CHC NEWS

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

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NEWS

Hospital indicators

League tables of hospital efficiency are to be made available for individual hospitals. A list to be published in June will include the following new indicators:

- ambulance waiting times
- number of A&E patients seen immediately
- number of out-patients seen within 30 minutes
- number of out-patients seen within an hour
- number of cancelled operations
- number not admitted within one month of having an operation cancelled at the last minute

The Health Secretary, Virginia Bottomley, has also announced that two further additions are under consideration. The Department of Health is working on a national standard for the time patients wait between a GP referral and seeing a consultant – this is likely to be set at 13 weeks. The Department is also considering whether death rates for individual hospitals should be published. Interpreting such data is difficult since death rates are affected by the mix of cases a hospital deals with, but publishing the information in some form would be in line with Mrs Bottomley's belief that "there is nothing like information to achieve change".

Guardian/Daily Telegraph 7 December

Mersey success on waiting lists

Mersey is the first region to have no patients waiting for treatment for more than a year. The RHA has achieved this by holding back money from districts and targeting it on specific initiatives to cut the longest waiting lists and to hold them down. Schemes have included the use of a mobile operating theatre, keeping lists of patients willing to accept cancellations at short notice and monitoring each consultant's waiting list in an attempt to spot lengthening queues before they become a problem and to make use of short ones. These data are made available to GPs and CHCs. More doctors have been giving patients firm dates for treatment at consultations and many have cut routine re-attendance at out-patients clinics. These two measures have reduced the numbers of patients who do not attend for treatment.

Independent 5 January

Fast-tracking fundholder patients

A BMA survey of 173 acute hospitals found that 73 (42%) of them were offering to patients of GP fundholders services which were not available to other patients. Of the 73 hospitals, 41 were offering faster admissions, seven on a routine basis and others because they had exhausted DHA contracts. In 27 hospitals fundholders' patients were waiting less time for out-patient appointments. A BMA spokesman opposed the suggestion that hospitals should pace their DHA work over the year, since that would mean artificially delaying the treatment of patients who needed treatment in order to disguise underfunding. John Chawner, chairman of the BMA's consultants' committee, said that GPs need a level playing field. At present DHAs pay for any emergency hospital treatment received by patients of fundholders. This limits the cash DHAs have left to pay for non-emergency work for the rest of the population.

Health Minister, Brian Mawhinney, has denied that there is any evidence of a two-tier service – it is simply that some hospitals have "spare capacity".

Independent 10 December

New NHS chief named

Alan Langlands is to take over from Duncan Nichol as chief executive of the NHS in April. Mr Langlands has been deputy chief executive since October 1992. He joined the NHS in 1974 and has worked in NHS hospitals in Scotland and London. He also had a spell in the private sector running the health care arm of a management consultancy firm.

Independent 4 January

Value for money?

Following the revelation that NHS trust chief executives received an average pay rise of 8.9% in the year ending March 1993, the Health Secretary set up a task force on corporate governance in the NHS. Since Mrs Bottomley was appointed to her post in April 1992, she has set up 20 task forces (not including a raft of working groups and inquiries). Each task force can have up to about 14 members, a chair and representatives from ministries. The cost is estimated to run into millions.

Sunday Telegraph 19 December

FOCUS ON ... CARE IN THE COMMUNITY

The procedures for the discharge of mentally ill people from hospital are to be tightened. New guidelines will require clinicians and other staff to take full account of a patient's needs before discharge. They must consider whether the patient requires continued in-patient treatment and whether s/he can be cared for effectively in the community. They must also assess whether, with adequate supervision and medication, patients could be at risk of harming themselves or others

New measures include proposals for supervised discharge orders and registers of patients considered most at risk of harming themselves or others.

The guidelines have received a somewhat sceptical response from campaigners and opposition MPs who have argued that they do not tackle the root problem of the resources allocated to mental health care. They believe the guidelines may merely exacerbate the problems in hospitals that were described in December in an extremely critical report from the Mental Health Act Commission.

In that report, the Commission says that many inner-city hospitals are ignoring their legal requirements to provide aftercare for compulsorily detained patients. The descriptions of hospital conditions are shocking. Overcrowding has reached such a level that patients are having to share beds, with patients being discharged "on leave" to make room for others. Acutely psychotic patients are mixed with less disturbed patients, who fear for their safety. In one case a woman with post natal depression was spending long periods standing as a sentry on her door because she feared what other patients might do to her baby. While disturbed patients are often controlled rather than treated, less disturbed patients receive little more than "residential accommodation, the administration of medication and visits from junior doctors who do not have sufficient expertise."

The Commission criticises the allocation of funding at various levels. Chair of the Commission, Sir Louis Blom-Cooper, says that health service managers are diverting money intended for psychiatric care to other services, leaving services for mentally ill people short of funds. Vice-chair, Professor Elaine Murphy, says that this shortage applies not so much to hospital beds as to community support. Psychiatric services are still being run using a conventional, hospital-based model. People stay inappropriately on acute psychiatric wards and some are shipped off to distant private hospitals. She has also called for a reallocation of resources towards health authorities in deprived areas where there is most pressure on mental health services.

The Community Psychiatric Nurses' Association has commented on the instructions to health authorities to create "at risk" registers of former psychiatric in-patients who are judged to be vulnerable or dangerous. In the context of deteriorating communications between different NHS providers, the Chair of the Association has said that a register will work only if it is based on a standard formula and set of criteria used throughout the country. It would need an alarm system that could be triggered by health professionals in different areas. The CPNA is also concerned about the civil liberties of people placed on the register. It has called for rights of appeal to enable people to have their names removed from the register when appropriate.

BMA community care survey

The BMA has called for an urgent review of community care after a survey of 2000 doctors (which received 553 responses) found that 85% of respondents believed that services had deteriorated or not improved since the community care system was introduced. Of respondents specialising in care of elderly patients, 43% believed that the service had deteriorated, and 25% that it had improved. The corresponding figures among psychiatrists were 52% and 11%.

Doctors were particularly critical of delays in the assessments of patients being discharged from hospital and increased bureaucracy. Three-quarters of doctors caring for elderly patients said that hospital beds were being blocked by patients ready to leave, but awaiting assessment. The BMA claims that previously these patients could be discharged and GPs could find residential care beds for them, with the fees being paid through income support.

Guardian/Telegraph 26 November, Times 11 December, Independent 13 January, Nursing Times 12 January

999 line leased to road repairers

Northumbria Ambulance Trust has been criticised by a Newcastle MP, Jim Cousins, and the Radio Communications Agency for leasing out its 999 radio airwave to Newcastle City Council's road maintenance crews and a local firm. Mr Cousins has called for an inquiry.

According to a former ambulance officer, NHS staff would often find that the road crews were using the lines they wanted to use themselves. Furthermore, traffic managers used to overhear health service messages – which obviously raises concerns about confidentiality.

The chief executive of the Trust, Laurie Caple, says that the lease was unauthorised and was cancelled when it came to light. However he denied that the action was illegal. Mr Caple was appointed this year to a task force which advises the Health Secretary on "public service values". The Trust was recently praised by Health Minister Tom Sackville as a "legend" because of its business acumen.

Observer 19 December 1994

Consultation on fertility treatments

The Human Fertilisation and Embryology Authority has launched a consultation process on potential fertility treatments which have recently caused much controversy. The consultation document *Donated ovarian tissue in embryo research and assisted conception* sets out issues around the possible use of eggs from aborted foetuses or from corpses. Five months are being allowed for replies, which will be considered by the 18-member Authority before it makes a ruling in the autumn. Changing or overturning its ruling would require legislation.

The report is available free of charge from the HFEA, 30 Artillery Lane, London E1 7LS.

Independent 8 January

Nurses to prescribe

Community nurses are to be authorised to prescribe medicines from a limited list of items such as painkillers and laxatives. There will be trials of the scheme in five areas from October, but it is not yet known where these will take place. If the scheme is successful, it is likely to be extended to include hospital nurses.

Guardian 23 November

PARLIAMENTARY NEWS

Salaried dentists

There is an increasing demand for salaried dentists within the NHS as many general dental practitioners are restricting the services they provide on the NHS. A question on the number of salaried dentist posts that have been requested by FHSAs in Wales and appointments made received the answer that Clwyd had applied for 2 (both under consideration); Dyfed 4 (2 approved); Powys 2 (1 approved, the other under consideration); and Gwynedd a staggering 26 of which four were approved. The remaining applications from Gwynedd will be reviewed when the approved vacancies are filled, but this seems to be some way off. So far only one has been filled and two applications for the posts received.

The same question asked about English FHSAs elicited the fact that there are 88 salaried dentists in post and the familiar refrain: "the remaining information is not available centrally".

Hansard 17 December, cols 1006 and 1076

Nursing in the community

In answer to a question on nurses, Tom Sackville said that immunisations, vaccinations and home assessments of elderly people could be carried out independently by a first level registered nurse with additional and appropriate training, or by a first or second level nurse under the direction of a qualified medical or nursing practitioner. Numbers of nurses working in the community over the last four years in England are as follows:

Year	Practice nurses at 1 October	Community nurses at 30 September
1989	4,630	39,790
1990	7,740	41,240
1991	8,870	40,650
1992	9,120	40,750

Hansard 16 December, col 810

Targets and indicators

The following statistics were provided in a Written Answer (all for England).

Quarter ending 30 September 1993:
- 80% seen immediately at A&E
- 117 patients not admitted to hospital within one month of a second cancelled operation
- 78% seen within 30 minutes of appointment time in out-patient clinics

From April to September 1993, 47% of elective episodes in the general and acute sector were seen as day cases.

Extraordinarily, given the emphasis placed on waiting list figures, waiting times in England by specialty are not available after 1989–90. For selected specialties, these were:

Specialty	Up to 3 mths (as % of all in specialty)	Up to 1 year (as % of all in specialty)
General surgery	78.3	96.2
Trauma & orthopaedics	63.8	92.0
ENT	61.2	92.6
Plastic surgery	68.3	88.3
A&E	80.3	98.6
Maternity function	50.2	100

Hansard 15 December, cols 726–728

Drug company incentives

The Secretary of State was asked to make a statement about drug companies offering incentives to GPs to prescribe their products. In a Written Answer, Tom Sackville replied that the Government "deplores" any improper influence on doctors and is taking steps to tighten controls on hospitality and other inducements offered by drugs companies. Regulations which would render offending companies or their representatives liable to criminal prosecution under the Medicines Act 1968 are to be brought before Parliament. The Prescription Medicines Code of Practice Authority is investigating recent allegations of improper practices and is to report to the DoH Medicines Control Agency.

Hansard 14 December, col 554

FROM THE JOURNALS

Mixed responses

Surprisingly few studies have been published on patient satisfaction with mixed-sex wards. In this review article Lucy Burgess could find only one survey published since 1980, though a few were published between 1978 and 1980. On the whole, dissatisfaction rates are low (e.g. 11.3% in one survey, 5% in another). However, the definition of a "mixed-sex ward" varies. Sometimes it means a ward separated into single-sex bays; sometimes it means a Nightingale ward with no partitions. In a survey of Nightingale style wards, many of them without partitioning, 34.5% of patients said that on a hypothetical return to hospital they would prefer a single-sex ward. The article also reviews evidence on satisfaction with privacy in washing and toilet areas.

Nursing Times 12 January

Good information

In the above article, the author suggests that it would be good practice to inform patients in advance of mixed-ward layouts and the reasons why wards are mixed. A high premium is put on good information practice at Leicester General's Ward 26. Patients (and a friend/ partner) are encouraged to attend pre-operative sessions and to ask questions. On admission, they are given written information and when they leave they get a sheet with contact numbers, including one for the ward so that they can call back to ask for advice.

Another example of good practice comes from Bridgend & District NHS Trust where a breast care resource nurse is in contact with patients from the time they are diagnosed as having breast cancer, throughout their hospital stay and at home after discharge.

The one critical note in this report is that in Leicester nurses run the sessions while other nurses cover for them and they produce the information themselves. This is a strain on nursing time. A researcher who studied the ward called on managers to contribute by introducing a framework in which such good practice can flourish.

Nursing Times 8 December

A&E telephone advice

A study which monitored and evaluated the telephone advice given to people who rang an A&E department for medical advice concluded that in almost all cases callers were given appropriate advice, and almost all callers were satisfied. In two cases out of 104 the advice was judged inappropriate, but not dangerously so since these two callers were advised, unnecessarily, to come to A&E. The four people who were dissatisfied did not think they had needed to come to A&E, though the researchers thought that three of them did. Five callers did not follow the advice they received. The researchers conclude that this low cost service is safe and improves access to health information.

BMJ 1 January

AROUND THE CHCs

North Birmingham CHC and its local acute unit, the Good Hope NHS Trust, have got together to produce a Charter of Rights for the CHC, which the CHC has just adopted. It sets out principles on which the relations between the CHC and Trust are based, and rights in relation to: information, access to premises, joint consultation and planning, complaints and quality monitoring. It ends with a list of responsibilities which the Trust and the CHC need to address. The first section talks of a wide range of service, planning and financial information being freely available and in usable form and, usefully, recognises that the Trust should be pro-active in offering information to the CHC. Right of access by the CHC should be provided not only to the Trust's own hospitals, but also to other organisations with which the Trust enters into partnership arrangements: this is to be written into any contracts the Trust enters into. Among other provisions on complaints, the CHC Chief Officer will be given access to all complaints files, with due regard to patient confidentiality. While the document calls on the CHC to be as constructive as possible in its criticism of the Trust, it recognises that the CHC must maintain its right of impartial criticism. This is a refreshingly positive document, and Birmingham CHC would be willing to make copies available to other CHCs.

Salford CHC has been working on ensuring that the planning processes for maternity and neonatal services both respond to local needs and involve "local voices" in individual care and service planning. To this end it has succeeding in obtaining agreement from all those involved in local maternity and neonatal services (including doctors, nurses, midwives and lay people) to restructure the Salford Maternity Services Liaison Committee. The Committee's remit has been made more specific and its membership widened to allow more lay input. New terms of reference have been agreed, and these are available from Salford CHC.

Salford CHC has also produced a clear advice sheet giving guidance to people making a complaint or enquiry through the CHC. In conjunction with this it has produced a written policy on confidentiality, which sets out in some detail the responsibilities of staff and members.

CHC PUBLICATIONS

Respite care in Rochdale

Rochdale CHC, 28 pages

Workshops arranged by the CHC gave a clear message of the need carers have for a break and frustration among them at lack of action. The CHC wanted to gain more concrete evidence from a wider sample of carers, including those unlikely to come to workshops and previous users and non-users. When asked what type of respite care they would prefer, 41% of those who answered said they wanted respite care in their own home; 34% wanted local residential care. Answers to all the questions point to the wide range of needs and preferences of respondents. As ever, the main problem is to prompt action which responds to people's needs. To this end, the CHC is to hold meetings with service providers to discuss the findings of the survey.

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 for the day: a survey of patient satisfaction with day surgery in Leeds

Leeds CHC, 23 pages + 48 pages of appendices

This is a detailed survey of 255 in-patients and 482 day patients (a 63% response rate). A basket of procedures provided on a day basis were identified, and both day patients and in-patients undergoing these procedures were approached. The questionnaire was based on one produced by the Audit Commission.

The responses provide a lot of useful information on where the needs of each group are being met, and on where services fall short. (There are 65 tables in an appendix.) It is a little difficult to make direct comparisons between the two groups, since it is likely that those admitted as in-patients were, on average, more ill than those admitted as day cases. Nevertheless, comparison is useful where the pattern of responses between the two groups diverges.

For example, it is not surprising that on getting home in-patients experienced slightly more difficulty with daily activities such as using stairs, bathing, shopping and lifting heavy objects. However, given this, it is interesting that day patients reported slightly more post-operative pain. They also reported slightly more anxiety on the day of the operation, about injections, the anaesthetic, the findings of the operation, pain after the operation and after effects. In-patients reported more anxiety about the success of the operation.

Day patients were more likely to report that they had received explanations and information than were in-patients. In both cases, though, a high proportion said they had received no information either before admission or on the day.

On the specific needs of day patients, timetabling was a problem in some of the sites surveyed. Whereas one site operated a staggered appointment system (there were no complaints about waiting on this site), others had block bookings. As a result, patients could wait up to four or five hours between arrival and the operation. 21% of day patients reported dissatisfaction with things to keep them occupied on the ward. At the other end of the stay, several patients commented that they felt they were being pushed out of hospital before they felt ready because the day ward was closing. However, in the fixed-format part of the questionnaire only 8% reported dissatisfaction with the length of stay and 6% with the warning of discharge. Timetabling poses problems for day wards if they are to use the facilities efficiently. The report recommends that attempts should be made to reduce long waiting times and that there should be arrangements for patients who are not well enough to go home when the day wards close. The hospitals are taking steps to address these issues, having received the results of the survey some months ago.

Very few patients had received visits from district nurses and physiotherapists after their operation. Although only 10% of patients said they wanted more care from community or primary health services, in individual comments some patients expressed this need.

Report on Race and Health Seminar

North West Thames CHCs, 21 pages

There was a plenary session, with workshops in the morning and afternoon. CHC membership was discussed in the plenary session and in a number of the workshops. Many participants felt that ethnic minority groups are under-represented. One workshop suggested that to change this, CHCs need to understand why some have failed to increase representation of ethnic minority groups even when they have tried to do so. CHCs must first ask why they are not attractive to people from minority communities. This may require independent local research. However, it was pointed out in the plenary session that this is not the whole answer. CHCs must ask about the credentials of their non-black members and about how representative they are of the whole community.

That these are important questions was indicated by the feeling expressed by some participants in the workshop on "Equal access" that CHCs marginalised race issues, so that they felt disheartened and discouraged from raising them. At the workshop on "Raising awareness of race issues" a similar perception was expressed: that many black and ethnic minority CHC members find it hard to raise issues of importance to their communities because of unsympathetic fellow members who view them as "trouble makers".

The "Raising awareness" workshop had a related debate on prioritising race issues. On the one hand, some felt many sections of the community are under-represented. They felt that CHCs should be representatives of the whole community, and that race and ethnicity should not be emphasised. Others felt that race and ethnicity issues should be raised boldly. They emphasised the importance of ethnic monitoring as a mechanism to demonstrate race

inequality in health care so that action could be taken to redress it.

A workshop on "Improving involvement with ethnic minorities" identified the need for more awareness in CHCs and clearer aims. They need to be clear about why they are consulting local communities and whom they consult. They should find ways of taking the findings of research forward, so that people are not continuously being asked about their needs to no effect. They need to be aware of and relate to the local networking within the ethnic minority group. An issue of relevance to this, which was discussed both in the plenary session and in a workshop on "Health information" is that health professionals (and presumably CHCs as well) need to extend their networking and community liaison beyond "community leaders". This is particularly important where women's and children's health is concerned.

IN BRIEF

Women's views on maternity services 1993
East Herts CHC, 46 pages

This questionnaire survey of women giving birth in hospital found that, while 88% were happy with where they gave birth, a majority felt they had not been given enough discussion, information or choice. Many women were not aware of the service options available to them. Despite high levels of satisfaction with care, only 58% said they would choose the same type of care next time (18% answered "don't know").

GP referral survey
South Buckinghamshire CHC, 10 pages

Survey of two fundholding and two non-fundholding practices. It asked elective gynaecology and orthopaedic surgery patients about waiting times at various stages after referral. Although partial filling in of questionnaires makes it difficult to interpret the responses, it is clear that average waiting times are shorter for patients of fundholders than for patients of non-fundholders.

Prescription survey report
North Tees CHC, 10 pages

Survey asked questions on: prescription charges; generic prescribing; the selected list; exemptions and prepayment; chemists. An overwhelming majority of respondents thought prescription prices too high. Most were prepared to accept generic prescribing, but there was considerable mistrust of the selected list. A very large majority considered exemption claim forms were easy to fill in.

A guide to counselling services in Barnet
Barnet CHC, £1 for p&p, 20 pages

Brief advice and a listing of services available on the NHS, through other organisations and privately. It includes a list of helplines and individual local practitioners.

IN BRIEF

Chiropody services in Dudley

Dudley CHC, 7 pages

A useful survey on chiropody services looked at actual times between treatments compared with those recommended by chiropodists; user satisfaction and a survey of knowledge/views of the service among groups of older people selected on grounds other than their use of the service. Gaps between treatment were longer than those recommended by chiropodists and the perceived needs of users, especially for those whose recommended gap was six weeks or more. Apart from waiting times, users thought very highly of the service, but a considerable number of non-users who had foot problems were put off by perceived difficulty of access or did not know about the service.

Making London worse

Richard Wiles for GLACHC, 24 pages

The problems of London's health services are particularly acute, though similar pressures may be expected to apply in many large cities. This report is based largely on a telephone survey on London CHCs. There is a pervading sense of uncertainty. Much rhetoric stresses improvements to primary services going hand-in-hand with planned hospital closures. However, the operation of the internal market makes many unplanned closures probable: the threat to A&E services is particularly dramatic. The report concludes that primary care must be developed before hospital closures take place even if this requires additional resources for some time.

Report of the survey on the Health of the Nation

Health Watch Project, Warrington CHC, 35 pages (+ separate 4-page summary)

Warrington CHC maintains a panel of local people from whom it can collect views on local health issues. Questionnaires were sent to 540 panel members (response rate 70%). The survey investigated views on national and local targets and lifestyle. The detail in which results are presented enables much information to be gleaned. For example, women are considerably more likely than men to rate highly sex education in schools as a measure to reduce under-16 pregnancies. Interestingly in the section left for comments on the questionnaire, one of the five comments presented in the report objected to being asked to give priority ratings. "Are priority ratings to be used to determine cuts in healthcare? How can you give priority to cancer v. accidents v. heart disease etc!"

OFFICIAL PUBLICATIONS

What seems to be the matter: communications between hospitals and patients

Audit Commission, HMSO, 75 pages, £9
CHCs should have been sent copies

An important publication for CHCs covering General information, Clinical communication, Feedback and Communication with non-English speaking patients. Among the mass of information that CHCs will find helpful, they should perhaps note the opening case study. After a catalogue of failures of communication: "At home Mrs Rogers received a questionnaire asking what she felt about the level of noise on the ward, and if the toilets were clean. As she ticked the boxes she thought, this was not really what she wanted to tell them about, but the three lines for other comments were not really enough." As the Audit Commission comments, the hospital survey did not include finding out what was important to patients.

The Health of the Nation: One year on

Department of Health, 131 pages

Another glossy 4-colour production from the DoH (though you will doubtless be relieved to hear that it is printed on environmentally friendly paper containing fibre from renewable forest resources and naturally occurring pigments, with no use of elemental chlorine). Part one gives an overview of the first year; implementation to date (including the contributions of sectors other than the health sector); action within the NHS; and monitoring, research and evaluation. Part two looks at each of the five key areas in turn (16 of the 19 targets are moving in the right direction). Part three provides background information on working groups, publications and data.

The powers, work and jurisdiction of the Ombudsman

House of Commons Select Committee on the Parliamentary Commissioner for Administration
First Report, Session 1993–94, HMSO, 182 pages, £12.15

The present Ombudsman, William Reid, holds two posts: he is both Parliamentary Commissioner for Administration (PCA) and Health Service Commissioner (HSC). In the former role he investigates allegations of maladministration in named Government departments and pubic bodies. In the latter role he investigates allegations of maladministration in the NHS. The public has direct access to the HSC, but can be referred to the PCA only through MPs. Confusion over the titles is presumably one of the reasons for low public awareness of the Ombudsman and his powers. One recommendation of the report is that the posts should be called "the Parliamentary Ombudsman" and "the Health Service Ombudsman".

The Committee took evidence from many organisations and individuals, including ACHCEW. In considering the NHS complaints systems, the Committee summarised the confusing procedures insofar as they relate to the Ombudsman. He can investigate non-clinical complaints, but not clinical complaints or complaints about primary care provided by FHSAs. He can, however, investigate the *administration* of the clinical complaints system and FHSA informal procedures, but not of the formal complaints system of FHSAs. The Committee comments "The current complaints system in the NHS seems designed for the convenience of providers rather than complainants." A number of their recommendations are aimed at improving at least some of the problems:

- We recommend that the Government introduce legislation to bring the formal complaints procedures of FHSAs and Health Boards within the Ombudsman's jurisdiction at the earliest opportunity.

By the time she gave evidence, the Secretary of State had come round to thinking that, on this point, she was ready to explore "whether or not the remit of the Ombudsman could be extended to look at some of these matters".

- We believe that the Wilson Committee and the Government should consider seriously the extension of the Ombudsman's jurisdiction to maladministration on the part of GPs.
- We recommend that the formal complaints system for FHSAs consist of an investigation of complaints by a designated official on the lines of the internal hospital complaints procedures.

Alongside this last recommendation, the Committee comments that the current system places the complainant in the adversarial context of a tribunal and that any disciplinary action should take place *after* consideration of the complaint.

The Committee was "astonished" at the inadequacy of information on complaints collected at a national level. Hence:

- We recommend that the NHS management executives gather centrally comprehensive statistics on the workings of the complaints system within the National Health Service.

Although the Committee recommends extending the Ombudsman's remit as listed above, it does not extend this recommendation to clinical complaints. This decision was partly due to workload considerations and partly because, in clinical cases, the Ombudsman would have to rely on expert opinions of others, diluting the personal responsibility he has always taken for all judgements made by his office. However in clinical reviews, fellow doctors are considering a complaint against one of their number. Given that "all professions have an instinct to defend the expertise and competence of their number from external criticism, [the Committee considers] that the present system does not do enough to ensure impartiality in its procedures". Therefore:

- We recommend that the clinical complaints system introduce a lay element into its procedures.
- We recommend that clinical judgement remain outside the Health Service Ombudsman's jurisdiction under the existing arrangements, although we believe that the Health Service Ombudsman should be seen as the apex of any unified NHS complaints system that may be introduced.

As pointed out in *CHC News* No 84, the NHSME "Guidance for staff on relations with the public and the media" was worded in such a way that NHS staff might believe that they could not "unjustifiably" approach their MP about concerns they might have about services. In evidence to the Committee, the Health Secretary stated that "staff are not prevented from seeking advice and guidance from their Member of Parliament at any time". In view of this a Committee recommendation is that:

- The wording of the Guidance in paragraph 27 concerning the rights of NHS staff to approach their MP is misleading and inaccurate. We therefore recommend that it be amended as soon as possible.

IN BRIEF

Cancer: how to reduce your risks
Health Education Authority, 31 pages

An advice booklet explaining what cancer is and how it can be caused. After dispelling a few common myths about cancer, it gives advice on prevention and early detection.

Effective complaints systems: principles and checklist
Citizen's Charter Complaints Task Force, 9 pages, single copies free (while stocks last) from Raymond Hill, Corporate Affairs Directorate, NHSME, phone: 0532 546100.

The Task Force was set up in June 1993 to review public service complaints systems. This document sets out some basic principles and a checklist under the headings Definition of a complaint, Access, Handling, and Outcome.

The Patient's Charter and family doctor services
Department of Health and Central Office of Information, 8 pages
Available free from Primary Care Initiative, Freepost BS4335, Bristol BS1 3YX
Please specify intended use if ordering more than 10 copies.

Leaflet listing basic rights to general medical services and standards of service to be expected from FHSAs. The leaflet is available in English, Bengali, Gujarati, Hindi, Punjabi, Urdu, Chinese, Vietnamese, Greek and Turkish.

IN BRIEF

GENERAL PUBLICATIONS

Consumer concerns 1993
A consumer view of health services: the report of a MORI survey
National Consumer Council, NCC Publications, 20 Grosvenor Gardens, London SW1W 0DH, phone 071 730 3469, fax 071 730 0191, 52 pages, £10

This report is based on interviews with a representative sample of 1905 members of the public throughout Great Britain aged over 15. It covers primary, community and secondary health services (including access and satisfaction), complaints procedures and the Patient's Charter. There is a separate section on dentists. The results are compared with those from surveys in 1979 and 1989. Many results are cross tabulated by age, gender, whether there are children in family, social group, work status, part of the country and type of residential area. Patterns of use of health service do not come up with major surprises. It is worth noting, however, that people in lower social groups (C2,D,E) use all primary services less than people in higher social groups (or to the same extent for health visitor/day nurse and chiropodist). This effect is particularly marked for dentists and opticians. In contrast, they use hospital services more.

The table below shows the proportion reporting difficulties fixing appointments or arranging treatment in the three surveys.

Experiencing difficulty with:	1979/80 %	1989 %	1993 %
GP/doctor	12	9	12
Hospital in-patient unit	1	6	12
Hospital out-patient unit	5	11	11
Dentist	4	3	6
Hosp casualty	2	4	3

On waiting times in waiting rooms, out-patients and casualty units scored worst: 27% and 25% respectively reporting inconvenience. These corresponding figures in 1989 were 28% and 27%, but they are much worse than the 16% and 16% in 1979/80.

The report goes on to consider the provision of information to patients, attention to patients' individual needs and the choice of

services available to patients. People aged 65 and over were the least likely to express dissatisfaction with choices available, except of opticians. People from London, and those from urban areas in general, were considerably more likely to be dissatisfied with the choices available, especially of dentists (31% of London respondents had tried to find a dentist in the previous 12 months, and 7% had had difficulty in finding one; the national figures were 15% and 6%).

The dental figures are worrying. Of those who had difficulty finding a dentist, 36% eventually had NHS treatment, 26% had private treatment, 3% were unsure which they had and 32% had no treatment. This last figure rose to 40% for social classes C2,D,E.

The final sections consider complaints procedures and the Patient's Charter. Public awareness and knowledge of both is low. A number of recommendations are made for the former, the central one being for a single uniform system.

Professional conduct: occasional report on selected cases 1 April 1991 to 31 March 1992

United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 104 pages
Available from Distribution Room, UKCC, 23 Portland Place, London W1N 3AF; phone 071 637 7181; fax 071 436 2924

Some cases in this report make shocking reading – others are simply sad. The 40 cases presented have been selected to reflect the 180 heard during the year. They range from misconduct not relating to work, through theft, to physical abuse of patients. Each case report sets out the circumstances of the case, the decision (i.e. verdict), further information (e.g. evidence on work record), and judgement (i.e. action to be taken). Of the 180 cases heard, misconduct was proved in 90; removal from the register followed in 55. The most common spheres of practice at the time of alleged incidence were, in descending order, mental illness, nursing home, mental handicap and elderly care nursing.

IN BRIEF

Access at Whipps Cross Hospital

Waltham Forest Access Group and the Disability Unit, London Borough of Waltham Forest
Available from the Disability Unit at Walthamstow Town Hall, Forest Road, London E17 4JE; phone (voice and minicom): 081 527 5544, £10 (£5 community groups)

Report on a two-year investigation into access barriers faced by disabled people at Whipps Cross Hospital. It comments on the site, buildings, toilets, bathrooms and equipment. It evaluates the usefulness of information and signing to people with disabilities and makes recommendations on awareness, training and consultation.

IN BRIEF

INFORMATION WANTED

ACHCEW would like to know if any CHCs are aware of local NHS trusts reducing their number of Executive or Non-Executive Directors, or if any trusts have *unequal* numbers of Executive and Non-Executive Directors.

Could you please let **ACHCEW** have copies of any posters or leaflets your CHC or local purchasers have produced as part of Local Voices initiatives.

Central Nottinghamshire CHC would be grateful for any information from CHCs who know of work that has been done on the health needs of gypsies. There are approximately 1000 gypsies living in part of the district, and the CHC suspects they are receiving little or no care. The CHC is hoping to work with the voluntary sector on this and would be grateful for any information from other CHCs which would help it avoid reinventing the wheel.

Wirral CHC is conducting research into emergency response teams for acute mental illness. The CHC would be like to hear from any CHCs who have information or concerns on this issue.

Zig Smits from **Leicestershire CHC** would like to hear from any CHC that has involved the public in an evaluation of the services it provides.

Following the addition of a range of medicines, foods, toiletries, pesticides and nicotine replacement patches to the list of items which may not be prescribed on the NHS, **ACHCEW** would like to know of any patients who have expressed concern that, since 1 November 1993, they can no longer obtain on prescription the medicines they need. We would also like to know the names of the medicines concerned.

Llanelli-Dinefwr CHC would like to contact any CHCs with experience of working closely with joint FHSA/DHA purchasing authorities, particularly those which have established a "one-stop-shop" with the involvement of the CHC.

A hospital in the **Hounslow & Spelthorne CHC**'s area is planning to contract out the administration of medical records. The CHC would like to hear from any other CHCs where this has happened or who know of companies involved in this type of work.

Sections 157–159 of the Road Traffic Act 1988 entitle hospitals to collect fees from NHS patients, in certain circumstances, to cover treatment following a road traffic accident. Although it is intended that insurance companies will meet any costs incurred, **ACHCEW** would like to know if patients have experienced problems in relation to the Act – particularly if motorists who were not at fault have been forced to forfeit a "no claims" bonus.

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

FROM THE VOLUNTARY SECTOR

RNIB
challenging blindness

Two magazines from the Royal National Institute for the Blind may be of interest to CHCs. Both are published termly.

Visability is aimed at parents and professionals concerned with the education of children with impaired vision. It focuses primarily on children and young people who are integrated into their local school or college, though it also covers major issues such as the statementing process, daily living skills, mobility and training. Each issue also includes information on books, courses, technology, art, sport and National Curriculum developments.

Also for parents and professionals, *eye contact* magazine deals with the needs of visually impaired children who have additional learning difficulties. It highlights work being done around the country both in schools for children with learning difficulties and in those which cater specifically for children with little or no sight. Future issues will cover child care and protection; communication; sex education and post school opportunities.

UK annual subscription rates (three issues): *Visability* £6.00; *eye contact* £4.80. Both are available in print, braille and on tape or disk from: Jane Pickerden, Editor, RNIB Education Information Service, 224 Great Portland Street, London W1N 6AA; phone 071 388 1266 ext 2297.

In the autumn, the RNIB launched a new corporate identity. Research had showed that the organisation had a somewhat stodgy, if honest, public image. The sprightlier logo above is part of an attempt to present a fresher and more contemporary style.

Homing in on health

Health Action for Homeless people and CHAR have produced a resource pack on health and homelessness: *Homing in on health*. The elements in the pack are printed under a distinctive logo, some printed on one side only so that they can be pinned to notice boards. The contents are:

- a fact sheet on the links between homelessness and poor health
- briefings on the NHS Act 1990; vulnerable homeless people and housing under the 1985 Housing Act and ways of improving the delivery of local health services to homeless people; community care and single homeless
- a checklist of effective health care strategies for single homeless people
- a wall chart showing decision making structures within the NHS
- a health Charter for single homeless people
- a leaflet on registering with a GP
- contact lists of health authority helplines; specialist health care projects for homeless people throughout the country; national organisations working in the field; London organisations working in the field; and useful contacts within FHSAs
- a reading list
- a blank sheet is provided for details of local sympathetic health care providers.

The pack is very clearly set out and contains information and contact details which would undoubtedly be useful for any CHCs intending to promote the health care needs of homeless people. It is available at £4.25 per copy (£3.55 for CHAR members) from CHAR, 5–15 Cromer Street, London WC1H 8LS.

FORTHCOMING EVENTS

What do we want? Consumers and communication

This one-day conference will include a discussion of the recently published Audit Commission report on communications between hospitals and patients, basic components of good consumer relations, the needs of some neglected groups, and examples of good practice.

- organised by the Institute of Health Services Management
- on 14 February 1994
- at New Connaught Rooms, London WC2
- £141 members; £158.63 non-members (inc VAT)

Application forms from:
Karen Medlyn
Conference Marketing Assistant
IHSM
39 Chalton Street
London NW1 1JD
Phone: 071 388 2626
Fax: 071 388 2386

Medical complaints and litigation

- one-day conference to examine the complaints process with a focus on the medical issues
- organised by the Institute of Health Services Management and Action for Victims of Medical Accidents
- on 28 February 1994
- at City Conference Centre, London EC3
- £141 members; £158.63 non-members (inc VAT)

Application forms from:
Karen Medlyn as above

An introduction to the NHS

Seminar covering the basic organisation of the NHS, particular relationships within the NHS and how parts of the system operate in practice

- organised by the Institute of Health Services Management
- 22 February 1994
- in London
- £130 + VAT members; £150 + VAT non-members

Further info from:
Conference Secretary – Seminars
IHSM Conference Unit
Address as above

Maternity Services

- a conference for CHCs, MSLCs, voluntary organisations and health agencies
- organised by GLACHC
- on 15 March 1994
- at The London Voluntary Sector Resource Centre, 356 Holloway Road, London N7 6PS
- £65 (£50 GLACHC members and associates)

Further info from:
Daniel Jakob
GLACHC
356 Holloway Road
London N7 6PA

National continence week

- 13–19 March 1994
- organised by the Department of Health and the Continence Foundation

Aims:

- to break down taboos on discussing bladder and bowel problems
- to increase awareness that such problems are often curable
- to encourage sufferers to seek treatment

The DoH will be distributing posTers, leaflets and stickers.

Further info from:
Andrea Kinghorn
DoH Press Office
phone: 071 210 5233
or
Christine Norton
The Continence Foundation
2 Doughty Street
London WC1N 2PH
phone: 071 404 6875

Breast cancer, randomised controlled trials and consent

- one-day conference
- organised by the Social Science Research Unit
- on 24 March 1994
- at Friends House, Opposite Euston Station, London NW1
- £25/£5 unwaged and students

Further info from:
The Consent Conference Secretary
Social Science Research Unit
18 Woburn Square
London WC1H 0NS
Phone: 071 612 6397
(SAEs please)

Models of locality purchasing and planning

- seminar designed to place locality purchasing and planning in the context of current practice and to explore implications for community representatives among others.
- organised by the School for Advanced Urban Studies, University of Bristol
- on 2 March 1994 at SAUS, Bristol
- on 26 March 1994 at the Royal College of Nursing, London (at which Toby Harris will be the key speaker)
- £130

Booking enquires:
Deborah Marriott, 0272 466984

Further info on content from:
Kevin Doogan, SAUS, 0272 741117
Barrie Taylor, South West Herts CHC, 0923 245285
or Pat Turton, Avon FHSA, 0272 744242 x 274

Training courses organised by CHAR, the housing campaign for single people.

Community Care and single homeless people

- to provide an overview of the NHS and Community Care Act, specific issues for single homeless people and models of local good practice.
- 22 February 1994

Understanding changes in the health service and improving access for single homeless people.

- to look at the rights of homeless people to primary care and ways of tackling barriers.
- 21 March 1994

Each course £48.50 CHAR members; £68.50 non-members

Further info on these and other courses from:
Marian Russell
Training Assistant
CHAR
5–15 Cromer Street
London WC1H 8LS
Phone: 071 833 2071

Speaking out for advocacy

- a 3-day workshop primarily for people already involved in advocacy
- organised by Labyrinth Training & Consultancy and supported by ACHCEW among many others
- on 25–27 March (starting 3.30 p.m. Friday)
- at the GMB Centre, Manchester
  residential statutory £190 + 33.25 VAT
  residential voluntary £120 + 21.00 VAT
  non-residential statutory £120 + 21.00 VAT
  non-residential voluntary £75 + 13.13 VAT

Further info from:
Labyrinth Training & Consultancy
7 Prince Street
Haworth
West Yorkshire
BD22 8LL
Phone: 0535 647443

Talking about drug treatment: who should say what to whom?

This symposium will address how laws, codes and ethical issues determine what doctors, pharmacists, industry and the media say, and what patients want to hear.

- organised by The Drug and Therapeutics Bulletin
- on 10 March 1994
- at the Royal College of Physicians, 11 St Andrew Place, Regent's Park, London NW1
- £76.38 (inc VAT) (payable to the Consumers' Association)

Application forms and further info from:
Symposium Administrator
Drug and Therapeutics Bulletin
2 Marylebone Road
London NW1 4DF
Fax: 071 935 3261

DIRECTORY AMENDMENTS

Page 3 **Bradford CHC**
Chief Officer: Lesley Sterling

Page 6 **North Lincolnshire CHC**
Chief Officer: Ms Helen Durnan

Page 8 **North West Anglia CHC**
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Kings Lynn
Norfolk PE30 1DE
Phone and fax unchanged

Page 11 **Haringey CHC**
Chief Officer: Nick Bishop

Page 12 **North East Essex CHC**
Main office fax no: 0206 563331
Add sub-office:
Hurlingham Chambers
61–65 Station Road
Clacton on Sea
Essex CO15 15A
Phone and fax: 0255 475650

Page 15 **Croydon CHC**
Fax: 081 401 3919

Page 19 **Milton Keynes CHC**
Chief Officer: Mrs Pat Thomas

West Berkshire CHC
Chief Officer: Ms Frances Johnson

Page 21 **Torbay District CHC**
Administrator: Mrs Ann Covell

Page 25 **Southport & Formby CHC**
Change of address:
53 Hoghton Street
Southport
Merseyside PR9 0PG
Phone: 0704 536262 (with 24-hr answerphone)
Fax: 0704 544179

If you have any items for the next issue of *CHC News* could you please get them to ACHCEW by 9 February.