CHC NEWS

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

CONTENTS

Number 87
October 1993

CONTENTS

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

NEWS

Priority for urgent cases

Guarantees are to be given of early treatment for patients with urgent conditions if the Health Secretary can reach an agreement with the Joint Consultants Committee. The emphasis on bringing down long waits has, it is claimed, resulted in some patients with relatively minor conditions being treated at the expense of seriously ill patients who have not waited as long. Virginia Bottomley hopes to agree with the JCC a list of urgent conditions, such as breast lumps and serious heart disease, which will be treated within a month or six weeks.

Independent 8 October

Mental health care shifting to private sector

A survey of mental illness hospitals in England has shown that, despite the sharp fall in places in NHS long-stay mental illness hospitals, the overall number of mental illness beds remains almost the same as a decade ago. This is largely due to a dramatic increase in the number of private places, many of them funded through the NHS, social services and social security. Whereas the private sector accounted for fewer than 10% of places in 1985, it now accounts for more than a quarter of the 84,000 hospital and residential home beds.

Reactions to the findings of the survey, conducted by the Health Services Management Centre in Birmingham, have been mixed. John Bowis, a junior health minister, has welcomed the growth of private provision as an indication of "the growing number and diversity of places for mentally ill people in the community". Martin Eede, chief executive of the National Schizophrenia Fellowship, is concerned about the cost. Some private hospitals charge £70,000 to £80,000 a year for a high level of care, compared to £46,000 a year for similar NHS hospital care. He suggests that private hospitals and homes are soaking up money that should be going to community care. He also believes that standards in the private sector range from atrocious to excellent. Marjorie Wallace, director of Sane, is concerned that most new places are in the private sector where, she says, "there is no evidence that there are staff skilled or knowledgeable about mental illness".

Independent/Times 5 October

Hospitals fined, but who feels the pinch?

Hospitals are being fined for failing to meet Patient's Charter standards on waiting times for surgery. The Health Department fines RHAs for each case which goes over the 2 year or 18 month limit – £4000 for a knee operation, £3600 for a hip operation and £900 for other procedures. The RHA can pass the fine on to the DHA, which in turn can pass it on to the hospital. The DHA is still responsible for ensuring that the patient receives the treatment. Fines have been applied in more than half the health regions. NE Thames heads the list, and has been fined £113,500 for 32 patients kept waiting longer than the target time. SW Thames has passed £31,000 of fines on to the relevant districts with an extra £1000 "administration fee" for every month a patient goes over the limit. The fines are clawed back from funds allocated to cut waiting lists, but have raised concerns about whether financial penalties will result in further failures to achieve targets in hospitals which are already finding themselves in difficulties.

Guardian 27 Sept, Independent/ D. Telegraph 6 October

Cutbacks to RHAs

Proposals to slim down RHAs are to be taken a step further, the Conservative Party conference heard. In February, Virginia Bottomley announced that they must lose over 5000 posts. RHAs currently have an average of over 500 staff. The Chair and non-executive Board members are appointed by the Health Secretary; most executives are appointed by the Chair. It now seems likely that RHAs will eventually become arms of the NHS Management Executive and that they will be reduced in number, possibly to eight. By next April, 90% of hospitals will be trusts, accountable to the Secretary of State through the NHSME rather than to RHAs. Six NHSME outposts have already been created – each consists of an executive director, a finance director and about 12 staff. These are likely to become the model for slimmed down RHAs which will coordinate the work of DHAs and FHSAs. DHAs have already been reduced in number from 190 to 140. More mergers of DHAs and mergers between DHAs and FHSAs (once legislation permits this) will further reduce their numbers.

Daily Telegraph & Independent 8 October

Doctors to face MOTs

The Government is backing plans for reaccreditation of doctors at intervals through their careers. Trials are being carried out by the Royal College of General Practitioners and schemes may involve videoing consultations between doctors and patients, with assessment by independent medical experts of a doctor's fitness to practise, probably at five year intervals. The BMA has expressed support in principle for independent and regular checks on doctors' performance. Detailed plans have not yet been drawn up and it is not yet clear whether there will be lay input.

Independent 20 September

BMA proposals for complaints

The BMA has called for local complaints offices financed by the region, which would act as a single starting point for complaints about any branch of the NHS. The Association also wants highly trained complaints officers to be appointed who could decide on the appropriate method of investigation for the various complaints raised by patients.

In its report to the complaints review chaired by Professor Alan Wilson, the BMA also makes suggestions for bringing complaints against GPs more closely into line with the practice in hospitals. An informal procedure for both contractual and clinical complaints against GPs should be introduced. If a local office received a complaint against a GP or hospital doctor which had not been through the appropriate informal procedure, it should be referred back to the general practice or hospital. In many cases, patients want only an explanation and/or apology, and complaints would go no further. The chairman of the committee which drew up the report said that apologising to patients was not the same as admitting responsibility for a mistake.

The second and third stages of hospital procedures should also be adapted for clinical complaints in general practice. At the second stage, a complainant against a GP would be referred to a team of conciliators. The third stage of a clinical complaint would be an independent review by two GPs. Complaints about contractual or administrative matters would be dealt with by a service committee.

Similar arrangements are proposed for public health and community health services.

While the broad principles of the BMA proposals were agreed at a BMA council debate, some hospital doctors remained concerned that their present informal procedures might be jeopardised. The main contention is over whether complainants should continue to receive only a letter summarising the investigation of a complaint or whether they should be given access to a formal report. This, some doctors believe, could open the way to legal action against doctors.

BMJ 2 October, Daily Telegraph 30 September

Light bulbs wrapped up in red tape

It takes six people to change a light bulb in the NHS, according to the Audit Commission. A report on an unnamed hospital found that the processes involved six staff in 17 administrative stages and took up 20 minutes of managers' time. In another unnamed hospital over two hours of staff time were used to take one X-ray, of which 23 minutes were spent on shooting and recording the material.

'Good news, the new light bulb is going to be fine'

The Chairman of the commission, Sir David Cooksey, said there is still huge room for improvement in reducing resources wasted in administration. In the five years to April 1991, the salary bill for hospital general and senior managers rose from £11 million to £251 million after allowing for inflation. It is estimated that over this period the number of managers increased from 1000 to 10,000, while the number of nurses in England rose from 428,000 to 431,000.

Daily Telegraph 30 September

A sign of the times

The Department of Health has announced an award scheme for NHS managers. The judges? Executives from McDonalds, Marks & Spencer, Sainsbury's, British Telecom, Thomas Cook and Virgin Atlantic Airways.

Guardian 29 September

Criticism of forced caesarean ruling

The decision of a senior judge to authorise a caesarean on a woman against her will has been strongly criticised by an expert in medical law. Sir Stephen Brown, president of the High Court Family Division, ruled last October that a Nigerian woman could be forced to undergo the operation on the grounds that her baby's life might be saved as well as her own (see *CHC News* No 78.) At a bar conference earlier this month, Andrew Grubb, executive director of the Centre of Medical Law and Ethics at King's College, London, said that the ruling ran counter to a 1988 Appeal Court judgement that only Parliament could give the power to force a mother to behave in such a way as to save her unborn child. To decide that "the woman's right to refuse treatment was outweighed by society's interest in preserving the unborn baby's life ... would be quite out of keeping with the policy of the law."

In his ruling the judge referred to similar cases in the United States. According to a barrister who also criticised the judgement, a spate of court-ordered caesareans carried out in the US in the 1980s had mainly involved black women.

Guardian 4 October

Woman will sue surgeon

A woman who had her womb and ovaries removed during an operation for a hysterectomy despite the discovery during the operation that she might be pregnant has said that she will prosecute the surgeon privately if the Crown Prosecution Service does not bring criminal charges. Mrs Barbara Whiten was suffering from endometriosis and had agreed to a hysterectomy when drugs failed to curb the pain caused by her condition. She had been told that she could never have children. During the operation Mr Dixon, the surgeon, found that her uterus was enlarged, possibly indicating pregnancy, but decided to carry on with the operation because he was unable to contact the husband. It transpired that Mrs Whiten had been carrying a healthy 11 week old foetus. It is alleged that Mr Dixon later said to Mrs Whiten that she wouldn't have wanted the baby anyway. He also said that he had taken Mrs Whiten's age of 35 and the fact that she had previously taken an overdose into account. Mrs Whiten says that she has been devastated by the termination of her pregnancy. If necessary she will bring a private prosecution with the help of the charity *Hysterectomy Legal Fighting Fund*, which raises funds to pay for legal action against surgeons who remove women's reproductive organs without consent.

Daily Telegraph 14 September

Teenage pregnancies fall

Teenage pregnancies have fallen sharply after a steady ten year rise. Figures in *Population Trends*, produced by the Office of Population, Censuses and Surveys, show that pregnancies among the under-20s fell from 115,055 in 1990 to 103,297 in 1991. Pregnancies among under 16-year-olds fell from 8634 in 1990 (10.1 per 1000) to 7829 in 1991 (9.3 per 1000). The Government's target is 4.8 per 1000 by the year 2000.

In 1991 there were 373,500 conceptions outside marriage and 480,200 within marriage. Of the former, 57.2% ended in births outside marriage, 34.2% in abortions and 8.5% in births within marriage. In 1981 40.5% of conceptions outside marriage led to births outside marriage. Figures for the last quarter of 1992 show that over 32% of births take place outside marriage.

Guardian 17 September

Children reject smoking messages

One in ten 11 to 15 year olds still smokes cigarettes, casting doubt on whether the *Health of the Nation* target of reducing child smoking to under 6% by the end of 1994 can be met. The figures from the Office of Population, Censuses and Surveys are published in the annual report of the Chief Medical Officer. The Health Education Authority has backed calls from the anti-smoking lobby to ban tobacco advertising and for tax increases on tobacco.

Other concerns raised in the annual report include the health gap between men and women; the increase in tuberculosis, particularly among homeless people and immigrants; increasing incidence of food poisoning caused by *Escherichia coli;* and the dangers facing mentally disordered offenders when they are discharged from hospital.

Guardian, Daily Telegraph 29 November

Improper use of aerosol inhalers may contribute to asthma deaths

A study published in the *BMJ* suggests that the design of aerosol inhalers used by people with asthma may have contributed to a rise in deaths from the disease. About 70% of people with the disease use metered dose inhalers such as Ventolin.

The inhalers deliver a measured dose of a drug which opens up the airways. Each canister is designed to deliver 200 doses of the drug. However, patients often continue to use the inhaler after the drug has run out. This is dangerous, since sudden withdrawal of the drugs can result in a severe rebound asthma attack.

The study of 51 users of inhalers found that many regularly ran out of the drug and did not have a replacement available. Nearly all continued to use the inhaler after the drug canister had delivered the 200 doses. A canister will float when it has delivered 200 doses, but only three respondents used this test. Glaxo has applied for a patent for a new inhaler which will have a counter to record the number of doses delivered.

Deaths from asthma have been rising over the past three decades, particularly among young people. Commenting on the study, Professor Sean Hilton of the National Asthma Campaign said that the study was speculative and that there are a number of reasons for the rise in deaths.

Independent 28 September

Action on standards of keyhole surgery

£4 million is being provided for training in keyhole surgery over the next two years, half of it from the Department of Health and half of it from the Wolfson Foundation. The announcement follows allegations that surgeons with insufficient training are using the technique, sometimes with serious consequences for patients.

In keyhole surgery, also called minimally invasive therapy (MIT), surgical instruments and a tiny camera are passed through small incisions. The surgeon must use a video monitor to see what is happening inside the patient's body.

The benefits of MIT are that trauma to the patient is reduced, leading to less time in hospital and faster recovery. Disadvantages can be that any mistakes are less obvious and that it is more difficult to manage any sudden bleeding during the operation.

MIT, first introduced in 1990, is used for 20% of abdominal cavity operations and 70% of urological operations. It is estimated that up to 70% of all surgery could use MIT by the end of the century.

Concern about standards has been expressed by the president of the Royal College of Surgeons and by a working party of surgeons commissioned by the Government to report on the technique. The working party's report has not been published, but its chairman, Professor Alfred Cushieri, says that there is evidence that some surgeons have attempted keyhole techniques without special training, despite repeated warnings that such training is vital. He has said that the picture in the UK is similar to that in the USA, where there have been 158 "adverse incidents", 24 of them "permanent or life threatening". Research in the United States has shown that most injuries to patients occur during a surgeon's first 50 cases.

Health minister, Brian Mawhinney, insists that clinical benefits rather than cost considerations are behind the initiative to train surgeons in keyhole techniques. The rapid development of the technique in the private sector, however, is undoubtedly encouraged by the lower costs. With hotel charges at hospital of about £200 a day, health insurers have a big incentive to shorten hospital stays.

Keyhole techniques are being used to reduce the number of hysterectomies. Women are being offered an alternative technique called uterine resection in which the lining of the womb is cut away surgically or by laser using instruments inserted through the vagina. Most women continue to have periods, but are left infertile. They experience less post-operation pain, and they can return home the same day. However, according to one specialist, a third of the patients treated using the technique have had to return for further treatment. Doctors in the field argue that this should not always be regarded as failure since the women may have had four or five good years in the meantime, and they still have the choice of repeating the procedure or having a hysterectomy. The technique is currently undergoing a safety trial by the Medical Research Council.

Daily Telegraph 4 October, Times 21 September, Independent 21&24 October

FOCUS ON ... THE INTERNAL MARKET

Warnings that there will be a dramatic increase in hospital bed closures come from both the NHS chief executive and an independent business development organisation.

Sir Duncan Nichol expects that hospitals may have to merge or close, and that plans for new hospitals may have to be scaled down or scrapped. Speaking at the NHS Trust Federation he said that, though "people hang on to their local facilities ... we have convincing points to make about these developments being clinically led and about good clinical practice". One in five beds closed during the 1980s as hospital stays shortened, and Sir Duncan believes that there is potential for the trend to be accelerated very dramatically. Asked to justify cuts when over a million people are waiting for treatment, he said that the queue represented less than four months' work. (Anyone with their own views on how the NHS ought to be managed should hurry: the closing date for applications for Sir Duncan's replacement is 27 October).

A similar message comes from Newchurch and Company in its report *Strategic Change in the NHS*. However, it sets out the prospects in rather more apocalyptic terms: the 1991 reforms "have set in train a process ... that may now be beyond the powers of politicians and policy makers to control". The analysts believe that this will "lead inevitably to a rapid and fundamental redefinition in the who, how and where of health care delivery." They estimate that one in three major hospitals will close or amalgamate within seven years. District general hospitals, which currently serve about 200,000 people, will be expected to serve up to 500,000. Another estimate is that trust status adds at least £250,000 a year to running costs, and that for some, this will prove too great a burden.

Another aspect of the NHS which may be getting out of control is the move to a two-tier system. According to Paddy Ross, chairman of the Joint Consultants Committee (JCC) of the BMA and the medical royal colleges, virtually all NHS hospitals and two-thirds of their consultants are "fast-tracking" patients of GP fundholders. Mr Ross said that consultants face moral blackmail and that they are being forced to give priority to fund-holders' patients, despite the fact that they find it abhorrent not to allocate treatment on the basis of medical need. The NHS internal market, he warned, is becoming dangerously out of control and is being run by demoralised and confused staff.

The JCC has presented a dossier of cases in which a two-tier system is operating to the Department of Health. Fundholders' patients may be treated after the treatment for DHA patients has ceased because a contract has been fulfilled. There are also reports that hospital managers have been told to prioritise GP fundholders' patients or to risk losing them to other hospitals.

Government ministers have rejected the JCC's claims. Health Secretary, Virginia Bottomley, said at a meeting with the JCC that fundholding was "increasingly providing real benefits to the NHS and represented a major force for good". Health Minister, Brian Mawhinney, said that it was Government policy not to permit fast tracking unless there was "spare capacity". He claims that this is policed by RHAs and "we have no evidence that it is being broken". The stated policy begs the question of what constitutes "spare capacity". It presumably includes beds that would otherwise be closed, not because there are not DHA patients waiting for treatment, but because a DHA contract has been fulfilled.

A different perspective on the future comes from Professor Howard Glennerster, author of the first review of fundholding. Saying that overspending by fundholders must be stopped, he predicts that the scheme may become less attractive to GPs as they have to make rationing decisions. Dr Gareth Emrys-Jones, chairman of the GMSC's fundholding committee, predicts that fundholding budgets will become tighter and that fundholders will have to stop referring patients for operations. These predictions come in an article in *Doctor*. What the article does not suggest, but must be of concern, is that if fundholders' budgets do become very tight, there will be incentives for GPs to avoid taking "expensive" patients on to their lists at all.

Lastly, as one might have expected, a more optimistic view of what lies ahead comes from Claire Rayner. While she is of the opinion that the government gives purchasers too little cash, she also believes that a major problem is that money doesn't follow patients, but follows contracts. The goals of the reformed NHS could be met if *all* GPs were fundholders. This she believes, would do away with the two-tier service we see at present. Whether it would replace a two-tier service with a multi-tier one is another matter.

Daily Telegraph 13 & 30 September, 1 October, Guardian 29 September, Doctor 30 September, Times 30 September

Filling the gaps

The private sector is expanding to fill the gaps left by NHS dentistry. Until recently most medical insurance has excluded dentistry. Dental insurance has been unrewarding to insurers, since the policies are bought to be used, unlike other medical insurance which is bought in the hope that it will not be used.

One way round this is for insurers to offer corporate dental plans, sold as an employee benefit. Cigna, for example, now offers a dental plan to companies with as few as 20 employees at £67 per employee per year. Premiums fall as the number of employees rises. PPP and BUPA are offering dental cover as an add-on to existing corporate clients. The policies vary in the contribution they make towards dental charges, and the coverage varies for routine and more complex work.

Individual insurance is also being sold, but insurers are devising ways of reducing the risk to themselves. Those wanting insurance from one company, for example, undergo an dental assessment which determines the premium they will have to pay. They are then covered for accident and emergency dental requirements.

Independent 24 September

FROM THE JOURNALS

Minor surgery in general practice

An editorial in the *British Journal of General Practice* draws attention to potential pitfalls of minor surgery in general practice. While the ability of GPs to carry out minor surgery has benefits for both them and their patients, a number of issues need to be addressed.

The first of these is training. Confidence to carry out procedures does not equate with competence. For example, most GPs excise fewer skin lesions in a year than most dermatology SHOs excise in a week. The authors believe that there is a need for formal training for GP trainees, a need which has been endorsed by the Royal College of General Practitioners. The editorial goes on to examine the practicalities of initial training and continuing education in minor surgery.

An important area in any training programme would be diagnosis. There is considerable pre-operative misdiagnosis of malignant skin lesions. Current guidelines from the royal colleges and others recommend that all specimens excised in general practice are sent for histological assessment, but this is not universally adhered to. The editorial stresses that it is imperative that all specimens are sent for histological confirmation, whether or not GPs agree with the guidelines.

A number of other factors also determine the adequacy of GP premises to carry out minor surgery, including record keeping, the availability of resuscitation equipment and the availability of sterile equipment. Factors such as these can be included as criteria for inclusion on minor surgery lists.

British Journal of General Practice, September

Patient choice in managing cancer

An article in the *Drug and Therapeutics Bulletin* calls for doctors to give cancer patients more information, and to consider different ways of getting the information across, including tapes of consultations.

While few patients want to take sole responsibility for deciding their treatment or even the major role, many want an active role. Even where they want to leave decisions to doctors, most patients want information, and good communication remains important. At the same time, doctors should respect the wishes of those patients who do not want to contribute to treatment decisions or who do not want to know more about their condition.

A variety of methods need to be used to get information across.

- Nearly all patients find it helpful to have a tape recording of a consultation. This can remind the patients of what was discussed and reinforces practical details. A tape can also help in breaking bad news to relatives.
- Written as well as verbal information.
- Simple non-technical language.
- Diagrams, summary sheets and calendar charts.
- Information specific to the patients as well as general pre-prepared information.
- Second opinions. These should be encouraged for those who wish it.

The article also calls for the extension of the use of trained counsellors to be explored.

Drug and Therapeutics Bulletin 27 September

The unaccountable in pursuit of the uninformed

Naomi Pfeffer, Chair of City & Hackney CHC, is co-author of this article criticising public consultation as currently practised in the NHS. Despite all the rhetoric of *Local Voices* there is little reason for health authority boards to be concerned with what the public think of them.

The authors believe it dishonest to sell consultation as a means of developing services to benefit the community, but then use it to legitimise contracts and rationing.

Representativeness of samples and the use of questionnaires when respondents are given insufficient information on costs or the effects of decisions both pose problems. Simple ranking of priority for services is difficult to interpret. When respondents to a survey in Surrey were invited to comment on a priority setting exercise, they made it clear that they were concerned about funding and cuts to services. A relatively low ranking for a particular service does not necessarily mean that people are prepared for it to be withdrawn. The authors conclude that there is a danger that *Local Voices* exercises may be given a false legitimacy in a process which will undermine the central tenets of the NHS.

BMJ, 25 September

Women and cancer

A *Which?* survey looks at screening and precautions against breast, ovarian and cervical cancer. Government targets for both cervical smears and breast scans are being met, though the UK still has high death rates for all these cancers. Ovarian cancer has a relatively low profile, though it accounts for 4,500 deaths each year, compared with 2000 for cervical cancer. There are technical difficulties in screening for ovarian cancer as the tests are not considered accurate enough for wide-scale screening. Some cases of ovarian cancer are known to be due to inherited factors, and research into this is currently under way. Women with two or more close relatives who have had ovarian cancer are being asked to contact the research team, who will recommend regular screening to the woman's local doctor if they think the woman will benefit (contact: Professor Bruce Ponder, Department of Pathology, Tennis Court Road, Cambridge CB2 1QP).

The Government target for cervical smears is that 80% of women aged 20–64 should be screened at least every five years, but 86% of women said they'd like screening at least every three years. One in four women said they wanted to be told the test result by a doctor or nurse, but this happens in only 10% of cases.

Which? Way to Health, October

NEWS FROM ACHCEW

ACHCEW has been invited to attend a BMA seminar about "Privacy, confidentiality and networking in the NHS". If CHCs have any points, e.g. about access to data, that might usefully be raised at the seminar, please contact Angeline at ACHCEW before **28 October.**

AROUND THE CHCs

Dewsbury CHC has been involved in setting up a local health panel for local minority ethnic communities. The project, which will run for a year, is being funded by the Department of Health following a submission from Kirklees FHSA. Multilingual interviewers from the local community will be trained and will identify a representative sample of around 250 households who are willing to give their views on health. Information obtained from them will be used to help plan local health and welfare services.

CHC PUBLICATIONS

The future of local health services

Merton & Sutton CHC, 9 pages

This discussion paper is intended to form the basis for Merton & Sutton CHC's approach to proposals for changes in local health services. It looks briefly at external pressures on the service, which set the limits within which local strategies can be framed. It then looks at local strategy in individual policy areas. This includes a consideration of how to involve the community in the *Health of the Nation* key areas; improvements needed to community care; primary services, particularly the need for the FHSA to develop standards of practice and accountability; acute and community health services, with various ideas about how services as close as possible to the patients can be developed and maintained; and, lastly, local patterns of purchasing health care.

IN BRIEF

Thinking for ourselves
Video. £10. A few copies are available to be borrowed.
Sandwell CHC

Sandwell CHC has held meetings with people with learning disabilities asking them about their lives and their experience of a range of services provided to them. This video shows lively group sessions in progress and interviews with individuals who talk about their day-to-day lives and their likes and dislikes about care in the community and the way other people treat them.

Directory of local and national services for the disabled
Kettering & District CHC, 74 pages

A directory providing local and national information for disabled people and their carers, covering: advice and help; education and training; finance; health care; holidays and leisure activities; self help and support; and transport and mobility.

IN BRIEF

Community access to health day: evaluation.
Compiled by Islington CHC for Islington Health and Race Forum, 38 pages

Islington Health and Race Forum has decided to organise a series of Community Access to Health days which offer an opportunity for health professionals and members of black and minority ethnic communities to meet and discuss local health services. This is the report of a day organised for the local Cypriot community. The report describes the planning for the event and the day itself. Seven advocates were on hand to help attenders and to act as translators – their input was much appreciated by participants. Qualitative evaluations from various health professionals describe the types of contacts they had during the day and are rounded off with recommendations for future events. Two women who attended were interviewed, and 63 of the 250 or so people who attended completed a questionnaire. Their responses make it clear that the event was a considerable success. The Forum is already making plans for another Community Access to Health Day for elderly people in the West Indian community in the next few months.

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

The needs of people with a visual impairment
Dudley CHC, 10 pages
Also available on tape and in large print

This report is based on visits at which the Primary Care Working Group talked to people with a visual disability and on discussions with others who have an input into service provision. Findings are presented alongside recommendations. A checklist for premises is appended. The CHC sets out some principles which it asks NHS staff to bear in mind. It intends to refine them to draw up a charter for people with visual impairment. The fact that it is necessary to set out principles which are so basic to people's needs is a little shocking, but they may well prove useful to other CHCs doing work in this area:

- Please introduce yourself
- Even if we don't have a white stick or a guide dog, please make sure we know how to get to the area to which you are sending us, and remember we cannot see where you are pointing.
- Written instructions are useful only to those who can see them.
- Please keep us informed – we do not know that we have not been forgotten.
- Please take the time to explain the layout of the ward or clinic area, especially where the toilets and refreshment areas are.

Patient's Charter: local views of the NHS in Hillingdon

Hillingdon CHC, 15 pages

In September 1992 about 100,000 households in Hillingdon received a copy of the Hillingdon Health Charter (drawn up by the DHA, the CHC and the FHSA). The opportunity was taken to obtain the views of local people about the NHS. Each charter included a tear-off questionnaire to be returned to the CHC using freepost. This report analyses the 2829 responses to the following questions: "What do you think is the best thing about local health services?" (of the ten categories of responses, GP/health centres came first, followed by the principle of the NHS and localness of services); "What gives you most cause for concern about local health services?" (waiting times and lack of resources were the most common responses); "What sort of things do you think we should do more to publicise?" (a mixed bag of responses, with 12.5% saying that there was no need to publicise the service or that more publicity would be a waste of money).

Health visiting services: a consumer satisfaction survey

Derwentside Health Care and North Durham CHC

Questionnaires were distributed to 880 parents on health visitor caseloads and 520 replies received. Overall satisfaction rates were high, with 98% of respondents finding the service helpful or very helpful. Conclusions are analysed in terms of the Patient's Charter, *Health of the Nation, Care in the Community,* relationships and the Children Act. Among the findings are that 58% would prefer arranged times for visits, whereas 41% did not want appointments. It is recommended that at the outset of each relationship, health visitors should establish with parents whether they want appointments or not. Parents wanted rather more home visiting than they were receiving. The most common improvement called for at clinics was the provision of a crèche/child supervision. Asked about specific groups health visitors might coordinate, 82% indicated they would be interested in stress management groups.

OFFICIAL PUBLICATIONS

A–Z of quality: a guide to quality initiatives in the NHS

NHS Management Executive, 260 pages

This is a glossy and colourful "celebration of good quality practice and a challenge to everyone in the NHS to develop good quality initiatives where they can be of benefit to patients". It contains over 300 examples of good practice covering the whole range of NHS services. The examples are alphabetically listed by key word (e.g. **advocacy)** and colour coded by category, such as **patient focus** or **organisation.**

City & Hackney CHC gets a mention for its advocacy scheme run in a hospital maternity unit, out-patients clinics and child health clinics. The scheme is managed by the CHC and funded by the DHA. East Cumbria CHC is praised both for its focus group sessions which have influenced the local ambulance service and for a survey into access for disabled people at all NHS premises in East Cumbria. NW Herts CHC's Twin Track Quality Monitor is also commended. This is a process designed to enable lay people to assess the quality of care in hospitals and long-term residential care through structured interviews with patients/residents and staff.

Copies of the A–Z are being distributed to all health authorities, trusts and directly managed units, which are being advised to distribute them within the organisation and to ensure that as many staff as possible have access to them.

Report of the Day Surgery Task Force

NHS Management Executive
Summary report 12 pages; Toolkit 7 sections

All CHCs should have received a copy of this report and "toolkit" which examines good practice taking place in the development of day surgery in the NHS. It focuses on non-clinical issues which the Task Force believes are significant in developing day surgery. The conclusions lay considerable emphasis on attitudes of patients towards day surgery and the information provided to them, while starting from the judgement that day surgery is the best option for 50% of patients undergoing elective surgical procedures. Action points are set out for various agencies. This suggests that, among other things, CHCs should find out what patient selection criteria are being used for day surgery treatment and establish what literature will be required for patients. They should also "seek to influence" patient satisfaction surveys.

GENERAL PUBLICATIONS

The health and lifestyle survey: seven years on

The Health Promotion Research Trust, 49–53 Regent Street, Cambridge CB2 1AB; phone: 022369636; fax: 0223 324138. Summary, 5 pages; Full review, 20 pages

In 1984–85 over 9000 adults in Great Britain living in private households were surveyed. They were asked a wide range of questions related to health in an interview; most of them were also examined by a nurse who carried out a series of measurements and they completed a questionnaire concerned with personality and mental health. In 1991–92 the survey was repeated. Researchers traced 5252 of the original respondents and resurveyed them. This summary and review are both based on a longer book, *The health and lifestyle survey: seven years on*, by Dr Brian Cox.

Going back to the original respondents, especially with such a large survey, has enabled researchers not only to get a snapshot which provides information for comparison between groups including age groups, but also to examine how the same people change over time. This enables them to separate out historical differences between age cohorts from the effects of ageing. For example, the first survey showed that the gap between social classes in various measures of health widen as age increases. This repeated survey shows that this is probably a true ageing effect rather than a historical difference between age cohorts. The data also should enable researchers to identify links between health and both individual lifestyle and wider socio-economic changes.

The review summarises a wealth of interesting findings. It explores the death rate, changing patterns of health, objective measures of health, changes in lifestyle, changes in mental health, life events and social support, the effectiveness of health messages and the light the findings throw on the *Health of the Nation* policy. The following are a taster:

- People's own assessment of their health and the measure of "general malaise" (e.g. tiredness, stress and worry) correlated well with death rates, even among those without chronic conditions which limit their lifestyle.
- For young men who were manual workers in the first survey, 64% said their health had shifted from fair or poor to excellent or good by the second survey.
- There has been a 30% increase in those taking medication at the time of the survey, with a dramatic increase in the use of anti-asthmatic medication.
- Hay fever shows a consistent increase for both sexes and most age groups.
- There has been an increase in the proportion of people who are overweight, though no increase in the underlying blood pressure of the population (possibly due to medication and/or to changes in diet).
- There has been some reduction in smoking, especially a reduction in "occasional" smokers. However, among young women, 41% who were "occasional" smokers at the first survey had become "regular" smokers by the second.
- The consumption of high fat foods has fallen for all ages and both sexes – and the pasta industry has clearly had a big boost.
- Alcohol intake has changed little overall, but shifted between groups. More professional women are now "regular" drinkers. It appears that drinking habits are not a stable personal characteristic, but change with life circumstances. According to the authors, this suggests a different model from that common in health promotion, which sees behaviours essentially as a characteristic of the individual.
- Among men, those aged 65+ in the "unskilled" category did the best on the emotional well-being score. In contrast, among women, those aged 65+ in the "unskilled" category did by far the worst. The mentally healthiest women were those aged 65+ in the highest socio-economic group.
- Becoming married produced better mental health scores. Becoming widowed produced a "massive" fall in mental well-being. Getting divorced had an adverse influence on men, but little effect (perhaps a slight improvement) for women.

The second survey data are still being worked on by the research team, and are to be deposited in the ESRC Data Archive at the University of Essex where they will be accessible to other researchers.

IN BRIEF

Registering with a doctor: why bother?
CHAR: the housing campaign for single people, phone: 071 833 2071 and Health Action for Homeless People, phone: 071 249 2560
Free, but P&P payable for orders over 40

Leaflet outlining reasons for registering with a GP and answering some of the questions commonly asked about being registered.

Teenagers in hospital
Action for Sick Children, Argyle House, 29–31 Euston Road, London NW1 2SD; phone: 071 833 2041, 12 pages
£1 each; £8 for 10; £35 for 50; £65 for 100

Booklet written with the help of teenagers and staff for young people in any hospital ward. Gives information on what to expect. Aims to help them think about consent to treatment and gives ideas on how to ask staff questions that might be worrying them. Includes a pull out satisfaction questionnaire which can be sent to the hospital.

IN BRIEF

Investing in patient's representatives
Shirley McIver, NAHAT, Birmingham Research Park, Vincent Drive, Birmingham B15 2SQ; phone: 021 471 4444; fax: 021 414 1120, £6

This publication is a preliminary report of NAHAT's patient's representative project, which has been running for a year. It draws on the experience of progress at two pilot sites (Brighton and Frenchay Healthcare Trusts) and on the experience of people in similar posts, both in the UK and overseas.

Unlike CHCs, a patient's representative sees patients while they are in the ward and attempts to sort out concerns immediately. S/he is a provider employee, offering an opportunity to influence provision directly. The patient's representative should be able to publicise the CHC and refer patients who need support in making a complaint. S/he can also act as a channel through which the CHC can influence providers and could organise training sessions on effective monitoring of provider units.

A discussion of the relationships a patient's representative has with other staff and agencies clarifies what the post entails and hints at some of the difficulties the postholder may face. It is a reflection of attitudes within the NHS that if patient's representatives report officially and only to the chief nurse adviser/director of nursing and quality, their ability to bring about change is limited. It seems that to be taken seriously and to be able to inform staff effectively, the patient's representative needs to be recruited at a fairly senior level and to have direct access to the chief executive and/or chair of the unit. This itself raises the problem that the postholder may been seen as a management "spy". S/he must seem useful to staff in order to get the cooperation s/he needs. The main advantages to staff are likely to be saving them time and using a knowledge of the whole unit and its bureaucracy to help in sorting out problems.

The report sets out some reasons for employing a patient's representative and briefly outlines the resource implications. A description of the work done at pilot sites and by others holding similar posts, with a list of their names and addresses, should be useful to any units considering making the investment.

The Salford Eye Care Project: Don't take your eyes for granted!
Henshaw's Society for the Blind, Warwick Road, Old Trafford, Manchester M16 0GS phone 061 872 1234; fax: 061 848 9889; and Salford FHSA; 40 pages, £2

The aims of this project were to identify effective ways of raising public and professional awareness of the value of regular eye examinations in the prevention of long-term disease; to improve quality of life through improved vision and function when sight is impaired; and to research and evaluate needs.

This report outlines how local agencies and Henshaw's worked together to put vision and visual impairment high on the agenda for action in Salford and to disseminate good practice. It lists 23 specific recommendations to Government and other bodies operating at a national, regional and local level. It describes what has been achieved by the project including the motivation of local opticians to establish

low vision clinics and the development of communication links between agencies.

The project identified some information needs: to promote understanding of common eye conditions and their effects on daily life; to promote awareness of the financial implications of obtaining eye care services; and information on services for people with visual impairments. Posters, information packs and leaflets have been produced to address these needs and training has been organised for those working in the field of eye care.

Louise Hutchinson, Henshaw's Research and Development Officer, believes that the project could be used as a basis to develop initiatives in other areas. The society would be pleased to share its experiences with others and to offer a partnership contract to facilitate the development and provision of similar services for visually impaired people, professionals and other service providers in other areas.

FROM THE VOLUNTARY SECTOR

The **National Asthma Campaign** has just completed its 1993 Asthma Week. As part of the week, it launched *The Asthma Manifesto*, an 8 page declaration of what people with asthma have a right to expect. It promotes best practices among health professionals, employers, schools and others who have an impact on the lives of people with asthma.

In order to respond to resulting enquiries, an accompanying booklet sets out some avenues for people with asthma to pursue if their rights are not being respected. It lists a range of booklets and factsheets about asthma and addresses of useful agencies.

Further information from: The National Asthma Campaign, Providence House, Providence Place, London N1 0NT. Asthma Helpline: 0345 010203. Open 9 a.m. to 9 p.m. and charged at local rates.

If you have any items for the next issue of *CHC News* could you please get them to ACHCEW by 10 November.

INFORMATION WANTED

FOR OUR FILES

ACHCEW would be grateful if any CHCs sending information direct to another CHC in response to a request information could also send a copy to ACHCEW

ACHCEW would be interested to receive copies of job descriptions for full- or part-time complaints workers employed by CHCs.

Dudley CHC would like to hear from any CHCs whose districts or trusts have introduced car parking charges under the guise of increased security, and whether or not this has led to a reduction in crime.

North Tyneside CHC wants to know more about how women can be supported during and following a miscarriage. The CHC would be interested in the findings of any research that might have been done to identify what service users see as good practice.

Do any CHCs have information on existing or planned advocacy services specifically for elderly people? If so, please contact Chris Dabbs, **Salford CHC.**

Rotherham CHC is interested in any recent work carried out on the provision of primary care to homeless people. Of particular interest would be information on pilot projects conducted by GP practices, examples of multi-agency working or problems generally experienced by homeless people.

Newcastle CHC would be interested in seeing any examples of leaflets on NHS complaints – particularly hospital complaints – which are available in minority ethnic languages.

Are any CHCs aware of self-help groups or voluntary organisations which assist patients suffering from Keloid scar tissue? This is a condition in which there is an overgrowth of scar tissue following an operation or injury, and tends to be more common in people with dark skin. Please contact **Bassetlaw CHC.**

FORTHCOMING EVENTS

Information is good for your health

- two-day conference and exhibition on the provision of health information to consumers
- organised by The Help for Health Trust
- on 24–25 November 1993
- at Bournemouth International Centre
- £100 two days, £50 daily rate (VAT extra for non NHS employees)

Further info from:
Sarah Farthing
The Help for Health Trust
Highcroft Cottage, Romsey Road
Winchester, Hants SO22 5DH
Phone: 0962 849100, Fax: 0962 849079

Mental Health, Race and Culture in Europe Conference

- three-day conference
- topics include ethnically sensitive therapies, identity, religious beliefs, legislation, women's rights, empowerment of users, institutional racism and good practice.
- organised by Transcultural Psychiatry Society, MIND and others
- on 6–8 April 1994
- at Bristol University
- £210; a few bursaries available for users or carers

Further info from:
Conference Secretariat
Mental Health, Race & Culture Conference
Richmond Bridge House,
419 Richmond Rd, Twickenham TW1 2EX
Phone: 081 892 3637, Fax: 081 744 9169

But will it work, doctor?

- one-day conference on involving users of health services in the outcome of medical care
- organised by The Cochrane Centre, The Consumer Health Information Consortium, Oxford RHA and the King's Fund Centre
- on 9 November 1993
- at the King's Fund Centre, London
- LIMITED PLACES
- £65 CHCs, £85 NHS and other public bodies, £45 community health information services

Further info from:
Sandra Eagles
The Oxford Consultancy, Oxford RHA
Old Road, Oxford OX3 7LF

Disputes between patient and doctor: is arbitration a solution?

- one-day conference
- organised by the Chartered Institute of Arbitrators, the Royal Society of Medicine and the BMA
- on 10 December 1993
- at the RSM, 1 Wimpole Street, London W1
- £50 for RSM fellows/BMA/CIArb members and students; £65 others
- 190 places allocated on first come first served basis

Further info from:
Nicole Aaron, Forums Executive
RSM, 1 Wimpole Street
London W1M 8AE
Phone: 071 408 2119, Fax: 071 355 3197

The health and poverty of the nation

- one-day conference seeking to clarify issues of health and low income
- organised by Birmingham City Council
- on 5 November 1993
- at the International Convention Centre, Broad Street, Birmingham
- £89 + 15.58 VAT

Further info from:
Kathy Molan, Conference Organiser
PMA Ltd, Wyse House, Halford,
Warwickshire CV36 5BT
Phone: 0789 740712, Fax: 0789 740980

Drugs: a conference for parents

- one day conference aimed at mobilising parents who are motivated to play a greater role in drug prevention activity and at promoting the establishment of regional parents' learning initiatives
- organised by DoH, Lifeline project, the Association for Prevention of Addiction and Adfam National
- on 23 November 1993
- at The Queen Elizabeth II Conference Centre, Westminster, London
- DoH will repay travel costs of individual delegates from outside the M25
- APPLY IMMEDIATELY

Further info from:
David Crewe Associates
101 Judd Street, London WC1H 9NE
Phone: 071 387 2221, Fax: 071 387 2485

DIRECTORY AMENDMENTS

Page ii

East Anglia
Mrs Heather Wood
Hon Secretary
East Anglian Regional Association of CHCs
c/o Huntingdon CHC
119a High Street
Huntingdon PE18 6LG
Phone: 0480 451657

Page iii

Wessex
Mrs Margaret Lovell
Secretary
Wessex Association of CHCs
c/o Portsmouth & SE Hants CHC
101c High Street
Cosham
Portsmouth
Hants PO6 3AZ
Phone: 0705 383832

Page 9

Barnet CHC
Fax: 081 343 3502

Page 15

Merton & Sutton CHC
Chief Officer: to be advised

Page 22

Kidderminster & District CHC
Fax: 0562 829704

Page 23

South Birmingham CHC
Chief Officer: Robert Gould

Page 32

South Gwent CHC
Chief Officer: Roger Coakham

Page 30

Clwyd North
Chief Officer: Miss Peta Smith