CHC NEWS

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

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NEWS

The new regions

The eight new NHS regions have been named and their boundaries finalised. They will be:

- North West, made up of North Western and Mersey
- North East and Yorkshire (from Yorkshire and Northern)
- South Thames (from SW and SE Thames)
- North Thames (from NE and NW Thames without Bedfordshire DHA)
- East Anglian and Oxford (from East Anglia and Oxford, plus Bedfordshire DHA)
- South West (from South Western and Wessex)
- West Midlands (unchanged)
- Trent (unchanged)

Following a consultation exercise it has been decided to keep Cumbria DHA within North East and Yorkshire. It was originally planned to include it in North West.

Sunday Telegraph 30 January

Party preparations

In a consultative policy paper, *Health 2000*, the Labour party has said that it would keep the purchaser/provider split within the NHS, while replacing competitive contracting with rolling "service level agreements", probably lasting three years. NHS trusts would be made more accountable, but would retain a degree of self-governing status. Health authority boards, and possibly those of trusts, would be democratised. Options for this include nomination of members, direct election or integration with local government. GP fundholding would be abolished, and GPs would be drawn into commissioning agencies with merged DHAs and FHSAs.

Accepting that some degree of health care rationing is inevitable, the party suggests setting up a panel, including doctors and patients' representatives, to "provide support and guidance" to doctors in making decisions on allocating resources, without prejudicing their clinical freedom. Costs and performance would be monitored centrally.

The document does not dismiss the possibility that hospitals could set their own pay rates and conditions, though pay review bodies and Whitley councils would at least set out minimum standards.

Pay beds would be gradually phased out. Other possibilities under consideration are levying charges on private health care, restricting the amount of private work NHS staff can do and abolishing tax relief on private health insurance. *Health 2000* is available from the Labour Party, 150 Walworth Road, London SE17 1JT for £3.

The Liberal Democrats have also issued a policy document, *A Caring Society*, which is expected to be adopted as party policy in March. It concludes that, to provide a seamless and accountable service, health and social services should be merged. FHSAs, DHAs and social services would be merged into a single department within democratically elected local authorities. It also proposes a regional health and social services authority. *A Caring Society* is available from Liberal Democrat Publications, 8 Fordington Green, Dorchester, Dorset DT1 1GB for £4.50.

Independent 7, 11 February, Guardian 11 February

Pilot to extend fundholders' responsibilities

Four GP practices in Bromsgrove, Hereford and Worcester are to be given £13m a year for the next two years to pay for their own primary care, general surgery, hospital emergencies and post-accident care for patients on their registers. The pilot scheme, which will run from April, will involve the allocation of 14% of the health authority budget to the GPs. Such a scheme would address one of the complaints some DHAs have been making – that it is unfair for them to have to fund all emergency treatment, while GP fundholders are responsible for funding only elective admissions of their patients. The effect, the argument goes, has been to siphon money away from DHAs towards fundholders. In Greenwich & Bexley, for example, four practices have underspent their budgets by £786,000 (13–19% of their budgets) while Greenwich DHA is forecasting a £1m overspend and Bexley DHA already has one of £631,000. However, schemes which extend fundholders' budgets and responsibilities clearly bring into even higher profile questions of accountability. They give fundholders – who are not democratically accountable and have responsibility only for patients they have (and keep) on their lists – control of very large amounts of public money. The Midlands scheme is to be closely monitored by the RHA.

There is considerable interest in extending fundholder responsibilities. At a recent NAHAT conference, the chief executive of Wessex RHA hinted that in the future DHAs may have a more residual role, but thinks that "there will be a role for health authorities of some kind". He warned that health authorities trying to "stifle" fundholders would be "dealt with". The chief executive designate of the NHS, Alan Langlands, has acknowledged that GPs could in the future effectively replace health authorities in buying all health care, though he insisted there was "no hidden agenda" and that whether or not GP fundholders would take over control of more funds would depend on what provided most benefit to the population and the taxpayer.

Times 18 January, Independent 24, 25 January

Say "no" to tobacco, but not to the advertising

The Government has rejected calls to ban tobacco advertising. Instead it is to pursue further voluntary agreements with the tobacco industry. Launching an "action plan" to cut smoking, the health minister, Brian Mawhinney, called for action by parents, teachers, school governors and retailers. A spokesman from Action on Smoking and Health commented "the Government seems to want action by everyone except themselves". The Advertising Association warmly welcomed the Government statement, while the BMA is strongly in support of a ban.

There appear to be splits within the Government on the issue. Although he presented the Government's case, Brian Mawhinney abstained in a private member's bill to ban all tobacco advertising (except in specialist tobacco shops), and sponsorship of sporting events. The bill, sponsored by Labour MP Kevin Barron, passed its second reading, despite attempts by some Conservative MPs to talk it out. However, the bill has little chance of becoming law. Mr Barron claimed that tobacco company advertising budgets were about ten times the budgets available to health educators.

Independent 8 February, Guardian 12 February

Giving with one hand ...

Programmes to reduce waiting lists are to receive an enormous cash boost (amounting to £20m according to the Guardian one day and to £14m according the Independent the next). The extra funds must be spent before the end of the financial year. This means that they are most likely to be spent at hospitals which have completed their contracts ahead of time and in the private sector. Some regions, East Anglia among them, feel they cannot make use of the money so quickly. The magical appearance of the bonanza has been ascribed variously to "savings on other budgets" (DoH) and "a cock up" (a regional official).

Guardian 1 February, Independent 2 February

... and taking with the other

NHS hospitals were fined £300,000 for failing to meet waiting list targets in the first nine months of the financial year. In the previous year fines totalled £45,000. Of more than 20 hospitals fined, 11 were in NW Thames region (£138,000) and 8 in NE Thames (£149,000). The money is redistributed and used elsewhere in the NHS. The Department of Health imposes fines on RHAs, which can pass them on to DHAs, which in turn pass them on to hospitals. As East Anglia and South West Thames RHAs have found, there is no mechanism for regions to pass the fines on to GP fundholders.

Independent 1 February

Out-patient waiting times

A survey in Mersey region and 14 other NHS trusts and districts shows that about 1.3 times as many patients are waiting for an out-patient appointment as are on waiting lists for in-patient admission. If this is representative of the country, some 2.3 million people are waiting for a consultation or an admission. The survey also found that some people have to wait up to two years for a consultation. Two extreme cases come from Bristol: Southmead NHS Trust told one woman that she would have to wait two and a half years to see a consultant about her hip and another woman with a collapsed toe that she could not see a consultant until 1996 (she wrote to Mrs Bottomley – and has been treated). The Department of Health does not collect out-patient waiting times, though health minister Brian Mawhinney says that he takes the waits very seriously and that regions are setting a target of a maximum wait of 13 weeks. However, the Department of Health has said that it has no plans to change the system of recording waiting lists to reflect the time from GP referral to treatment. This appears to be at odds with earlier instructions to hospitals from the NHSME (see *CHC News* No 83).

Observer 16 January

Roller-coaster prescribing

Over-medication of women at Ashworth Hospital, followed by abrupt reductions of dosages has caused the women great distress and led to a string of assaults on staff and other patients according to staff representatives.

After a visit in January 1993 to two female wards in Ashworth Hospital, the Mental Health Act Commission reported "grave concern" about high levels of medication prescribed without considering therapeutic benefits. Staff allege that drugs were being used to keep women sedated. The chairman of the Local Pharmaceutical Committee said that dosages "grossly" above the levels recommended by the *British National Formulary* were being prescribed on a long-term basis, and for inappropriate conditions. Side effects could be serious and in some cases permanent. Three months later, the hospital commissioned an "independent external advisory group". The group's report is now described as an "internal management document" – it has not been published. An action plan was drawn up, apparently using the group's findings. The doctor responsible for prescribing on the wards was moved – to treat male mentally ill patients – and medication levels "reviewed". Subsequently, levels of medication were suddenly reduced. Senior nursing staff claim that the withdrawal effects caused even greater distress than the distorting effects on behaviour of the drugs themselves. They say that patients had convulsions and epileptic fits and that they would "attack and assault and run riot" to get more drugs.

In the same month as the Commission's visit, a senior social worker, Susan Machin, had arranged a meeting in London with the chief executive of the Special Hospital Services Authority to discuss problems at Ashworth. She has since been suspended and faces a disciplinary hearing over what her MP has called "trumped up" charges. She is reported to have been on of the group which alerted the Mental Health Act Commission to the "oppressive sub-culture" among staff at the hospital in 1992 (see *CHC News* No 75).

Independent 31 January

Recalls for cervical smears – again

Once again women are being recalled because of failures in the cervical smear system. A computer programming error and failure to check monitoring systems meant that women in Merton, Sutton & Wandsworth in south London were not sent reminders that they needed re-testing because of slight abnormalities or because the laboratory could not read the original smear. The women had been notified of this once, but no action was taken over the 3,860 women who did not attend for a repeat smear. All women in the area who had moderate or severe changes in their smears had been treated correctly.

A week before the error came to light, the Chief Medical Officer, Dr Kenneth Calman, had announced measures to restore confidence in the cervical smears system. These include:

- guidance to GPs on the correct way of taking cervical smears
- refresher courses for nurses who take smears
- clear information for women invited to have a smear
- a national coordinator to set standards and monitor performance
- tighter measures for checking laboratories that assess smears

Dr Calman said that the most effective measure to detect cervical cancer would be to encourage more women to attend for smear tests. At present only 72% respond to invitations to attend. That this is important has been confirmed by research carried out in Rotherham. The research analysed all deaths from cervical cancer in the District, reanalysing smears where these were available. Half of the women had never had a smear test. Some had refused repeated invitations to attend. However, 20% of deaths were attributed to poor management or misdiagnosis and in 14% early abnormalities had been missed. The number of women who died within five years of a correctly analysed negative smear is worrying. The researchers call for the recommended interval between smears to be reduced from five years to three years.

Guardian 18 January

Off your trolley

The Health Secretary, Virginia Bottomley, has asked Duncan Nichol, NHS chief executive, to instruct health authorities and hospitals that it is unacceptable for patients to be left on trolleys in A&E departments while they wait for beds to become available on hospital wards. Hospitals are to be told that they must give patients a suitable bed on a ward as soon as possible after a decision that they should be admitted. Health authorities must make sure that satisfactory arrangements are in place to achieve this.

Daily Telegraph/Times 21 January

FOCUS ON ... LONG-TERM CARE

What is striking about the Health Ombudsman's recent report of his investigation into a complaint about the care of a brain damaged man is that a conclusion which would have been taken for granted a few years ago – that the NHS should have continued to provide care for a neurologically damaged, immobile and doubly incontinent patient – now draws shocked reactions from health authorities.

Since the issues raised by the Ombudsman's investigation are of general public interest, he has taken the unprecedented step of issuing a report on this single case.

Continuing care

The complaint was made by the wife of a man who had suffered a stroke and spent 18 months on a neurosurgical ward at Leeds General Infirmary. After 18 months (when the man was aged 55) the consultant decided nothing more by way of active treatment could be done for him. It was clear that he still needed full-time nursing care – he was doubly incontinent, immobile and unable to communicate or feed himself and had a kidney tumour, cataracts in both eyes and occasional epileptic fits. Since he could not be cared for at home and was too young to be admitted to an elderly care ward, the ward staff recommended that he be discharged into a private nursing home. The man's wife objected, believing that he would not receive adequate care, but eventually acquiesced. The man is now in a nursing home. He receives income support which leaves an annual shortfall of £6000 on the nursing home fees, which are met by the family. The man's wife complained to Leeds CHC who took up her complaint with Leeds Health Authority

The stated policy of Leeds Health Authority is to make no provision for the continuing care of such patients. In line with this, the contract between the DHA and the Infirmary for neurosurgical services makes no mention of continuing institutional care. The DHA argued that its policy of reducing continuing care beds in hospital reflects national policies and in a meeting said that its "hands were tied" by national policy.

On this point, the National Health Service Act 1977, section 3(1), states that:

"It is the Secretary of State's duty to provide .... to such an extent as he [sic] considers necessary to meet all reasonable requirements –

(a) hospital accommodation;
(b) other accommodation for the purpose of any service provided under this Act;
(c) medical, dental, nursing and ambulance services;
...
(e) such facilities for ... the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service; ..."

The crux of the Ombudsman's argument that Leeds Health Authority was guilty of a "failure of service" is that the man concerned "manifestly still needed what the National Health Service is there to provide". This holds good even though the NHSME has stated that "the level of service provided overall is a matter for individual health authorities in the light of local circumstances and priorities". The Ombudsman has recommended that the DHA should make an *ex gratia* payment to the man's wife to cover the costs she has already incurred and should provide for appropriate nursing care at NHS expense in the future. He has also recommended that the DHA review its provision of services for this group of patients in view of the apparent gaps.

Discharge arrangements

Although they were not formally part of the investigation, discharge arrangements at the hospital also come in for criticism. Department of Health guidance (HC(89)5) states that "Where a person moves from hospital to a private nursing home, it should be made quite clear to him/her in writing before the transfer whether or not the health authority will pay the fees. No NHS patient should be placed in a private nursing or residential care home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges." Hospital staff were unaware of the requirement to set down in writing who would pay the fees and the patient's wife was not given this information (the hospital's April 1993 Discharge Policy makes no reference to the requirement). The Ombudsman therefore considers that she had been placed under duress and her eventual agreement to pay the nursing home fees was inequitable.

Reactions

Leeds Health Authority has since apologised to the complainant and has agreed to implement the Ombudsman's recommendations. However, the authority has commented that if it were expected to pay nursing-home fees, it would soon become financially over-stretched. Philip Hunt, director of NAHAT said that the Ombudsman's findings will draw to people's attention the NHS rules and could prove a financial "time bomb" for health authorities and Government. Gill Pitkeathley, director of the Carers' National Association, has welcomed the Ombudsman's decision and believes that it will force the debate on long-term care into the open. The Government, in the meantime, is closely studying the findings "for any further implications it may hold for the health services". Looking at the wording of the NHS Act 1977 above, it is clear that a great deal of discretion lies with the Secretary of State as to what services should be provided under the NHS. At least, however, the publication of this report may make it more likely that decisions on curtailing provision will be challenged and not simply accepted as part of an inevitable and almost invisible process.

Training call for keyhole surgeons

A Government-commissioned report on keyhole surgery produced by a working party of surgeons (see *CHC News* No 87) concludes that there is an urgent need to draw up guidelines to ensure that the techniques are used safely. The report was quietly published by the Scottish Office in January – it was not released to the English press. Keyhole techniques are being taken up so rapidly (they are expected to be used in 70% of operations by the end of the decade) that they are often practised by surgeons who have very little experience. "Occasional avoidable incidents are occurring which have led to serious morbidity and mortality". One woman supposed to have been sterilised using keyhole techniques has since become pregnant. Another 29 women operated on by the same locum surgeon have been recalled to check whether their operations were effective.

Times 8 February

Needlework class

At least locum surgeons have more experience than the two 15 year olds who were asked to stitch the wounds of two patients at the A&E Department at Glasgow Royal Infirmary. A senior house officer asked pupils to insert stitches, not realising they were pupils on a work experience programme. In each case he took over when he judged that the "medical students" weren't particularly proficient.

Daily Telegraph 18 January

Computerised self-help

A new form of self-help group is springing up. Forums on computer networks, particularly Compuserve, are increasingly used to share experiences and get advice. Subscribers across the world use computers and modems to access forums where they can exchange messages (anonymously if they so choose). Users apparently find support and involvement they have not found elsewhere as well as information and questions to take back to doctors. Compuserve has forums on cancer, diabetes, disabilities, health and fitness and human sexuality as well as AIDS news clips and health information databases. You have to pay to subscribe and to access the forums, though not as much as you might think – once you have the computer and modem of course. Information on Compuserve is available from: 0800 289378.

Guardian 1 February

PARLIAMENTARY NEWS

Increase in NHS managers

Staff group	1990	1991	1992
General and senior managers	8,990	12,420	14,980
Admin & clerical	111,730	118,900	122,990

Excludes most staff in FHSAs and other statutory authorities, but includes ambulance service staff.

Dr Mawhinney urged caution in interpreting these figures. He said the increase is largely due to the reclassification of professional and administrative staff as senior managers. This would imply that few resources are being switched from direct patient care. (He did not mention the effects of clinical staff recording increasing volumes of information required for the internal market.) He added that general and senior managers account for only 2% of the NHS workforce and that forthcoming changes to the regional structure will bear down on management numbers. The *Guardian* (21 Jan) reports that of the rise in senior and general managers between 1989 and 1992, 12.5% are attributable to increases at RHA level.

Hansard WA, 14 January, col 314–315

Shifting towards day cases

General and acute admissions	1991/92	1992/93	1993/94 (forecast)
	thousands		
Elective	2,416	2,323	2,263
Day case	1,536	1,784	1,958
Non-elective	3,505	3,644	3,753
Total	7,457	7,770 (sic)	7,974

It is estimated that 80% of non-elective admissions are emergencies. Information on readmissions is not collected centrally.

Hansard WA, 4 February, col 973

Complaints statistics

A regional breakdown of written patients complaints for 1992/93 is expected to be available by the end of March this year.

Hansard WA, 17 January, col 392

FROM THE JOURNALS

Over the counter medicines

Over the counter (OTC) sales of medicines are increasing as the prescription charge of £4.25 per item (£4.75 from April) is increasingly likely to exceed the cost of a medicine and as the list of medicines not prescribable on the NHS is lengthened. The *Drugs and Therapeutics Bulletin* has produced advice for GPs on OTC medicines. It outlines GPs' responsibilities and suggests how they may advise their patients.

Drugs and Therapeutics Bulletin 20 January, pp4–5

Inappropriate patient placements

A study of acute wards (excluding psychiatry and obstetrics) at three inner-London hospitals found that 15% of patients were perceived by staff as being "inappropriately placed". The staff judgements on these patients tallied well with a classification system called the Oxford Bed Study Instrument. The "inappropriately placed" patients had high levels of physical and mental dependency – 43% were perceived as needing alternative health services; 22% as having social/housing problems; 14% as needing local authority services and 12% a nursing home place. Over the five month study period the patients were estimated to have cost the health services £836,547 (£209,138 taking only marginal costs). However, without costing the alternative provision these patients need, it is not obvious what the implications of these costings are. What is clearer is that patients placed inappropriately are not getting services which meet their specific needs.

Health Trends 25(3) 1993 pp 94–97

Psychiatric services satisfaction

A study with 516 psychiatric patients who had at some stage been admitted to hospital (contacted mainly through local MIND associations) sought qualitative and quantitative data on satisfaction with various interventions. Talking therapies received the highest satisfaction ratings (74% helpful, 15% harmful) followed by antidepressants, industrial therapy, occupational therapy, major tranquillisers and, lastly, electroconvulsive therapy (43% helpful, 37% harmful) (48% of the sample had received ECT). The paper briefly discusses the influence that media images may have on satisfaction ratings and the finding that the quantitative data were more closely aligned with media images than were the qualitative data, which revealed more about individual experiences.

Nursing Times 26 January, pp 11–12

Consumer involvement in outcomes measurement

When consumers are asked about what criteria they would use in evaluating health care, they rate the nature of the health care they receive as more important than the surroundings in which it is delivered. Yet too often professional designers of questionnaires, rather than consumers themselves, set the agenda for satisfaction surveys. In addition, the pressure to convert findings into numerical data leads to the loss of the richness and meaning of consumer responses. This paper by Richard Wiles considers how consumer involvement in the NHS could more accurately reflect the criteria consumers consider important. It outlines the political, conceptual and methodological barriers to involving users and discusses some approaches that have been used to overcome these barriers. The College of Health consumer audit programme, which uses focus groups, semi-structured interviews and observation, seeks to be rigorous in collecting and analysing consumer views, but to acknowledge they are qualitative. The approach reveals what may be lost by simple satisfaction surveys. For example in a focus group discussion among mental health services users, initial gratitude to GPs gave way to serious criticisms of the GP service. A questionnaire would probably not have picked up on the dissatisfaction. The reports of consumer audit exercises generally present direct quotes from users, and as a result may be criticised as being emotive. But a degree of emotion, the author points out, is not out of place since they enable the impact of outcomes to be understood. They are a supplement to, rather than a substitute for, clinical evaluation. Other ways of enabling patients' experiences to inform the assessment of outcomes are through consumer involvement in committees responsible for commissioning clinical and medical audit and ensuring that individual consumers have access to information on outcomes.

Critical Public Health 4(4) 1993, 35–40

SPECIAL GENERAL MEETING TO BE RAILROADED OR SIDELINED?

A view from the floor

The Special General Meeting started as a very literary affair, with talk of taking the tide at the flood and so leading on to fortune. Toby Harris was recalling the stirring experience of acting in a school production of Julius Caesar though not, he had to admit, as Brutus, but as Murellus – a tribune of the people who was silenced in the first Act having the effrontery to pull garlands off statues of Caesar. Fortunately dissent isn't punished quite so harshly these days. Despite some heated debate, all delegates left the floor unscathed.

The tide in affairs which Toby is so anxious that CHCs should catch is the process of Government legislation. Recent NHSME guidance on the operation of CHCs is largely positive in tone, but CHCs cannot afford to ignore some details of emphasis within it. Whereas regions *should* properly resource CHCs, they should *require* CHCs to develop and publish their own annual plans, following discussion with the region itself and local purchasers and providers. They should then discuss with CHCs the progress of the annual plans and the use they make of their resources. In a document that is generally unwilling to impose requirements on regions, does this proposed requirement on CHCs herald a closer interest in the details of their working? If so, the nature of the establishing authority for CHCs becomes critical.

In mid-January, the ACHCEW officers had a meeting with Alan Langlands (chief executive designate of the NHS) who made it clear that decisions on the future establishing authority of CHCs had not yet been taken, but – with drafters of legislation working to a very tight schedule – they soon would be. Toby warned that, while the importance of the genuine independence of CHCs may seem obvious to CHCs, others would not share this aspiration. There would be a strong lobby pushing for purchasers as the establishing authority. There would also be legal, administrative and political disincentives to ensuring that CHCs were established in a way that would ensure their genuine independence.

Burnley, Pendle & Rossendale CHC had submitted a resolution for the SGM to be postponed. The resolution could not be taken for constitutional reasons, but any delegate was free to move a motion at the SGM for the meeting to be adjourned. Mike Landriau from Burnley, Pendle & Rossendale made it clear that the importance of the issues was not in dispute. His CHC's argument was that CHCs should have time to debate them internally, rather than being forced to give a hurried response that would be set in stone.

After some initial skirmishes about the length of time the Standing Committee had devoted to setting up the SGM, no-one took the opportunity to move a motion for adjournment of the meeting, perhaps because, now delegates had turned up, they would be less than enthusiastic about trailing home again or perhaps because of a suspicion that the NHSME might be less scrupulous about gathering views from all interested parties than CHCs would like to be themselves. The agenda was overwhelmingly adopted. Nevertheless, a number were concerned that they might be railroaded.

Railroaded or not, the debate was now firmly on the tracks. No-one spoke against an amendment on a national resourcing formula. It was carried – as was the next amendment on staffing levels, though this evoked some disagreement on the merits and demerits of multiple CHC offices. Few seemed to disagree with the next amendment on rights to visit NHS trust premises, but some delegates felt it was taking the debate onto the wrong route. It was about external relations whereas the issue for the day was the establishing authority for CHCs. The amendment was remitted and the debate picked up speed.

North Birmingham's amendment to the effect that the new regional offices of the NHSME should become the responsible bodies for the establishment of CHCs brought near unity among other delegates. They were unconvinced that the regional offices would be local bodies, something which can hardly be claimed for the NW region, for example, which will stretch from Warrington to South Cumbria. The hope that regional offices would support CHCs was countered by a belief that, staffed by non-elected bureaucrats, they would be more likely to want to secure compliance with central NHSME policy. Being established by regions might give CHCs a direct path into the NHS

hierarchy, but this would be more likely to be used to their disadvantage than their advantage. North Birmingham's suggestion that RHAs had rarely interfered with CHCs met with a sceptical response, and its hope that the new regional offices may become more democratic in the future with outright laughter.

While there was general mistrust of the new regional offices, there was much less unanimity about whom CHCs *could* trust. There were concerns about who would appoint members of an "independent" establishing authority and about a centralised body. Nevertheless, it seemed on this occasion to be a case of better the devil you don't know. North Birmingham's amendment was defeated by a large majority.

ACHCEW was not exempt from the sense of mistrust, a feeling which was reflected in debate on amendments to proposition B and in a flurry of points of order. If the SGM had to be held before CHCs felt ready for it, the proposers of the amendment at least wanted to ensure that they were consulted over the setting up of an establishing authority for CHCs.

Tim Murphy from Torbay warned CHCs that individual consultation will divide CHCs so that they can be destroyed. He called on CHCs to use ACHCEW to speak with one voice, but not to abuse it. On the other hand Justin Dix from NW Surrey said that CHCs were being asked to jump through a window, but they didn't know if they would have a soft landing. He called for clarification from Toby Harris, who reiterated what he had said about his meeting with Alan Langlands. He believed that it would probably be too late to influence decisions by the end of February. Mike Landriau from Burnley, Pendle & Rossendale expressed the frustration many felt at being forced to do things so quickly. CHCs would be setting a bad example by allowing the Government to set the timetable – whether the Government would be in the least bit impressed by CHCs attempting to set a better example is, of course, open to doubt. The debate by now had picked up a good head of steam, and Richard Edwards from South Beds tried to exert a calming influence. It had been made quite clear to the Society of CHC Staff a week earlier that the drafting of legislation would soon begin, so it was hardly ACHCEW's fault that CHCs had to make decisions.

The original proposition B was that:

> "following the proposed abolition of RHAs, an independent agency be set up to act as the establishing authority for CHCs."

The upshot of the debate on Amendments 5a and b was as follows:

(a) "delete: 'an independent agency be set up to act as the establishing authority for CHCs' and replace with 'a national independent agency to be set up as the establishing authority for CHCs in consultation with CHCs'"

This was defeated by 70 votes to 64.

(b) "Add at the end of the proposition: 'Full and thorough consultation should take place with individual CHCs before any final decisions are taken on the future organisation and establishment of CHCs'"

This was carried by 90 votes to 39.

The amended proposition B still had to be voted on. A spectre was raised of sending Toby naked into the conference chamber. This seemed to clinch the matter, and the proposition was overwhelmingly carried.

The debate heated up again over Proposal C(i) on the membership of CHCs. Opposing claims for the merits and demerits of members from local authorities and voluntary organisations were flung back and forward. The former, it was argued, are accountable to democratically elected bodies, but too often have a poor attendance record; the latter may be more dedicated, but sometimes to single issues, and their organisations may now be providers of care under contracts. The variability of CHC areas may require flexibility over membership, but a number of CHCs argued for the safeguard of having LA representation. The formula suggested in proposition C could lead to the LA representatives being removed altogether. South Bedfordshire's amendment provided the necessary compromise. A national standard would be for equal numbers of members appointed by local authorities and elected from the voluntary sector, but local variations would be possible in view of such factors as the number of LAs in a CHC area.

As the debate was coasting towards a close, Proposition D again raised the issue of consultation. North Manchester's amendment on the establishment of an inquiry team which will meet with the NHSME and consult with regional groupings of CHCs was carried, though Salford's amendment calling on the NHSME to consult with individual CHCs rather than ACHCEW fell.

Full details of propositions, amendments and voting will be in the minutes.

AROUND THE CHCs

Liverpool Eastern CHC suffered a serious disappointment when its Chair's application for leave for a judicial review of the decision to close the A&E Department at Broadgreen Hospital was turned down. Despite the CHC having minutes of meetings dating back to 1989, which showed that the decision to close the department was made then, and despite support for the application from MPs, councils and local medical committees, the judge ruled that Liverpool Health Authority had carried out a meaningful consultation. The impending closure of the department will be in the face of massive opposition from CHCs, GPs, MPs, councillors, community groups and local people.

With the operation of the internal market, differences in provision for different populations will increasingly occur as a result of different purchasing decisions by DHAs and possibly by GP fundholders. Similarly, specified standards of performance vary between contracts. There has been little serious discussion of the benefits and drawbacks of such variations. **Airedale CHC**'s area provides a good setting for a study on this issue. The former Airedale Health District is now split between Bradford DHA and North Yorkshire DHA, though the whole is still represented by Airedale CHC. In addition, the Worth Valley consortium of GPs will soon control a purchasing budget of £20m. The CHC has commissioned a small-scale, qualitative study of services provided to different purchasers by the main local provider. It will look at differences between services purchased and standards specified in contracts, at whether standards actually differ and the costs of any differential arrangements. Lastly, it will look at public and media awareness of identified differences.

Kidderminster & District CHC is in the process of drawing up an agreement with the local Trust which provides services for people with learning disabilities. The agreement covers the right of the CHC to have an observer on the public part of Trust board meetings and the involvement of CHC members in informal meetings, working groups and project teams. A senior member of the Trust management team will attend CHC formal meetings. The CHC will send draft visit reports to the Trust for comments and correction of factual inaccuracies at least two weeks before discussion at the People with Learning Disabilities Working Group meetings and may append the Trust's comments as an addendum. The Trust will advise the CHC of proposed changes to service except in special circumstances when immediate action needs to be taken.

CHC PUBLICATIONS

Report of a visit to the John Denmark Unit (National Centre for Mental Health and Deafness), Prestwich Hospital

Salford CHC, 7 pages

Salford CHC is anxious that other CHCs should be aware of the good work that is being done at this Unit. Although it currently has supra-regional status, this status is to be withdrawn in April. As a result, its funding will now depend on winning individual contracts and referrals from across the country.

The Unit provides multi-disciplinary mental health services to deaf people, including deaf people who are also blind or who have physical disabilities. It has 24 beds, and provides in-patient, day case and out-patient care (clinics are also held in Pontypridd and Belfast). It does not provide long-stay care. Of course, the visit found some areas that need attention (e.g. particular provision for people from ethnic minorities and independent advocacy), but it found much more to commend. Of particular note were excellent access for people with disabilities including people with sight problems and the communication facilities (for example minicoms, a proposed video telephone, a loop system for the use of those with hearing aids, and the use of audible, visual and vibrating indicators for fire alarms and emergencies). A good deal of thought has also gone into providing information, developing activities and coordinating discharge.

Salford CHC comments that other CHCs might like to point out to GPs in their area that this service is available and suggest that they make use of it. Copies of the visit report are available from the CHC

Response to consultation document - Maternity services: the way forward

Blackburn, Hyndburn & Ribble Valley CHC

The closure of two of the three GP maternity units in the Blackburn, Hyndburn & Ribble Valley District over the last few years seemed inevitable on the grounds of safety and lack of use. Now that a new Maternity Unit is to be opened at Queen's Park Hospital, the DHA has confirmed CHC fears that it is proposing to close the third GP Unit at Accrington. The DHA implies that by having all in-patient maternity services on one site, women will be offered a more flexible service and more choice – in effect it is arguing that the new unit cannot open unless funds are released by the closure of the GP Unit. This would leave local women with the choice of a delivery at Queen's Park or a home delivery. The CHC welcomes the opening of the new facilities at Queen's Park Hospital, but does not believe the closure of the Accrington Unit is justified, and certainly doesn't believe that it would extend choice.

The DHA consultation document used the all-too-common ruse of accentuating changes in activity by using a graph with an axis that does not start at zero. This gave a distorted impression of the fall off in activity at Accrington. The CHC presents graphs replotted on an axis starting at zero: the fall off in activity suddenly looks much less marked. In addition, the CHC argues that there are various reasons why some GPs have not been referring women to Accrington, one of them being precisely that the unit is under threat – they feel there is no point in booking in as the unit will be closed before the baby is due. Another reason is the reported advice of a consultant (to refer first time mothers to Queen's Park Hospital) which does not tally with the written policy agreed by the MSLC.

The CHC has drawn on DHA planning figures, its own maternity surveys, public meetings and meetings with GPs, midwives and midwife managers (presented in a sheaf of appendices) to put together a detailed argument on why the DHA should withdraw its consultation document and keep the Accrington Unit which should be either midwife-led or a joint midwife-led/GP Unit. In this way local women might have a genuine choice about maternity care.

Maternity services: a consumer viewpoint

North Lakeland Healthcare, Carlisle Acute Hospitals and East Cumbria CHC

The purchasers, providers and the CHC in East Cumbria have a well established relationship in which they work together on research into quality issues. This report is one part of a joint survey to find out to what extent the recommendations of *Changing childbirth* are being met in the District and if the national recommendations reflect the wishes of women in East Cumbria. The research team concludes that there are several areas which need to be reviewed to ensure the implementation of national recommendations at local level.

A total of 1998 women in the area fitted the study criteria. From this list, 666 women were selected at random and sent postal questionnaires. A response was received from 348. Women were asked about the choices they would make at various stages in pregnancy and the importance of being able to make those choices. This provides useful information. For example, 58% of women rated being able to choose where to book in as essential, very important or important, whereas nearly all women rated choosing the place of delivery in one of these categories. Women rated being able to choose who gave antenatal care highly, though they gave different responses as to who that person would be (34% GP, 31% midwife). Over 70% wanted a community location for antenatal check-ups. Even among the 171 Carlisle women, 77 would choose the local surgery, though there was a hospital maternity unit locally. Two suggestions received only moderate support: 44% of women said they would not choose to make a birthplan (but nearly all those who would choose to make one considered it important) and 67% did not think it would be helpful to have carried their own medical notes.

These and a series of other questions enable the researchers to reach conclusions on antenatal care, antenatal classes, place of birth, lead professional/continuity of care, postnatal classes, information and communication, women in a central role and equal access. Definite and practical local recommendations are made on most of the topics, though in some further review is advised.

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

Growing old and needing care

Dr Tom Chapman and Alan Johnson
Southport & Formby CHC and DHA, Edge Hill University College, 264 pages, £17.95 (inc p&p, cheques payable to Sefton Health)

This is a very hefty report on a health and social care needs audit of Formby residents, aged 65 and over which took nine months to complete. A primary aim has been to develop and apply tools for assessment from the standpoint of the client. It is important not to design instruments with the existing range of services in mind. This is especially necessary given the extent to which the nature of practitioner and professional intervention frequently sustains stereotypes, which are often shared by elderly people themselves.

There is a brief review of the literature on needs assessment and the framework used for the analysis of data collected in this study is set out. This uses a typology of "basic needs" and "intermediate needs". Basic needs are divided into health and "autonomy", which itself has three attributes: mental health, cognitive skills and opportunities to engage in social participation. Intermediate needs include housing, nutrition, employment, physical environment, appropriate health care and others. Respondents' own rating of their health is used as the measure of their general state of health.

Data were collected from a postal questionnaire which was sent to 1065 elderly people selected by systematic sample (every fourth name of the age group on the FHSA register) and achieved a 72% response rate. Nine focus group sessions were held, three with professional groups, four with elderly people and two with carers. Numerous interviews were held and case studies carried out. Some of these are included in this report, while future research will use them to gather the views of individuals whose voices tend to go unheard.

There is no space here to discuss the results, except to note the general conclusion that local purchasing decisions need the courage to depart from traditional ways of doing things and that a vital part is to be played by regular and independent monitoring. There is an eight-page summary document, but it is probably the bulk of the report showing methods and analysis which would be of more use to other CHCs.

Information: do leaflets help?

Sheila Jefferson, Jefferson Research, York for South West Durham CHC, 23 pages

A consultant in South West Auckland has for some time been producing a series of patient information sheets written in clear and simple English. They give information on what happens in operations, preparing for the operation, what happens during a hospital stay and a little on complications and after effects. Since they are held on computer disks, they can easily be updated. The sheets are given to patients to be admitted for operations and bound compilations of the sheets have been sent to each General Practice that refers patients to Mr Roberts, the consultant.

This report is of an evaluation of the leaflets by sending questionnaires to two groups of patients. One group of patients (the pre-issue sample) had not received the leaflets because they consulted Mr Roberts before the leaflets were in use. The other group (the post-issue sample) had been issued with a leaflet before being admitted to hospital for an operation or clinical procedure. Since expressed satisfaction was high overall, it was difficult to achieve a statistically significant difference in the responses of the two samples. However, there was a significant difference in the answers to some questions.

The post-issue sample were more likely to answer a question on the reason for the operation (and also to give a more specific reason), suggesting that the information may have made them more aware of why an operation was needed. The post-issue sample were more likely to be satisfied with information about the operation, though satisfaction with all information was not significantly higher in this group. Both groups showed low rates of satisfaction with information about complications (average 55%) and long-term effects (49%). Not surprisingly, the post-issue sample were more satisfied with information from leaflets and almost all found the information clear.

The report concludes that an information leaflet should be given to each patient at the first mention of the operation by the consultant. This would enhance the importance of the leaflet in the patient's mind and encourage him/her to ask questions on a return visit. It is also suggested that more information is made available on alternative treatments and long-term effects and that patients should be told when to expect results.

GENERAL PUBLICATIONS

IN BRIEF

Beyond the Patient's Charter: working with users
Christine Hogg
Health Rights, Unit 405 Brixton Small Business Centre, 444 Brixton Road, London SW9 8EJ
phone: 071 274 4000 x 326
£7.50 to CHCs/voluntary/individual, £13.50 DHAs/trusts etc.

A practical report examining rights and standards of patient's charters from a user's perspective. Gives detailed guidance on involving users in developing and monitoring charters. The report is based on work with two groups: people living with chronic pain and women who have HIV. Respect for privacy and dignity was found to be the foremost concern.

Guidelines for domiciliary family planning services
Royal College of Nursing, 20 Cavendish Square, London W1M 0AB
phone: 071 872 0840
13 pages

The aim of a domiciliary family planning (FP) service is to provide care to those who cannot or will not attend a GP or FP clinic. Many of the requirements on nurses delivering the service are the same as for other FP nurses. The guidelines set out here focus on the additional demands of delivering care in a domiciliary setting. They cover the service; the nurse; training and professional development; legal, professional and ethical issues and health and safety. They then cover the skills/awareness needed in providing services to specific groups of clients.

The market menace: the internal market and its impact on the health service
Unison, Civic House, 20 Grand Depot Road, London SE18 6SF
phone: 081 854 2244, fax: 081 316 7770
38 pages

A thoroughly critical report of the NHS reforms. Unison believes that the main problem the NHS faced before the reforms was underfunding, and that this has not been addressed. The report examines the internal market and its effects on cooperation within the NHS, financial security of providers, quality, pay and staffing practices. It also concludes that fundholding is incompatible with other NHS reforms and undermines equity and strategic approaches to health care.

Dial 999? The state of the Ambulance Service
Unison, Civic House, 20 Grand Depot Road, London SE18 6SF
phone: 081 854 2244, fax: 081 316 7770
7 pages

A report based on official figures which, among other things, finds that 30% of services in England (44% in Wales) failed to meet minimum response time targets; staff levels in England fell by 7% between 1987 and 1992; funding has fallen by 10% in real terms; and the pay of first wave ambulance trust chief executives rose by an average of 9.1% in 1992/93.

IN BRIEF

IN BRIEF

Helping to have a healthy baby
The Health Promotion Research Trust, 49–53 Regent Street, Cambridge CB2 1AB
phone: 0223 69636; fax: 0223 324138
Copies available free of charge in English and Urdu.
A companion leaflet is available for GPs.

Leaflet prepared for those considering starting a family and for pregnant women. It explains simply why some genetic diseases may be more common in the children of cousins. It gives advice on what to do before marriage, on becoming pregnant and when a baby is born.

Needs assessment for hospice and specialist palliative care services: from philosophy to contracts
National Council for Hospice and Specialist Palliative Care Services, 59 Bryanston Street, London W1A 2AZ
phone: 071 611 1153; fax: 071 724 4341,
34 pages, £3

A report presenting the contributions made at a conference designed to address issues involved in assessing the need for palliative care and to relate them to the process of contract setting. An introductory section sets out a framework of needs assessment, drawing on the points made by speakers, issues raised during the conference and questions raised in recent research findings.

Open memorandum: developments within GP fundholding and the future of maternity services
Royal College of Midwives, 15 Mansfield Street, London W1M 0BE
5 pages

The College urges extreme caution before extending the remit of fundholding to maternity services. It questions the ability of GPs to be both purchasers and providers of maternity care and particularly whether they will offer choices to women. The memorandum outlines three possible models for GPs as purchasers of maternity care. It concludes that only one is acceptable: in which GPs purchase continuous maternity care from a range of providers.

Health promotion at the crossroads: a study of health promotion departments in the reorganised NHS
Society of Health Education/Promotion Specialists, c/o Sheffield Health Authority, Westbrook House, Sharrow Vale Road, Sheffield S11 8EU
phone: 0742 670333 x 6158
fax: 0742 660498
43 pages

Report of a survey into organisation; staff morale; what national action staff want; and multi-disciplinary working. There is great variation in how health promotion deptartments fit into the local NHS (36% in purchasing, 38% in providing, 22% in both). Many had recently been moved between DHAs and units and many specialists felt marginalised. This has taken its toll: 81% of respondents felt that morale had fallen, though 77% felt generally optimistic about health promotion. There are recommendations on what the DoH could do to foster health promotion expertise and its effectiveness within the NHS.

IN BRIEF

OFFICIAL PUBLICATIONS

Pressure sores: a key quality indicator
A guide for NHS purchasers and providers

Department of Health, 31 pages
Available from Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancashire OL10 2PZ

Pressures sores are an unglamorous but hugely important issue in health care. Some horrifying photographs in this publication bring home the toll in pain and sickness caused to individual patients. The figures in the text show the scale of the burden of pressure sores on the NHS as a whole. The document gives advice on policies for prevention and management, equipment and training. It includes steps that provider units should take, gives examples of good practice and lists sources of further information.

Healthy environments:
protocol for investment in health gain

Welsh Health Planning Forum, NHS Directorate, Welsh Office, 100 pages
Info on availability from Mrs Pat Davies, on 0222 823313

Welsh CHC Chief Officers should have received a copy of this final protocol in the series. Multi-disciplinary approaches to solving problems are particularly necessary on environmental issues. The longest section in this document is useful in this respect. It takes many environmental problems in turn, and for each considers its impact on health, current and future trends and identifies opportunities for action both within and outside the NHS.

INFORMATION WANTED

Scunthorpe CHC would like to know if any CHCs have particular knowledge or experience of **Munchausen's Syndrome** or **Munchausen's Syndrome by Proxy**.

Ceredigion CHC would be interested to hear from any CHCs which have conducted surveys on local **ENT service** provision.

West Berkshire CHC would like to know if any CHC has recently revamped its publicity material or found new and interesting ways of **raising the profile of the CHC** within the community. The CHC is keen to discover new ideas and would welcome an exchange of views.

Mid Essex CHC has had difficulties getting appropriate **lay representation on its Maternity Service Liaison Committee**. It would like to hear from any CHCs with good, or bad, experiences in relation to lay representation on MSLCs.

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

MIND is moving

MIND's national office and MIND publications are moving to:

MIND
Granta House
15–19 Broadway
Stratford
London E15 4BQ
Office phone: 081 519 2122
Fax: 081 522 1725
Information line phone: 081 522 1728

The national office departments are: National Director's, Finance, Policy, Legal, Developments and Appeals & Marketing. The regional office addresses remain unchanged.

FORTHCOMING EVENTS

Beyond the Patient's Charter: working with users

- one-day conference to bring together user groups, health service managers and health professionals
- organised by Health Rights
- on 18 May 1994
- at the King's Fund Centre, London NW1
- £45 for CHCs

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

Medical negligence

- one day conference
- covers among other topics developments in medical litigation, consent to treatment and GP responsibilities
- organised by the Word of the Law
- on 17 March
- in London
- £220 plus VAT

Further information from:
The Word of the Law
Lloyds House
22 Lloyd Street
Manchester M2 5WA
Phone: 061 839 0053,
Fax: 061 839 2026

Eve fights back: achieving change in women's mental health

- one-day conference organised by MIND
- on 8 March 1994
- at Connaught Hall, 41 Tavistock Square, London WC1H 9EX
- £75; £60 MIND members
- application deadline 28 February

Further info from:
The Conference Administrator
MIND
Granta House
15–19 Broadway
Stratford
London E15 4BQ
Phone 081 519 2122, Fax: 081 522 1725

Community care assessment

- conferences aimed at those assessing clients for community care and those providing advice, information or direct services
- organised by Age Concern Training
- on 23 March 1994 at Senate House, Tyndall Avenue, Bristol
  and 11 April 1994 at Britannia Street Conference Centre, London WC1
- £60 statutory/private; £50 voluntary; £30 Age Concern groups

Further information from:
Henrietta Ayoola
Age Concern Training
Astral House
1268 London Road
London SW16 4ER
Phone: 081 679 5481
Fax: 081 679 6069

Mental health issues in Europe: user and provider perspectives

- seminar organised by the School for Advanced Urban Studies, Bristol
- 12.30 p.m. 9 May – 1 p.m. 10 May 1994
- at SAUS
- £269, but limited places available for £29 for locally and regionally-based community and voluntary organisations
- crèche facilities if applications received ASAP

Further info from:
Deborah Marriot
Course Bookings Secretary
SAUS
Rodney Lodge
Grange Road
Bristol BS8 4EA
Phone 0272 466984
Fax: 0272 737308
Queries on course content to Randall Smith or Deborah Wilson on 0272 741117.

DIRECTORY AMENDMENTS

Page i **Scottish Association of Health Councils**
Director: to be advised

Page 2 **West Cumbria**
Fax: 0900 871299

Page 7 **Sheffield CHC**
Fax: 0742 727807

Page 12 **Redbridge CHC**
Chief Officer: Dominic Ford

Page 15 **Kingston & Esher CHC**
Phone: 081 399 **8467**
Fax and answerphone: 081 399 8415

Merton & Sutton CHC
Chief Officer: Ms Clara MacKay

Mid Surrey CHC
Phone: 0372 745641
Fax: 0372 724955

Page 22 **East Birmingham CHC**
Fax: 021 328 4335

1994 edition of the directory

In view of the changes to RHAs taking place on 1 April, it has been decided not to issue the 1994 Directory of CHCs in February this year. A revised directory will therefore be sent out after 1 April. In the meantime, please continue to send in any changes which need to be made to entries in the current edition.

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