ◆ Drawing the line, 14 May
- ◆ Kick starting change, 16 June
- ◆ Reskilling management, 14 July
- ◆ all at St Albans Centre, Baldwin's Gardens, London EC1
- ◆ £182.13 per programme (discounts for more than one)

Further info from:

Judy Spry
Education Programme Manager
Office for Public Management
252b Gray's Inn Road
London WC1X 8JT
Phone: 071 837 9600; Fax: 071 837 6581

Health care reform in Britain and America

- ◆ one-day conference
- ◆ organised by the Institute of Economic Affairs and the American Enterprise Institute
- ◆ on 28 June 1993
- ◆ at St Ermin's Hotel, Caxton Street, London
- ◆ £141 (discounts for bookings before 7 May and subscribers to the IEA)

Further info from:

Annette Chandler
IEA Health and Welfare Unit
2 Lord North Street
Westminster
London SW1P 3LB
Phone: 071 799 3745

Care in the community: understanding benefit changes

- ◆ one-day course
- ◆ organised by Disability Alliance
- ◆ on 26 May and 17 June 1993
- ◆ at HERA Training Centre, 2 Valentine Place, London SE1 8HQ
- ◆ £75 members/£90 non-members/£50 concessions

Further info from

Training/Membership Worker
Disability Alliance ERA
Universal House
88 Wentworth Street
London E1 7SA
Phone: 071 247 8776; Fax: 071 247 8765

Success at what price?

- ◆ public meeting on setting criteria for success in research and evaluating outcomes of research and treatment
- ◆ organised by Consumers for Ethics in Research
- ◆ 5.30 p.m. on 15 June 1993
- ◆ at The Institute of Education, Bedford Way, London WC1
- ◆ free of charge

CERES would be grateful if you would let them know if you plan to attend. Contact:

CERES
PO Box 1365
London N16 0BW
Phone: 0732 458021 or 081 802 8231

Copies of info notice from: 0703 582492.

DIRECTORY AMENDMENTS

- | | |
|--|---|
| <p>Page ii NW Thames Region CHCs
 Change of address:
 North West Thames Region CHCs
 'D' Block, North Wing
 Bedford Hospital
 Kimbolton Road
 Bedford MK40 2NU
 Direct line: 0234 345714
 Assistant: 0234 327427 Ext 3719</p> <p>Page iii North West Regional Association of CHCs
 Fax: 061 833 3839</p> <p>Page 2 South Cumbria CHC
 Chief Officer: To be advised</p> <p> West Cumbria CHC
 Secretary: Bernard Kirk</p> <p>Page 3 Grimsby CHC
 Change of address w.e.f. 26 April
 New Oxford House
 2-4 George Street
 Grimsby
 DN31 1HB</p> <p>Page 9 North Herts CHC
 Chief Officer: Peter Coleman
 Phone: 0462 459629</p> <p>Page 11 Bloomsbury CHC
 Change of address w.e.f. 14 April
 197 Kentish Town Road
 London NW5 2JU
 Phone: 071 284 1504</p> | <p>Page 18 West Dorset CHC
 Fax: 0305 251302</p> <p>Page 19 Wycombe & District CHC
 Fax: 0494 474756</p> <p>Page 20 Bristol CHC
 Frenchay CHC</p> <p>Page 21 Southmead CHC
 Weston CHC
 w.e.f. 1 April, these four CHCs have merged to form Bristol and District CHC. At the time of going to press, no decision had been made on the location of the newly formed CHC, nor had a Secretary been appointed. As soon as details are known, we will advise you.</p> <p>Page 25 Halton District CHC
 Change of address
 74 High Street (above Trustee Savings Bank)
 Runcorn
 Cheshire
 WA7 1BR
 Phone: 0928 560926</p> <p>Page 28 Manchester Central CHC
 North Manchester CHC
 South Manchester CHC
 Fax: 061 833 3839</p> <p>Page 31 Llanelli/Dinefwr CHC
 Phone: 0554 742240 (Secretary 24 hour answer phone)
 0554 742210 (assistant)</p> |
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