# CHC NEWS

ASSOCIATION OF **COMMUNITY HEALTH COUNCILS** FOR ENGLAND & WALES

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30 Drayton Park London N5 1PB Tel: 071 609 8405 Fax: 071 700 1152

# NEWS

## Suspended treatments

Five months into the financial year, five hospitals have suspended non-urgent treatment under at least one of their contracts. University College Hospital (UCH) and the Middlesex have been told to stop such treatments by Camden & Islington Health Authority; the Royal London, the Royal Orthopaedic Hospital and the Royal National Throat, Nose and Ear Hospital have been told to do so by Redbridge & Waltham Forest Health Authority.

UCH has a contract from Camden & Islington to treat about 1000 patients a month, but it had treated 3600 in the first quarter of the year. The DHA is proposing to switch most of its patients to cheaper hospitals outside central London. UCH says that this will force the closure of its accident and emergency service and will put the future of the hospital at risk. It has already planned bed closures and is to make 30 of its 150 consultants redundant. The hospital claims that the DHA has underestimated the number of patients who need treatment, and argues that costs cannot be brought down until the facilities are centralised (at present the unit comprises UCH, the Middlesex, Elizabeth Garrett Anderson Hospital and the Hospital for Tropical Diseases).

Sir Bernard Tomlinson, who proposed the closure of some London hospitals, has called for management of the process of change and for extra resources for London hospitals. He would be "horrified" if reorganisations in other cities were as disorganised as that in the capital. Virginia Bottomley, however, has indicated that the momentum of change will be maintained. She rejected suggestions that UCH/Middlesex would close, but also stated that DHAs do not have a loyalty to any particular hospital. She pointed out that the hospitals were continuing to accept all urgent and emergency work – a defence of the situation which we seem to be hearing with increasing frequency.

*Daily Telegraph 28 August, 3 September*

## Avoidable deaths

The National Confidential Enquiry into Perioperative Deaths has published its report covering 1991/92. It reveals a wide range of death rates, and some identifiable deficiencies in care. A notable finding was that many patients are dying from deep vein thrombosis. Blood thinning drugs are not always given when they are indicated and it is unclear to what extent simple preventive measures are used.

Another finding is that some hospitals lack facilities such as properly staffed and equipped recovery rooms, operating theatres dedicated to emergencies 24 hours a day or enough intensive therapy beds. In some cases inexperienced doctors were carrying out operations without adequate supervision and some operations were unnecessary.

The enquiry receives information from surgeons and anaesthetists on a voluntary basis. For this report 1381 surgeons reported on 2739 deaths. Five surgeons refused to cooperate and information was not available in about one-third of cases. The death rate following surgery is about 0.6%, almost all among old or very sick patients.

*Independent 8 September*

## Hospitals not meeting standard

Audit Commission figures have shown that many hospitals are failing to meet Patient's Charter standards: 73% of out-patients are seen within 30 minutes of the appointment; 74% of A&E patients are seen immediately for assessment; and 78% of hospitals admit a patient within a month if his/her operation has been cancelled twice.

*Daily Telegraph 24 August*

## An informed prescription?

The NHS drugs bill has increased yet again. It went up by 9.6% in real terms last year.

The Health Minister, Dr Mawhinney, has called for everyone to play a part in reducing unnecessary spending on prescriptions. "We have come to expect a pill for every ill. We should be ready to accept a doctor's advice and reassurance on minor ailments, rather than expecting a prescription at the end of a consultation" he said. Unfortunately the articles reporting his comments do not state whether they are based on any formal studies – on whether patients *do* demand a pill for every ill, and whether they *are* offered advice and reassurance – and time – as an alternative.

Dr Mawhinney also called on doctors to prescribe non-brand name drugs more frequently (last year only two out of five

prescribed items were for non-brand name drugs) and to control the number of repeat prescriptions (see National Audit Office report in Official Publications).

The argument that too many medicines are being prescribed has been challenged by the Association of the British Pharmaceutical Industry. The average number of items in Britain last year was 8.8 per head, compared to 38 in France, 21 in Italy and 17 in Portugal.

Another way of reducing the drugs bill is to reduce the price of drugs. It seems that threats by the Department of Health to disallow NHS prescriptions of overpriced drugs have already triggered price cuts. In August, the price of the sleeping pill Zimovane fell from 98p per tablet to 16p. The limits on drugs which may be prescribed on the NHS seem increasingly to be informed by cost considerations – manufacturers are being presented with benchmark prices they must offer if their products are to qualify for inclusion on the accepted list. And for the first time, GPs controlling their own budgets have a financial incentive to back moves to reduce prices.

In addition to this, the Government has ordered drug companies to cut prices by 2.5% under the pharmaceutical price regulation scheme which governs the profits which drug companies can make from the NHS.

*Telegraph 9 & 20 August, Guardian 11 August, Independent 20 August*

## Unit for health needs of ethnic groups

The Department of Health is setting up a unit to address the health care needs of people from ethnic minority groups. The unit will highlight good practice and identify areas for research. One aim will be to improve equality of access to services. A recent survey in Leicester found that half the Asian women surveyed did not know about cervical smears. The unit intends to monitor purchasers and providers to see that they are including people from ethnic groups in prevention programmes. Junior Health Minister, Baroness Cumberlege, also said that more women doctors are needed, especially to meet the needs of many women from ethnic minority groups. Another focus will be the different health needs of different groups arising from differences in the incidence of certain illnesses, such as schizophrenia, thallasaemia and sickle cell disease.

*Guardian 12 August*

## Ombudsman doubts heaven on earth

The Ombudsman, William Reid, has called for the public to have open access to his services. At present, complaints can only be referred to him by MPs, but 150 (unnamed) MPs have never passed on a complaint from a constituent. Mr Reid tends to the interpretation that complaints are not getting through, rather than the alternative – that some constituencies are in a state of nirvana.

The Ombudsman already investigates complaints about the DSS, Inland Revenue, Customs & Excise and other Government departments, as well as the NHS. From next April, he will be able to look into complaints that Government departments are unjustifiably withholding information. He has asked for more staff to achieve this – he has just 113 and a half staff, of whom 29 deal with NHS complaints.

His job would be made easier if complainants were referred to him correctly. Some CHCs and health authorities have been sending letters to the Local Government Ombudsman in error, or inviting patients to raise matters outside his jurisdiction. He has made a plea for CHCs to get it right – the correct address is in ACHCEW's leaflet on Patients' Rights, but for the record is: Parliamentary Commissioner for Administration, Church House, Great Smith Street, London SW1P 3BW.

*Independent 20 August 1993*

## Advertising waiting lists

West Midlands RHA has published a league table of waiting times for operations in the region under the names of individual hospital consultants. The RHA argues that the public has a right to the information, which has been circulated to GPs for several years. A local newspaper donated a four-page advertisement for the purpose. Local doctors are angry at the move, arguing that they are being scapegoated when long waits are due to funding shortages and to pressure from management to give priority to patients of fundholding practices. They also claim that the published figures are inaccurate

*Telegraph 6 September, Guardian 6 & 10 September*

## Causes for concern

There has been a spate of reports about possible serious side-effects of treatments given to NHS patients, and about blunders on the part of NHS staff:

**Creutzfeldt–Jakob Disease fears**

Some 300 women who received fertility treatment with hormones prepared from human brain tissue may be at risk of developing a degenerative brain disease related to bovine spongiform encephalopathy. Four Australian women who were injected with human pituitary gonadotrophins have developed Creutzfeldt–Jakob Disease (CJD). It may take up to 35 years for symptoms to develop, and the disease is incurable. The Government has asked GPs to check records to identify patients at risk, so that they can contact the national coordinating centre at the Jessop Hospital for Women in Sheffield. There is a freephone helpline on 0800 979797 for women who think they may be at risk. The treatment also involved the collection of 24-hour urine samples – this may help women to distinguish it from other fertility treatments. Its use was discontinued in 1985.

Several thousand more patients may be at risk of developing CJD. It is possible that the disease can be contracted from a graft of human tissue trade-named Lyodura. Between 1971 and 1991 (when it was withdrawn from the UK) the graft was used by neurosurgeons who inserted it into the brain during certain operations. At least nine patients treated with Lyodura have subsequently died from CJD, three of them in the UK.

*Independent 2 September*

**Misdiagnoses of bone cancer**

The cases of 2300 cancer patients are to be re-examined following an enquiry into the bone tumour service at Birmingham's Royal Orthopaedic Hospital. The enquiry was set up by South Birmingham Health Authority after it was found that a 9 year old boy had been given needless chemotherapy. Another 42 cases diagnosed by pathologist Dr Carol Starkie have already been identified as probable misdiagnoses. The enquiry, headed by a pathologist from Newcastle, criticised Dr Starkie, two consultants in the hospital, and the hospital as a whole. The pathologist was accused of a dogmatic and confrontational approach and a reluctance to seek a second opinion. Although the two consultants had expressed doubts about the diagnoses over several years, they had failed to speak out officially (and they believed that the health authority had over-reacted in setting up an enquiry). Even when it was realised that patients were at risk, the hospital did not take decisive action, said the enquiry.

The health authority has since said that people claiming to have been wrongly diagnosed or treated will not automatically be entitled to compensation: "It depends on what they are claiming and if in their case medical negligence is demonstrated".

*Times 27 August, Guardian 28 August*

**Radiation side-effects**

RAGE, a group which campaigns for women suffering from the effects of radiation exposure during treatment for breast cancer, hopes to launch a group action for compensation for side-effects once it has completed a survey of all the cases it has come across. Over 550 women have contacted the group during the last six months, saying that they have suffered from side-effects including swelling of the arms and chest, limited use of hands and arms, burns to the skin and lungs and severe pain.

It is not yet clear whether the women concerned are among the estimated 1% who react badly to radiation, or whether hospitals are using faulty techniques. Dr Clive Harmer, a radiotherapy specialist in London, says that it is now known that larger doses given over a shorter time can substantially increase the risk of radiation damage. He believes that most hospitals had stopped using this technique 4–5 years ago. However, RAGE claims that it knows of cases where the shortened treatment is still being used.

RAGE can be contacted via 071 837 2808.

*Times 20 August*

**Faulty smears**

For two and a half years a nurse in a GP practice in Birmingham was using a broad wooden spatula to take cervical smears instead of the specially shaped spatula designed to collect the correct cells. The nurse has since been dismissed. 1100 women have been recalled for repeat tests.

Smear tests go through several stages, and mistakes can occur at any of them. Survey findings indicate that between 4% and 12% are not taken properly.

*Times 9 September*

# FROM THE JOURNALS

## Casualty departments compared

*Which?*'s survey of A&E departments received responses from 133 health authorities. Its findings revealed a predictable variability, from no standards, through low standards to high standards. (One London district had clarified the standard of immediate assessment by a doctor or nurse: "immediate" was interpreted as "within an hour".) The variability comes on both the purchaser and the provider sides: one district appointed a director of quality assurance with eight full-time staff engaged on various projects. Others added the responsibility on to the full-time job of an existing member of staff. One of these said that it was up to hospitals to monitor themselves and that in the new NHS DHAs should not "interfere" with the details of how services are provided.

*Which?* takes a refreshingly no-nonsense approach to our needs for an A&E service. It quotes the Government's response to the Tomlinson report: "Too many hospitals provide accident and emergency services and these need to be rationalised" ... "in other words cut" explains *Which?*. The report does not agree with the Government. Nine of the responding health authorities set a target waiting time of four hours for non-urgent cases. This, *Which?* simply says, is not acceptable and it is difficult to see how the waits can be reduced if there is a radical reduction in the number of A&E departments.

Arguments for fewer well-equipped centres are increasingly heard in the NHS. While allowing that such arguments have some merits, *Which?* points out that most patients attending A&E have relatively minor injuries or illnesses. They want and need a local, accessible service. And they should not simply be dismissed as "inappropriate attenders" who should have gone to their GP. Many people go to A&E because they suspect (often rightly) that they may need services that GPs don't provide, especially in the middle of the night.

The report concedes that a few small A&E departments might have to go, but calls for improving services at others by bringing GP and nurse practitioner services into them.

*Which? Way to Health August*

## Minor surgery by GPs

An estimated £23 million was paid to GPs for minor surgery in 1991 under the terms of the 1990 contract. This research sought to determine how far minor surgery carried out by GPs under the contract has substituted for hospital out-patient workload.

Figures from 22 practices for the first quarter of 1990/91 were compared with those from the first quarter of 1991/92. These showed a 41% increase in surgical procedures carried out by GPs. However, referrals to hospital for conditions treatable by minor surgery, and the minor surgery procedures carried out among these referrals, did not fall. Overall, therefore, more minor surgery was being carried out among these practice populations. There has not been a simple transfer of treatment to more cost-effective settings.

Much of the article discusses why. The authors conclude that it is not because GPs were treating more trivial conditions (for example shifting towards more cauteries as compared with excisions, which are more complex). However, since the severity of lesions etc. is rarely recorded, they cannot rule out the possibility that GPs are treating less serious examples of each diagnostic type. GPs may be meeting needs which they previously had felt unable to meet. Shorter waiting times and greater convenience may make patients readier to seek treatment, as may greater awareness of the service.

*BMJ 14 August*

# NEWS FROM ACHCEW

**Rose Walter**, who has worked for ACHCEW since 1979, is retiring. This is not the first time she has retired. She first did so in 1981, but was persuaded to come back part-time to help out initially on a temporary basis and has done so ever since. Many CHC members and staff who have met her at ACHCEW AGMs, or have spoken to her on the phone, will want to join the staff of ACHCEW in wishing her well on this, her second retirement.

# AROUND THE CHCs

Graham Girvan, Secretary of **Bexley CHC**, has elicited an uncharacteristically contrite response from the Department of Health. An Assistant Private Secretary at the Department has written to Graham admitting the department wrong, and regretful, on all counts. His letter demonstrated a complete U-turn in approach. Sadly the issue prompting this refreshing attitude was nothing more than the failure of officials to adhere to the basic courtesies in their style of letter writing. Perhaps, though, while they are in this mood ...

**Burnley, Pendle & Rossendale CHC** has launched a new magazine, HealthWatch. With plenty of photos and other illustrations, it is produced in-house. It is hoped that the magazine will raise issues for debate in the community and contributions from readers are invited. It will also be used to disseminate information about the CHC and its work and about local services and to stimulate improvements. The first issue investigates why almost a quarter of pregnant women in the area have their babies in hospitals outside the district and presents findings from their monitoring of local maternity services. It also explains the new structure of the CHC, discusses the role of complaints and presents smaller items of local health service news.

**Deadline**

If you have any items for the next issue of *CHC News* could you please get them to ACHCEW by 6 October.

**Lambeth CHC** is calling for a change in complaints regulations after a case in which it has taken three years for a local GP to be suspended. Three women brought complaints that Dr Asirifi had carried out long and sometimes unnecessary breast and internal examinations on them. Dr Asirifi joined the Clapham Manor Health Centre in September 1990 and the first complaint was received a month later. Complaints from the three women where brought before the FHSA Medical Service Committee in June 1991, which found in each case that Dr Asirifi had breached his terms of service. However, the FHSA had no power to suspend him. The case was referred to an NHS Tribunal. It was heard in July 1992 and a decision that Dr Asirifi should not practise was issued in October 1992. Dr Asirifi appealed to the Secretary of State, and still could not be suspended, though he did agree to take extended leave. The appeal was heard in August. The Tribunal's decision was confirmed and Dr Asirifi was immediately removed from all NHS GP lists. The case has now been referred to the General Medical Council which could decide to strike him off the medical register. The GMC does not look at cases while they are being investigated within the NHS.

Shelley Eugene, Chief Officer of Lambeth CHC, has called for the current Complaints Review to consider the inability of FHSAs and the NHS Tribunal to suspend doctors being investigated for gross misconduct. She was also very critical of a system which expected some of the women to give evidence three times.

# CHC PUBLICATIONS

**Staff induction programme**

*North West Thames CHCs*

This programme for the induction of CHC staff below chief officer level was developed by Julie Cox with the support of Riverside CHC. It opens with a number of suggestions for the overall induction process, then moves on to specifics. A timetable (which can of course be adapted) sets out two weeks worth of activities, including meetings, work activities, visits, time for reading etc. Items which should be covered by the chief officer and assistant chief officer in two or three sessions each are listed. It is recommended that joint sessions are held to cover an issue of importance to the CHC. The example used here is NHS complaints procedures. Sample materials on this which might be included in an induction pack are appended.

**Partners in purchasing? The role of the CHC in commissioning health services**

*Greater London Association of CHCs, 356 Holloway Road, London N7 6PA, phone: 071 700 8125, 40 pages, £9*

*NOTE NEW ADDRESS.*

Take the usual recipe: limited resources, new roles within the NHS, increased demand for help with complaints. Add in an extra dash of uncertainty (26 of the 32 CHCs responding to this survey are working with DHAs which are about to be merged or whose boundaries are changing). It is perhaps surprising that there is any agreement between CHCs and DHAs on the role of the former in purchasing. However, this survey of CHCs in the Thames Regions and interviews with four DHA purchasing directors did find some agreement, particularly over such aspects as specification of standards and monitoring.

An important area in which views differed was involvement in priority setting. Most CHCs wanted to steer clear of it, and two of the DHA purchasers could see that CHCs would be in a difficult position if they became involved. However, another DHA purchaser thought that CHCs would be irrelevant unless they took part in rationing decisions. Under this view, in effect, CHCs can't complain if they were involved and can't complain if they weren't. This is part of the more general issue of the independence of CHCs. Not all the DHAs appear to appreciate the importance of this, hoping to use CHCs as a junior partner in the purchasing role and in some cases as extra "pairs of legs". One of the purchasers, however, thought that a role of the CHC was to challenge the DHA. Overall, even where there is a perceived role for CHCs, it is undeveloped in practice. Involvement tends to be informal and *ad hoc*. This may change as DHAs become more certain of their own role.

This report investigates current CHC involvement throughout the commissioning cycle and CHC relations with purchasers. There is a section on the distinctions between the roles of CHC members and CHC officers (insofar as there is a difference, members are more likely to be involved in provider issues and specifics, rather than structural issues and purchasing) and between the roles of the CHC and the DHA. A section on "the future" summarises best practice, looks at ways of increasing effectiveness and sets out issues to be addressed. Recommendations are made for CHCs, DHAs, RHAs and the NHSME.

**Evaluation of a Community Health Council's complaints work**

*Rory O'Kelly and Beverley Thompson, Lewisham CHC, published by GLACHC, as above. 22 pages, £2 single copies, discounts for more*

Complaints work presents an opportunity for CHCs to evaluate their activities: it is easy to say who the clients are and feasible to ask them about the value of the CHC to them. The same cannot be said for activities such as commenting on health authority plans.

This report is based on surveys of complaints handled during 1989 and 1990, results from the first year being used to refine the survey form used in the second year. The researchers tried to design questions which would separate out respondents' views of NHS complaints systems in general from their views of how useful the CHC had been to them, with a degree of success. Many more respondents found the CHC "extremely useful" (63%), than were "completely satisfied" after the complaint (20%) or thought the NHS procedures for handling complaints "completely fair" (29%). At the other end of the scale, 12% of respondents thought the CHC "completely useless", whereas 23% were "not at all satisfied" with the outcome. Dissatisfaction was higher with complaints against hospitals than against any other category of service.

A finding with practical implications was that complainants valued CHC independence and assertiveness. Those who considered the CHC useless thought it lacked these characteristics; those who found it useful thought it possessed them. Some CHCs are seeking to "empower" complainants to act for themselves (thus reducing direct CHC assistance). Some health authorities are hoping that improved internal procedures will reduce the need for independent advocacy. It seems that respondents to this survey do not agree with either of these views.

The authors comment that the people who approach the CHC for help are not a random cross section of health service users, or even of dissatisfied users. This makes it difficult to interpret how well the CHC is doing in its complaints work. A fuller picture might emerge if a number of CHCs were to undertake evaluations. This exercise did, however, identify areas where improvements could be made: keeping complainants informed of progress even where not much is happening and discussing the responses they have received.

**Care of the dying**
**Experiences of people who have cared for someone who has died of cancer**
*Northumberland CHC, £5, 66 pages*

This careful and detailed survey makes moving reading. Where services have met people's needs the carers show enormous appreciation; where they have not, the effects on carers can cause sorrow and bitterness. The sense of gratitude or of regret clearly lasts long after the services were rendered. Carers' comments also convey a sense of just how important good or inadequate services have been to patients in their last weeks or months.

The report is based on a survey of 107 carers contacted through district nurses: 22 were interviewed, and 85 completed a questionnaire. A great many positive responses were received on nearly all counts, though some of the deficiencies are noted below. Carers were asked about the information provided to them (what information, how it was given, its timeliness and clarity). Only 6% reported being given written information – a clear lack when many of them found it difficult to take in the information on first being told it. Nearly half the patients had been told of their condition when the carer was not present; in a number of these cases, the carers thought they should have been there. Carers were asked about support provided by various professionals. A large number of positive comments show the importance patients and carers attach to having a dependable health worker whom they feel free to contact whenever they need to, even if only for reassurance or someone to talk to. The few negative comments show up how isolated and frightened people can feel if health workers seem not to have time for them or seem unconcerned. GPs, district nurses, night nurses, Macmillan nurses and home helps all came in for praise, though quite a few respondents commented on the need for more provision of the last three services. Many respondents valued highly the ability to look after their relatives at home, given enough support from professional services and others.

Three areas of questioning show up where more could be done for a significant number of people. One was on benefits. A number of carers were told too late of benefits for which they might be eligible, and many had not received this information at all. The second was when patients were admitted to hospital: communications between hospitals and carers could be improved. The last was bereavement services. A third of the carers said they had received no bereavement visits, and 62% of these would have welcomed a visit. Some of the comments in the report make it clear how carers felt suddenly cut off when they had a lot of questions to ask and feelings to work through.

This survey was carried out with the involvement at all stages of the Northumberland manager of the Macmillan Service and the report has been circulated widely in the district. It is to be hoped therefore that it will be acted upon where necessary. It would also be useful to other CHCs considering work in this area.

**Mobility aids and appliances: a study of the supply and management of aids and appliances for children and young persons with disabilities**
*Stockport CHC*

There are some very angry parents in Stockport, and presumably some angry young people as well. They have had to wrestle with the system for getting the mobility aids that they need. This report is based on interviews, questionnaires and visits to the health authority and manufacturers. There are some positive comments – from some people and on some aspects of the services. But the overwhelming impression is of frustration on the part of those who already have a lot to deal with. Information is inadequate (and at times seems to be wilfully withheld), delays are long and unpredictable, quality is variable, and the wastage is frustrating (one parent describes sitting down and crying after a pair of hand-made boots worth £400 arrived after seven months – they were too small). Parents and users often feel they are not listened to, despite their day-to-day experience: "The voice of the consumer holds no value. Suggestions for improvements are treated as complaints." The catalogue of deficiencies could continue, but perhaps it is enough to point out that a few parents (with enough money) buy their aids direct from the manufacturer, by-passing the problems they have experienced when going through the NHS. It is surely not acceptable that the recommendations should still need to include a call for the definition and publication of standards for quality, safety and delivery times.

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

IN BRIEF

**Maternity services in Dorset**
*East Dorset CHC in collaboration with West Dorset CHC*

This survey is based on responses from 708 women living in Dorset who have recently had a baby. The questionnaire covered all stages from confirmation of pregnancy through to post natal care. The report includes details of services offered and satisfaction ratings and a list of specific recommendations.

**CHC and Trust relations in NW Thames Region**
*Julie Cox, North West Thames CHCs, 10 pages*

Table setting out findings from 11 CHCs under the headings: CHC, Trusts in district, Observer status, Meetings/ joint working, Relations, Comments.

**Services for elderly people at the Royal Oldham Hospital**
*Oldham CHC, 28 pages*

Reports on visits to all wards and departments offering services to elderly people. Day care provision for mentally infirm patients was considered excellent. There were more (though not severe) criticisms of hospital wards, among them that the decor on male wards was poorer than on female wards. Members were sceptical of the explanation that "this is how the men prefer it"! The CHC calls for the prominent display of charter standards, and a stricter adherence to them.

**A guide to choosing a nursing home in Bradford**
*Bradford CHC, 56 pages, £2.50*

An introductory section on choosing a nursing/residential home, then an alphabetical listing of nursing and residential homes, describing in some detail accommodation, fees, staff, food and "general", all clearly set out.

**Guide to nursing and residential care**
*Wandsworth CHC, 36 pages, free to callers*

Introduction and alphabetical listing, giving details of homes. The middle pages of this stapled booklet is a pull out checklist with five columns of tick boxes enabling readers to make an easy comparison of five homes.

**Recommendations towards standards for CHC offices in health & safety, accommodation and security**
*NW Thames CHCs*

Sets out proposed standards on the above, which have since been accepted by NW Thames RHA. Appended are:

- guidance on regulations concerning Display Screen Equipment Work
- brief NHSME guidance on six H&S regulations which came into force on 1 January 1993
- tabulated results on safety & security arrangements in NW Thames CHCs, office accommodation, access and opening hours.

IN BRIEF

**Tranmere research project**
*Wirral CHC, 44 pages*

Rapid appraisal techniques were used to try and ascertain the health needs of people living in Tranmere – a community with more than its fair share of health problems. The research involved open-ended questioning of key informants in the community. These key informants were asked to suggest other people for interview. Every effort was made to question as wide a cross-section of the community as possible. Questions concerned factors that would improve health and quality of life, and information about health services. The report was sent to a number of local agencies, whose responses are appended.

The open-ended questioning and range of interviewees have drawn out many varied factors which influence health. Even where interviewees were not talking specifically about health, their comments on unemployment, housing, leisure, open spaces, pollution, dogs, lighting and paving, public transport, cars, drug use, crime and education make the links clear. What is more, "health" defined narrowly is seen as a low priority by people who are having to cope with unemployment, bad housing and local drug problems – indeed some were angered and alienated by health promotion messages. There are many fewer comments specific to the health services than concerning these wider factors and those that there are tend to be about very basic needs: not getting "struck off" a doctor's list and provision of a bus up the hill to the hospital.

Perhaps one comment best sums up all the findings: "Sort out the unemployment and everything else will be OK".

# OFFICIAL PUBLICATIONS

IN BRIEF

**Code of Practice**
**Mental Health Act 1983**
*Department of Health and Welsh Office*
*£4.50 from HMSO*
*copies have been sent to CHCs*

This revised Code of Practice comes into force on 1 November. Among the main changes is new wording making it clear that patients may be compulsorily admitted under the Act in the interest of their health even if there is no risk to their own or other people's safety.

**Committee on medical aspects of food policy, 1992 Annual Report**
*Available from the Department of Health, Room 652c Skipton House, 80 London Road, London SE1 6LW*

Summarises the work of panels and working groups and additional work during 1992. Includes the recommendations of its 1992 report on the nutrition of elderly people.

**Giving up smoking: does patient education work?**
*Diana Sanders*
*Summary published by the Health Education Authority, Hamilton House, Mabledon Place, London WC1H 9TX, 20 pages, £4.99*

Summary of a literature review which examined interventions aimed at encouraging health service patients to stop smoking. Provides guidance on which interventions are likely to be most effective; the impact of advice of different health professionals; and advice to particular groups.

**Summary of the promotion of healthier eating: a basis for action**
*Lynn Stockley for the Health Education Authority. Availability details of summary and full report from Lynn Lewis, HEA Publications, Customer Services Dept, phone: 071 413 1946, 28 pages*

Summary of a discussion paper designed to provide a strategic framework (based on Health of the Nation targets), background information and ideas for action for everyone working to promote healthier eating at local and national levels.

IN BRIEF

**Changing childbirth**
**Part 1 Report of the Expert Maternity Group, Part 2 Survey of good communications practice in maternity services**

*Department of Health, HMSO, 173 pages, £18.50*

The Expert Maternity Group was set up in 1992 following the publication of the Winterton Report. It follows the spirit of that report in seeking ways of organising maternity services which will enable women to take control of their pregnancies. The group maintains that pregnant women are well placed to decide for themselves the type of care they should receive, the sort of professional they wish to carry it out, the place of delivery and the degree of intervention. The report also emphasises the need for a "kinder, more welcoming" service, and suggests that this can be achieved without compromising safety, partly by giving women information and real choice and partly by making efforts to improve continuity of care.

The group sets out numerous objectives and action points, the great majority of them for purchasers and providers. It warmly welcomes formal representation for local National Childbirth Trust branches and CHCs on bodies involved with planning maternity services, and hopes that the practice will be adopted in all DHAs. At the same time it notes that purchasers must involve those who do not normally take part in formal consumer groups. The need for consumer involvement is stressed in many of the action points. It does not however appear in the 10 "indicators of success", which may become the benchmarks purchasers and providers will work towards. The indicators include a target that within five years all women should be entitled to carry their own notes.

Of particular use to CHCs may be the second volume on communications. As it points out, good communications cannot compensate for poor healthcare practice, but they are a vital part of good practice. Many examples of communications in the field were submitted to an assessment panel, which selected examples of good practice, all of which are briefly described and a contact given. Among these are a survey from Darlington CHC and a number of other publications in which CHCs were involved. The team identified a number of principles of good communications which they set out as a guide. Among the key findings are that effective communication need not be expensive or glossy. For example, the suggestion of a community midwife to rename a (little attended) parentcraft class to "pregnancy club" increased attendance from 1 to 21. The findings also include ideas that could easily be neglected. The panel found, for example, that both home pregnancy kits and telephone helplines advised pregnant women to contact their GPs, but tended not to mention choices available or other sources of advice.

The proposals in the report are subject to consultation until 29 October. The DoH will then issue guidelines on action to be taken in the NHS. Any comments should be sent to Jane McKessack, Secretary to the Expert Maternity Group, Room 404, DoH Wellington House, 133–155 Waterloo Road, London SE1 8UG.

**Repeat prescribing by general medical practitioners in England**

*National Audit Office, 27 pages, £6.80 from HMSO*

It is estimated that two-thirds of prescribed items are prescribed on a repeat basis. While repeat prescriptions can be convenient for patients and GPs, they carry the risk that GPs may not be monitoring the condition of patients as often as desirable. They may not detect side effects, treatments may be taken beyond when they are being of value or they may prove ineffective, and doctors may not be aware of changes in a patient's medical condition.

There is also a risk of increased wastage of drugs. Multiple prescriptions include drugs to be taken for different durations and patients tend to ask for a new prescription when they have used up one of the items. Doctors are also less likely to be aware if their patients are not taking prescribed drugs.

Some work has been done to promote safe and effective repeat prescribing. The Medical Adviser to West Sussex FHSA, for example, has produced a guide giving advice on repeat prescribing arrangements, review, practice organisation and audit. The Medical Audit Advisory Group in the district has produced a "repeat prescribing audit pack" which deals with specific drug groups. The NAO calls on all FHSAs to consider similar initiatives and on GPs to monitor their own activities.

Beyond such approaches, the NAO discusses the possibility of repeat dispensing, which in effect is a system by which community pharmacists dispense a prescription in parts. This has already been recommended by a Joint Working Party, and the NAO calls on the DoH to take a decision as soon as possible. There is also a need for better data on new and repeat prescribing which could possibly be provided through existing systems.

**Establishing district of residence**

*NHS Management Executive, 19 pages*
*Copies have been sent to CHC secretaries/chief officers*

One of the side-effects of the NHS reforms has been that the district of residence of patients has become an important issue. It determines which DHA is responsible for purchasing a patient's care. The Purchasing Unit of the Performance Management Directorate of the NHSME has been at work drawing up this guidance which covers commonly presented cases of difficulty. It covers everything from "no fixed abode" to "hyperbaric treatment, including diving recompression".

The introduction notes that: "for a provider, identifying the residence of a patient will be an internal management process which must not delay the response to patients' medical needs".

**A unique window on change: the annual report of the Director for 1992/93**

*The NHS Health Advisory Service, HMSO*
*250 pages, £25*

The HAS is a "Non-Departmental Public Body" with a Director appointed by the Secretaries of State for Health and for Wales. Its main objective is "to help secure measurable improvements in services for mentally ill and elderly people". A ministerial review of the HAS's work in 1991 was followed by the appointment of a new Director, Dr Richard Williams, who took up his post in April 1992. The review identified two broad areas of work. The HAS will respond to commissions from Ministers for "thematic reviews" and "ministerially-inspired trouble-shooting reviews". It will also provide advisory and consultancy services to RHAs. This report details work it has been undertaking including proceedings of a series of meetings and discussion groups on different services within the HAS remit. It also sets out the programme of work until March 1994.

# GENERAL PUBLICATIONS

**Manual for research ethics committees**

*Claire Gilbert Foster*
*Centre of Medical Law and Ethics, King's College London, Strand, London WC2R 2LS*

Last year the Claire Foster produced a manual for research ethics committees (RECs) giving basic information, guidelines and regulations. (see *CHC News* No 74). She has now produced update materials, and a second edition.

The new materials include revised versions of many of the articles. There are a number of entirely new articles and checklists and booklets of recently published guidelines from the British Paediatric Association and the Medical Research Council.

There are two versions of last year's manual in circulation: one with pouches bound between hard covers and the other a ring binder. Separate update material has been produced for each, so be clear which you have if you contact the author. A small charge will be made for multiple copies of the update material: contact the author for details.

All new manuals bought from now will be in the ring binder form. They will be up to date and will cost £25 for committee members of RECs and for individuals. Institutions buying the manual for people other than REC committee members will be charged £50. Anyone buying this second edition will be entitled to one free update.

**Balancing acts: conflicts of interest in the regulation of medicine**

*National Consumer Council, 20 Grosvenor Gardens, London SW1W 0BD, phone: 071 730 3469*

The NCC has this month launched a report calling for an end to the secrecy surrounding the development of medicines and withdrawal of unsafe ones. In particular it draws attention to the dual responsibility of the Department of Health: for public health and for the pharmaceutical industry. It believes that the two interests should be separated, so that consumers can have confidence in the impartiality and independence of those responsible for regulating public health. Similar potential conflicts of interest arise elsewhere in the system: more than half the members of the Committee of Safety of Medicines have financial links to pharmaceutical companies and the Medicines Control Agency is funded entirely by the industry.

**Sexual health and family planning services in general practice**
*Family Planning Association, 27–35 Mortimer Street, London W1N 7RJ*
*phone: 071 636 7866, fax: 071 436 5723, 44 pages, £11*

This report was commissioned from the Institute of Population Studies by the FPA and the Health Education Authority. A qualitative survey of general practices covered:

- the range of contraceptive methods in each practice
- communication and information methods used with patients
- current levels of training of GPs and practice nurses
- the availability of various sexual health services

The report also covers information, education and training needs of primary health workers. The FPA intends to follow this up by producing an information and training package for general practice. The questionnaire is included.

Needs identified by practice staff (mostly for information, training and practical support) and by the researchers (mainly for information and choice) are listed. Among the latter is the need for practices to be explicit in their practice leaflet about services they are unwilling or unable to provide. One finding was that only 37% of practices now offer pregnancy testing, mainly because of financial constraints. Referral for testing is diminishing as local hospitals have stopped providing the service.

# INFORMATION WANTED

Having received a number of complaints concerning GP deputising services, **Help the Aged** are planning to undertake a small study into the issue. Before starting the study it would be useful for them to find out from CHCs the number and characteristics of complaints being received about such services. Contact: Wally Harbert, Help the Aged, St James's Walk, Clerkenwell Green, London EC1R 0BE, phone: 071 253 0253.

**Salford CHC** would like to hear from any other CHCs which have been approached by a woman who has had both breasts removed, particularly if she has had breast reconstruction afterwards. If so, information about any reactions to breast reconstruction surgery and breast implants, and about any related auto-immune disorders, would be helpful. Salford CHC has a client who has undergone this surgery, and it would be extremely helpful if she could be put into contact with another woman in a similar situation.

**Salford CHC** would also like to know of services or self-help groups for battered husbands/men battered at home.

**ACHCEW** would like to know of any CHCs which have established formal arrangements with GP fundholding practices and, if so, what these arrangements include.

**Ceredigion CHC** would like information on any mental health trusts in England which are managing both mental illness and learning disability services.

**Kettering & District CHC** would like to hear from any CHCs aware of problems with the provision of paediatric physiotherapy services in their district.

**North Tyneside CHC** is doing research work on miscarriages and would like to hear from other CHCs which have recently been involved in similar work.

**Found:** Colour film, 36 exposures, marked Lloyds Photostop. At Manchester Fayre at the Town Hall, during the AGM. If it's yours, please contact ACHCEW.

# FROM THE VOLUNTARY SECTOR

## Action on Elder Abuse

This new organisation, which comes under the auspices of the National Council on Ageing and is housed at Age Concern England, was launched earlier this month. It is committed to stopping all forms of abuse against older people. It aims to change the perception of elder abuse from a taboo subject into a problem that can be tackled. It will promote research into abuse of all kinds – physical, psychological sexual and financial – and provide information and advice, initially for those working in the field.

Further details form: Ginny Jenkins, Executive Officer, Action on Elder Abuse, 1268 London Road, London SW16 4ER, phone: 081 679 2628; fax 081 679 6069.

# FORTHCOMING EVENTS

**Quality 93.**
**Raising quality in the NHS: what progress?**

- conference organised by the BMA, the BMJ, the King's Fund, the College of Health and Quality in Health Care.
- on 11 November 1993
- at The Brewery, Chiswell Street, London EC1
- £100 (cheques payable to BMA)

*Further info from:*
Ms Pru Walters
Conference Unit Manager
BMA
BMA House
Tavistock Square
London WC1H 9JP
Phone: 071 383 6605; fax: 071 383 6400

**Legal rights and mental health**

MIND's Legal and Parliamentary Unit is running a series of courses between 22 October 1993 and 23 March 1994. Its two-day foundation course on legal rights and mental health may be of particular interest to CHCs. It is being run on:

- 10 & 11 November 1993 in London
- 2 & 3 March in Leeds

Fees: £200 health/social services workers or their professional advisers, £160 other solicitors, £100 voluntary sector

*Further info from:*
Rhys Davies
MIND Legal and Parliamentary Unit
22 Harley Street
London W1N 2ED
Phone: 071 637 0741; Fax: 071 323 0061

**Live for tomorrow**

- a one-day conference to discuss the prevention of accidental injury in those aged over 65
- organised by Clwyd County Council, FHSA and DHA
- on 21 October 1993
- at the Royal International Pavilion, Llangollen
- £70

*Further info on content from:*
Julia Hobbs
Clwyd FHSA
0978 26555515

*Further info on arrangements from:*
The Road Safety Unit
Highways & Transportation Dept
Shire Hall
Mold
Clwyd CH7 6NF
Phone: 0352 702668

**Health care in an ageing society**

- public seminar at Health Rights' AGM with speakers and discussion
- on 20 October 1993, evening
- at Unison, 1 Mabledon Place, London WC1H 9AJ
- free of charge

*Further info from:*
Health Rights
Unit 405
444 Brixton Road
London SW9 8EJ
Phone: 071 274 4000 x 326

**Consumers for Ethics in Research meetings**

**Antenatal testing**
- public debate
- on 25 November 1993

**Mental health and research**
- open meeting
- on 16 February 1994

- both at the Institute of Education, 20 Bedford Way, London WC1 at 5.30 for 6 p.m. to 8 p.m.
- free of charge

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

**Listening to the patient – the role of the patient's representative**
- one-day conference to explore issues raised by a pilot study into the use of patient's representatives at Brighton and Frenchay
- organised by NAHAT
- on 11 October 1993
- at Kensington Town Hall, London
- £47
- APPLY IMMEDIATELY

*Further info from:*
NAHAT Conference Office
Birmingham Research Park
Vincent Drive
Birmingham B15 2SQ
Phone: 021 414 1536
Fax: 021 472 7783

**Cancer treatment – patient choice?**
- conference organised by Marie Curie Cancer Care and BACUP
- chaired by Rabbi Julia Neuberger, with a speaker from ACHCEW
- on 30 November 1993
- at St Thomas' Hospital, London SE1
- £35 (£40 for GPs claiming PGEA)

*Further info from:*
Education Department (Conferences)
Marie Curie Cancer Care
11 Lyndhurst Gardens
London NW3 5NS
Phone: 071 435 4305

**The health of refugees**
- one-day conference to review the health needs of refugees largely through input from refugees themselves
- organised by the Refugee Council
- on 17 March 1994
- at London House, Mecklenburgh Square, London WC1N 2AB
- £35 (refugee community organisations are not being charged)

*Further info from:*
Sean Risdale or Parizad Bathai
National Development Unit
Refugee Council
3 Bondway
London SW8 1SJ
Phone: 071 582 9925

**Social Services Conference 1993**
- organised by the Associations of Metropolitan Authorities, County Councils and Directors of Social Services
- speakers to include Brian Mawhinney and David Blunkett
- topics will include: users' perspectives on disability and services for elderly people; views from the NHS; ethics of rationing; mental health and many others.
- on 27-29 October 1993
- at Conference Centre, Solihull
- £293.75 for all three days, various fees for part-attendance and for accommodation

*Further info about conference from:*
Guy Robertson
AMA
35 Great Smith Street
London SW1P 3BJ
Phone: 071 227 2812
Fax: 071 227 0878

*Further info about bookings from:*
Jacquie Brown/Mick Aldridge
Conference Officer
AMA, as above except:
Phone: 071 227 2913/5

# DIRECTORY AMENDMENTS

**Page 3** **East Yorkshire CHC**
Chief Officer: Mrs Carol S Bond

**Page 4** **Scarborough CHC**
Chief Officer: Suzanne Carr

**Page 6** **Doncaster CHC**
Fax: 0302 344554

**Page 8** **Great Yarmouth & Waveney CHC**
Chief Officer: Ms Angelene Mechen

**Page 9** **Hounslow & Spelthorne CHC**
Change of address:
28 The Butts
Brentford
Middlesex TW8 8BL
Phone: 081 568 8558
Fax: 081 568 8418

**Page 19** **Wycombe & District CHC**
Change of title:
South Buckinghamshire CHC
Chief Officer: Mrs Joy Bennett

**Page 20–21** **Bristol and District CHC**
Address until further notice:
1 Unity Street
College Green
Bristol BS1 5HH
Phone: 0272 277840
Fax: 0272 259541

**Frenchay, Southmead** and **Weston CHCs**: delete entries.

**Page 25** **Crewe CHC**
Chief Officer: Mrs Jean French

**Page 28** **Preston CHC**
Phone: 0772 259089

**Page 30** **Aberconwy CHC**
Change of road number:
4 Trinity Square

**Note also GLACHC's new address:**
Greater London Association of CHCs
356 Holloway Road
London N7 6PA
Phone: 071 700 8125 or 700 0100
Fax: 071 700 8126