CHC NEWS

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

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NEWS

Improved Charter standard

From 1 April, if a patient's operation is cancelled on the day that s/he was due to arrive in hospital, s/he should be admitted to hospital within one month of the first cancellation. This will replace the present requirement that a patient should be readmitted within a month of a *second* cancellation. As at present, this standard does not apply if treatment is postponed because a patient is found to be unfit. RHAs, DHAs and provider units have been asked by the NHS Management Executive to publicise locally this change to the standard.

Department of Health press release 21 February

Spreading medical negligence costs

The Government is to publish proposals to spread the risk of rising medical negligence compensation paid by the NHS. Payments have risen rapidly, from £53m in 1990 to an estimated current cost of £125m annually. It has been suggested that they will continue to rise by about 25% per year. Individual NHS trusts and health authorities are now responsible for meeting most of such settlements. Payments could bankrupt individual hospitals. Even where money for payments is borrowed from the Department of Health, interest and repayments can knock budgets off course for years.

It is likely that the Department of Health consultation paper will propose a central negligence settlement fund administered by a new special health authority. Trusts and health authorities would pay annual premiums into a pooled fund, their level being determined by a hospital's track record, its use of 'best practice' guidelines and the quality of its record keeping. The system could have the advantage from the patient's point of view that there would be less incentive for trusts/DHAs to drag out the settlement of cases over many years. However, the deputy finance director of the NHS has warned that 'fund managers ... should seek to dissuade trusts from settling at an early stage cases which could be properly defended'.

Observer 27 February

Simulation spins out of control

The fourth Rubber Windmill exercise, in which developments in the NHS were simulated with 60 participants in different roles (including members of the public for the first time), ended with health commissioners overwhelmed by the range of bodies they had to deal with until they were unable properly to conduct their day-to-day work. They could not deliver on what the public wanted or on national objectives. As fundholding increased, they were decreasingly able to maintain a strategic direction. Initial good intentions to consult the public soon dissipated. The public felt frustrated with health service managers and had uneasy relations with GPs, especially fundholders. Those members of the public who could afford to turned increasingly to the private sector for care. The public blamed trusts for raising their expectations about real involvement, then ignoring them as business survival took priority.

In an article in the *Health Service Journal* Alasdair Liddell calls for formal mechanisms to draw the public into discussions. He comments that, although CHCs have tried to provide such a forum, the public do not seem to see CHCs as capable of influencing decisions. He suggests that a more independent watchdog operating at arm's length from the NHS might have more credibility. As Toby Harris points out in a letter in response, CHCs can influence decisions only if purchasers and providers listen to them and resource them properly. He invites Alasdair Liddell, who is general manager of East Anglian RHA, to make CHCs more influential. He also welcomed the idea that CHCs should be even more independent of the health authority structure, reflecting as it does the outcome of the recent Special General Meeting of CHCs.

The Rubber Windmill report, *Power to the people?* is available from Public Relations Division, East Anglia RHA, Union Lane, Cambridge CB4 1RF for £5.

Health Service Journal 17 February/10 March, Independent 17 February

Chairman resigns

Bryn Davies, chairman of Mid-Glamorgan DHA for 16 years, is to stand down in July following criticism by the Health Ombudsman of the DHA's handling of complaints. In the most recent case, a woman had to wait for months to receive replies to her complaint, her letters were lost by the DHA and replies were signed in the name of managers who were not involved.

Guardian 10 March

Recommendations to protect children

Sir Cecil Clothier's report of his investigation into the case of Beverley Allitt, an enrolled nurse who murdered four children in her care and harmed others, concludes that, had the available evidence been assembled with due urgency, she could have been identified as the murderer earlier. While 'feeble and indecisive' steps were being taken, Ms Allitt killed and attempted to murder more children. A ward manager, her immediate manager, senior managers and two consultants are all criticised. The report makes 12 recommendations:

- the most recent employer/place of study should provide sickness absence records for all nursing candidates:
- the provision of such records from earlier work/study should be considered;
- post mortem reports should be sent to any consultant involved in patient care;
- specialist paediatric pathologists should carry out all post mortems when a child death is unexpected or clinically unaccountable;
- no-one with evidence of serious personality disorders should be employed as a nurse;
- nurses should undergo health screening when they get their first job;
- procedures should make clear the criteria which should trigger management referrals to occupational health departments;
- consideration should be given as to how nursing applicants with a history of excessive problems related to sickness absence and mental health could be prevented from taking up training until those problems have been resolved;
- consideration should be given as to how GPs might be asked to certify that there are no reasons in a candidate's history indicating unsuitability for NHS employment;
- the DoH should take steps to ensure that its guide, *Welfare of Children and Young People in Hospital*, is more closely observed;
- if an alarm or monitoring equipment fails, an untoward incident report should be completed and it should be serviced before reuse;
- reports of serious untoward incidents should be made in writing and through a single channel known to all.

Mrs Bottomley has promised to take action on the 11 recommendations within her remit and has said that the Home Secretary has accepted the twelfth.

Guardian 12 February

Waiting lists growing

As the financial year nears its close, surgeons are once again being asked to slow down routine operations as contracts are fulfilled. A Royal College of Surgeons survey of 234 surgeons found that respondents in four out of ten hospitals have been asked to reduce the number of operations. The worst affected area was general surgery, followed by orthopaedics, urology and ear, nose and throat treatment. As a result, waiting lists, particularly for general surgery, have been lengthening. The survey also found that hospitals were giving preference to patients referred by GP fundholders, and some surgeons had been asked to treat more extra-contractual referrals.

Figures on overall waiting lists suggest that lengthening queues are not simply a matter of an end-of-the-year slow down. Waiting lists in England are 9% (88,000) higher than last year. The numbers waiting over a year have increased by 2,200 to 74,079. Waiting lists rose by 3.3% between September and December, rising most sharply in the 1-year-plus category.

Daily Telegraph 15 February, Independent 18 February

Little evidence of benefits of reforms

An evaluation of the NHS reforms, based on seven research projects commissioned by the King's Fund, concludes that they have yet to produce significant improvements. The one exception is GP fundholding, though this is selective in its operation and the improvements it produces for some may be at the expense of equity. The report says that systems have been put in place which may improve performance in the long-run, but there is little evidence that they have yet done so. Medical audit, for example, may improve quality, but in the hospitals investigated it was dominated by senior doctors and interpreted too narrowly. Claims that the creation of trusts has led to greater efficiency cannot be proved since the more efficient units were selected for early trust status. The sharp increase in numbers of patients treated cannot be shown to be due to reforms given the large extra sums spent on the NHS in the run-up to the last general election.

Evaluating the NHS Reforms is available from BEBC, PO Box 1496, Poole BH12 3YD; £9.95 paperback version.

Guardian/Independent 24 February

MENTAL HEALTH SERVICES

Lessons from the Clunis inquiry

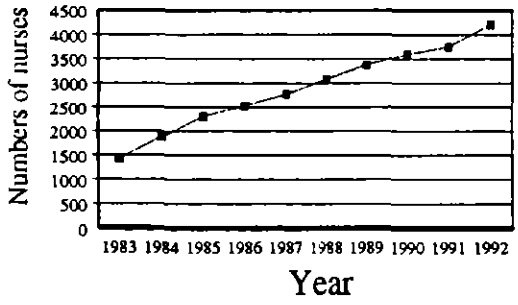
The report of an independent inquiry into the stabbing to death of Jon Zito by Christopher Clunis is highly critical of many involved in Christopher Clunis's care and has implications for professional practices, funding and communications systems. Mr Clunis had received in-patient hospital care for paranoid schizophrenia and had then been discharged into the community. The hospital from which he was discharged was criticised for the decision to discharge him, for a 'virtually non-existent' after-care plan and for poor communications. The police failed to act on warnings and social services were guilty of indecision and procrastination. There was a lack of co-ordination between community psychiatric nurses. A doctor and other staff failed to emphasise Mr Clunis's violent tendencies – a failure which the inquiry believes was detrimental to Mr Clunis's own best interests. A GP had removed Mr Clunis from his list after an attempted assault, but did not record the incident. The report comments that it is of concern that in these circumstances a GP is not required to communicate with anyone other than the FHSA: again, this is not likely to be in the best interests of the patient. Lastly, with occupancy rates of 130% in the psychiatric wards of four London hospitals, the inquiry gained the impression that the lack of a bed was partly responsible for Mr Clunis being placed on very high doses of medication.

Since the publication of the report, the Health Secretary, Virginia Bottomley, has admitted that there may be a shortage of acute psychiatric beds in some parts of London. Giving evidence to the House of Commons Health Committee, Mrs Bottomley said that an extra 137 medium-secure beds were to be opened under long term plans, but at first denied that there was a shortage of general beds. When pressed, however, she conceded that services might be 'out of balance' in some areas. She also acknowledged that the £10m 'extra' spending she announced in February for community mental health services in London is in fact part of the £85m she had announced for investment in community and primary health care in the capital for 1994/95.

Times/Telegraph 25 February, Guardian 3 March

Community psychiatric nurses

A parliamentary written answer gave the figures for the rise in nurses working in community psychiatrics, as shown below:



Remarkably, despite the growing importance of psychiatric nursing care in the community, the Department of Health is 'unable to identify nurses with a community psychiatric nursing qualification', so the figures include both qualified and unqualified nurses.

Hansard WA, col 764, 2 March;

Ministers unenthusiastic over mental health report

Health ministers have distanced themselves from a Government-commissioned report on mental health nursing. *Working in partnership* was launched earlier this month by Professor Tony Butterworth, chairman of the inquiry team, and Yvonne Moores, the chief nursing officer. No health ministers attended the launch and, although Mrs Bottomley has said that the report is 'an excellent pointer' for the future, she has fallen short of accepting its recommendations. Among these are that:

- patients should be more involved in the planning of care
- patients should be offered a choice of single-sex accommodation
- patients should be offered a choice of a male or female nurse
- the suitability of treating psychiatric patients in general hospitals should be urgently reviewed (day centres or sheltered accommodation might be more suitable)

If accepted the recommendations would have considerable cost implications. The NHS chief executive has warned managers that some could be implemented only as resources become available.

Guardian/Independent 11 March

Long-term care – a muddle

Given the confusion over the responsibilities of the NHS towards people who need long-term care and since Duncan Nichol, the chief executive of the NHS, has been accused of 'really muddying the waters' on the issue, it seems worthwhile recording a few facts and quotes:

Patients receiving hospital care receive it free of charge. Patients deemed to be ready for discharge who enter a nursing home for long-term care have to undergo a means test and the patient will be asked to make an 'appropriate' contribution to the costs of future care. However, under certain (decidedly unclear) circumstances the NHS should pay all the fees for patients going into nursing homes or receiving nursing at home.

Official guidance states that:

> *'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' (Discharge of patients from hospital, HC(89)5, section A2.ii)*

> *'Health authorities have a responsibility under the National Health Service Act 1977 to provide **nursing** care for those who cannot or do not wish to pay for it. Department of Health guidance is clear that people should not be discharged into private nursing homes when they have no wish to pay.' (Memorandum submitted by the Departments of Health and of Social Security. Fourth report of the Social Security Committee, Vol 2, p 92 para 3.8, HC421-II, HMSO, 1991, our emphasis.)*

The NHSME has confirmed to ACHCEW that the community care arrangements:

> *'do not affect the continuing responsibilities of the NHS to secure long term care for those who need it for reasons of ill health, either at home through the provision of community health services or in a hospital or nursing home setting'.*

In addition,

> *'Individuals can not be forced to enter nursing homes or residential care homes against their will ...'*

However,

> *'If an individual no longer requires the kind of care which it is the responsibility of the NHS to provide, there is no statutory obligation on the DHA to retain the person in an inappropriate NHS facility.'*

The crucial question seems to be what type of care 'it is the responsibility of the NHS to provide'.

A Parliamentary written answer to a question on what steps have been taken to ensure that Leeds Healthcare's failure to provide long-term care (see *CHC News* 90) is not repeated elsewhere focused on the co-ordination of discharge arrangements and local agreements rather than on what types of care the NHS is required to provide:

> *'As part of the new community care arrangements we have required health and local authorities to agree their respective responsibilities for long-term care. This should be done in the light of their assessment of the best way to provide a comprehensive service to meet the needs of their local populations. We have also required them to agree co-ordinated hospital discharge arrangements. In addition the chief executive of the NHS Management Executive wrote to all health authority managers, trust chief executives and unit general managers on 20 January 1994, EL(94)8, to remind them of the importance of having in place explicit and comprehensive discharge procedures which should be reviewed regularly.'*

Giving evidence to the House of Commons Health Select Committee Duncan Nichol shed little light on the question. Asked if the guidance quoted on the left still stood, he said that he did not withdraw the statements. He added that, where a *medical* assessment showed that continuing care was needed, that was plainly an NHS responsibility and the NHS would pay. However, 'in a majority of situations' a mix of health and social care would be required. Social services would be involved and that could lead to nursing home care for which there will be a means test. From what Duncan Nichol said, it seems that the NHS should provide a bed or pay for nursing home fees or nursing at home where medical treatment is needed. However, without a definition of what constitutes 'medical' treatment the rights of patients remain very unclear. Moreover, the previous evidence to the Social Security Committee (see above) stated that health authorities had a duty to provide *nursing* care. As reported in last month's *CHC News*, the legislation gives the Secretary of Health of State discretion in deciding what type and extent of services should be provided by the NHS.

Hansard, col 328, 9 February, Guardian/Independent 10 March, letter from NHSME to ACHCEW 3 December

A recipe for ill health

A report from the National Forum for Coronary Heart Disease Prevention paints an alarming picture of the eating habits of children in Britain, with a typical 11-year-old's weekly diet including four packets of crisps, six cans of soft drinks, seven bars of chocolate or sweets, seven biscuits, three bags of chips and seven cakes or puddings, but a fruit and vegetable intake equivalent to only four small carrots and three small apples. One in nine children misses breakfast, one in six has no cooked evening meal and only 42% of children eat school meals. Three-quarters of children have excessive fat intake, risking obesity and its attendant health problems, including heart disease, in later life.

The report, which has widespread medical backing, calls for restrictions on advertising, nutritional guidelines for school meals and the creation of a health-promoting environment. Vending machines and tuck shops in schools tend to promote poor eating habits. This is reinforced by 'information packs' (often designed to resemble national curriculum documents) which are provided to schools by the food industry and in fact target 200 products at school children.

Independent 2 March

Morning-after pill may be sold over the counter

It is likely that health ministers will support a proposal to make the morning-after pill available without a prescription. The proposal has the approval of many leading gynaecologists, who argue that using the morning-after pill is less risky than continuing with a pregnancy or having an abortion. A steering group of the Royal College of Obstetricians and Gynaecologists is to hold a conference before making recommendations. The conference will consider whether the pill should be available in supermarkets, vending machines and all-night garages as well as pharmacies. However, health ministers are likely to want to restrict its sale to pharmacies – a restriction that would also have the support of the BMA. The proposal has not been universally welcomed. Opponents of the proposal believe that the availability of the morning-after pill would provide an excuse for careless sex. The Education Secretary, John Patten, has insisted that, in trying to achieve the goal of reducing teenage pregnancies, moral considerations should take precedence.

Times 21 February

Norplant proves popular

The contraceptive hormonal implant, Norplant, has proved more popular with women than expected. GPs are being asked to prescribe it by women across the social and working spectrum and by 18–25 year olds as well as older women. Its popularity is causing some problems, however, since it is about five times more expensive than a five-year supply of the cheapest oral contraceptive. Some family planning clinics are asking women to obtain a prescription from their GP, unless they are at particularly high risk of pregnancy. Birmingham FHSA has urged local GPs to be very selective in providing the implant, particularly in view of the fact that it does not suit some women and its early removal increases costs further. Evidence from Birmingham also suggests that some women are having to fight hard in order to be given the implant.

Daily Telegraph 15 February

PARLIAMENTARY NEWS

DoH-commissioned research

Research commissioned by the Department of Health into patients' views in the year to April 1993:

Subject	Questionnaires	Groups to be questioned
Pregnancy booklet	Omnibus survey	Pregnant mothers
Oral syringe	Group discussions/ interviews	Parents of children having treatment/ had treatment
NHS waiting lists	Group discussions/ interviews	Sample of general public
Health Information Service	Group discussions/ interviews	Sample of general public

Since 1990 the DoH has also contributed to the cost of the British social attitudes survey and had questions on service use included in the general household survey carried out by the Office of Population Censuses and Surveys

Hansard WA, col 325–6, 9 February

Prescription charge increases

From 1 April, the prescription charge will go up 12% from £4.25 to £4.75. The rates for prescription prepayment certificates will rise in line with this increase.

Charges for fabric supports supplied through the hospital service will increase by 50p. Charges for elastic stockings and tights, and wigs supplied through the hospital service, will go up in line with the prescription charge increase.

The value of optical vouchers will be increased by an average of 4%. Within this average, the value of the most commonly used vouchers will go up by 4.5%.

Hansard WA, col 668–9, 15 February

Charges for diabetic treatment

Disposable insulin injection pens are available on NHS prescription. People needing medication for diabetes mellitus are exempt from prescription charges. Reusable injection pens and their needles are not available on GP prescription, and there are no plans to make them so. *However, the pens may be provided free of charge from hospitals if the consultant in charge of a patient's treatment thinks this is appropriate.*

Hansard WA, col 666–7, 15 February

Waiting times

Estimates of waiting times as at 31 March 1993, both based on samples:

- 74% of patients were assessed within 5 minutes at A&E Departments.
- 73% of patients were seen within 30 minutes of their out-patients appointment time.

Hansard WA, col 665, 15 February

FROM THE JOURNALS

Dental laboratories

The cost in pain and discomfort of ill-fitting dentures, crowns and bridges is high, but the Government is unwilling to legislate on quality standards in dental laboratories. Dental labs are unregulated: there is no minimum qualification requirement and no register of dental technicians. There is evidence of very variable standards, with much of the work failing to match the prescription provided by dentists. However, it difficult to detect sub-standard work, since problems may not emerge for a long time.

A Select Committee has recommended that all labs should have an independently monitored quality assurance system. Sir Kenneth Bloomfield has recommended that they should conform to British Standard BS5750, which is used by many organisations and requires just such an independent inspection. While the health minister, Brian Mawhinney, accepts that such quality assurance is in the best interests of patients, dentists and laboratories, he has refused to make it mandatory, since this would 'restrict dentists' freedom'.

Some labs would welcome the imposition of a standard, claiming that dentists are to blame for low standards since they choose labs on the basis of price rather than quality. The Select Committee, commenting on incentives for dentists to use low-cost labs, recommended that they should not be allowed to use fees for this type of work to cover any other expenses. Dentists have also been blamed for inadequate information on prescriptions.

Most dentists deny these accusations. However, while a British Dental Association representative opposed the imposition of the BS5750 standard, not all dentists take this line. Not surprisingly, there was more agreement among dentists that the fees they receive for the NHS work of this kind is insufficient to safeguard quality.

Which? Way to Health, February

Pharmacy consultation study

A study on the benefits of consultation areas in community pharmacies is to be funded by SW Thames RHA. The Region is to provide £20,000 for consultation areas in 10 pharmacies. The research will be carried out by Norman Evans, the pharmaceutical adviser to Merton, Sutton & Wandsworth FHSA. He will select the pharmacies, train the pharmacists and hopes to demonstrate that having consultation areas results in savings in GP time and prescribing costs.

The Pharmaceutical Journal 19 February

OUT-OF-HOURS VISITING

Fastest increase in very affluent areas

After changes to out-of-hours visiting provisions were introduced with the 1990 GP contract, there was a sharp acceleration in the rate of increase of night visiting. The GP contract extended the hours which qualified for a night-visiting fee and created a two-band fee structure: £15 for a visit from a deputising service and £45 for a visit by the GP. From 1987 to 1989 the rate of night visits increased from 170 per 10,000 population to 187 per 10,000. In 1990, the rate rose to 248 per 10,000, a rise of 33% over the previous year. In the same year the proportion of visits made by deputies fell by 19%. Though some of the increase in visiting is due to the extension of eligible hours, the authors who carried out this research conclude that the incentive provided by higher payments also played a part:

Their paper also relates increasing night visiting rates to two variables which are expected to influence demand for primary care, with striking results. The first variable is the socio-economic make-up of the population in FHSA areas. Whereas visiting rates increased by 29% in the 'very deprived' areas, they increased by 62% in the 'very affluent' areas. In 'deprived' and 'affluent' areas they increased by 24%. The second variable is age-related demand. Visiting rates increased by 40% in areas with a high proportion of the population aged 65 or over and by 22% in areas with a very low proportion of people in this age range. Both a high proportion of elderly people in the population and relative economic deprivation contribute to a high Jarman score rating. These results indicate the value of disaggregating the components of the Jarman score in analysing the effects of some policy changes on the demand for health care.

British Journal of General Practice February

The GP's viewpoint

Whereas the above research suggests that the increase in night visits, at least in 1990, was largely due to changes in GP contracts, GPs are much more likely to put it down to unreasonable demands on them by some of their patients. A survey of 2837 GPs (about 10% of GPs in the country) revealed massive dissatisfaction with out-of-hours responsibilities and widespread support for sanctions against patients whom GPs judge are calling them out unnecessarily.

Eighty-eight per cent of respondents want different ways of providing out-of-hours cover, and 64% want to give up 24-hour responsibility for their patients. Single-handed, older and rural GPs were less likely to want to give up this responsibility. The most popular alternatives for providing out-of-hours cover were primary care emergency centres and an NHS-run deputising service. However, primary care emergency centres could do little about the 10% of 'non-emergency' call-outs that are estimated to be due to lack of transport. There was little support for a medical message handling service – the facility being advocated by negotiators for the General Medical Services Committee.

GPs judge that over half their out-of-hours calls are unnecessary, though, as opposition spokesman David Blunkett points out, what appears trivial to an experienced GP may not seem so to a worried patient. An article in Doctor lists many reasons given by patients for calling out doctors. GPs can justifiably be angry in most of these cases, such as when a patient rang because a medicine spoon was broken, but in some cases it is not difficult to imagine how anxious patients might be. The couple who thought their child had swallowed the bath plug may have been misguided, but hardly wilfully careless of the doctor's time.

Eighty-five per cent of GPs want sanctions for patients who abuse out-of-hours services. Of these 66% want financial penalties, 18% removal from list, 11% a formal warning and 10% withdrawal of 24-hour cover – and one 'shoot them'. Financial sanctions are unlikely to be introduced, however. A Department of Health spokesman said 'We have no plans to introduce such fines. Any such scheme is likely to deter people from seeking the help they need in an emergency.' Similarly, Dr Ian Bogle, chairman of the BMA's GP committee said that penalties against patients were not a practical solution.

Guardian/Independent/Doctor 17 February

AROUND THE CHCs

Aberconwy CHC, Arfon/Dwyfor CHC, Meirionnydd CHC and **Anglesey CHC** have worked together to consult the public on Gwynedd's local Strategy for Health. This involved 619 interviews over a six-week period using a questionnaire based on agreement or disagreement with statements previously gathered from users, GPs, CHCs, etc. Opinions were gathered on 17 topics, including 11 of the most expensive services that purchasers were considering developing over the next five years. Qualitative data were also collated. The purchasers will be using the information gathered to inform planning decisions and as a basis for further research.

Chester & Ellesmere Port CHC has available a set-up plan for self-evaluation for CHCs. It is available to those who send a floppy disk to the CHC. Further details on 0244 318123.

Wakefield CHC has published a 'public version' of its Annual Report in order to gain a wider readership. While avoiding the more off-putting detail of the full report, it explains the role of the CHC and describes some of its achievements through the year and some objectives set by the Special Interest Groups for the year to come. It is distributed widely in as many health and community settings as possible.

With effect from 1 March, Gordon Tollefson has replaced Joy Gunter as the **Society of CHC Staff**'s Co-ordinator of Assessors at the Appointment of CHC Staff. Gordon is the Chief Officer of Pontefract & District CHC and can be reached at: 6 Cornmarket, Pontefract, West Yorkshire WF8 1BJ; phone 0977 796470; fax: 0977 600959 (NOTE CHANGE OF ADDRESS). Could CHCs requiring the services of an assessor please contact Gordon as soon as possible in order that the assessor can be involved from the time that the post is advertised.

Deadline

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

From **Liverpool Eastern CHC**:

Liverpool CHC has won a minor health promotion victory against the local DHA. The DHA's Trust Funds Committee purchased nearly £12,000 of shares in BAT industries – nothing to do with the small furry mammals which sleep upside down, but British American Tobacco!

Several executive and non-executive directors protested at the undermining of the health promotion work carried out in a city with some of the worst cancer and heart disease rates in western Europe, but to no avail – the shares were a good buy, not all of the company was devoted to tobacco - they also own financial services companies etc., etc.

The following week, on No Smoking Day, "somehow" the media got hold of the story, resulting in it being the main story on Granada Reports, our local nightly TV news (as well as the local papers and radio) an interview with the CHC Chairman being shown.

The DHA has now said it will sell the shares.

Who says CHCs are not effective!

All the CHCs in **Yorkshire and Humberside** have participated in a joint review of the first nine months of the implementation of the Community Care Act. The co-ordinating manager for Yorkshire CHCs has collated the information on CHC responsibilities and involvement, service changes, local developments, monitoring structures and carer and user representation. These should prove useful to individual CHCs when they are discussing their role with local social services departments. The CHCs are also to hold a regional seminar on community care in the Autumn.

North West Herts CHC has set up a Holistic Advice and Relaxation Centre in a room at the CHC office. It has assembled leaflets, posters and lists of alternative therapy practitioners, which are available five days a week. There will be a drop-in session on one morning a week staffed by a specialist in counselling and stress management.

NEWS FROM ACHCEW

Recent Health News Briefings which have been circulated to CHCs:

Charity fundraising and the NHS

Outlines some of the implications of recent legislation to regulate charitable fundraising and looks at the changing interface between NHS provision and health services which have been financed by public donations.

Information services for CHCs

An updated version of a briefing paper summarising how ACHCEW's information service operates, particularly how the various computerised databases are organised and updated. There is also a section listing major library and information services which may be of use to CHCs in their own research work.

Access to Health Records Act

CHCs have come across a wide range of problems with this Act and with the official Guide to the Act. The Briefing recommends a number of changes to the Act and the Guide to strengthen patients' rights.

Fundholding and access to hospital care

Sets out the results of a survey of CHCs about fundholders' patients getting priority use of NHS hospital services. Concludes that the guidance issued by the NHS Management Executive is not intended to rule out 'fast tracking'.

CHC PUBLICATIONS

Roles and relationships:
Community Health Councils, Family Health Service Authorities and Family Practitioners
Yorkshire Regional Council of CHCs, 20 pages

A working group with CHC, FHSA and RHA representatives has been discussing areas of mutual interest:

- relationships between FHSAs and CHCs
- services provided by family practitioners
- GP fundholding and FHSA commissioning
- complaints against family practitioners

Material which formed the basis of discussions was gathered from the 16 CHCs and seven FHSAs in the region. This discussion paper presents the outcome of the discussions and is intended to act as a focus for local discussion and negotiation between CHCs, FHSAs and GPs. As well as outlining current procedures and examples of good practice, each section suggests ways of moving forward, of which a few are mentioned below.

Under relationships between CHCs and FHSAs, there is a need to work together throughout the year, and not simply to store up problems for discussion at formal meetings. Relationships with GPs are in many (not all) cases problematic, partly because GPs tend to focus on the role of CHCs in complaints work. FHSAs have a role in presenting a more balanced view of the role of CHCs to GPs, though CHCs have also found it helpful to share information such as survey results with GPs. Though a number of CHCs have concerns and reservations about GP fundholding, the scheme offers some opportunities for CHC input since some fundholders may be interested in collaborating with CHCs in the monitoring of service provision. Since the impact of fundholding on local provision is increasingly significant, the CHCs would look to FHSAs to keep them up to date on changes in guidelines and regulations relating to fundholding and on shifts in purchasing patterns among fundholders. Many of the suggestions on complaints procedures are practical ideas based on good practice in the region. Wakefield FHSA for example is trying to ensure that female conciliators are available for female complainants, while some areas produce joint FHSA/CHC leaflets on complaints.

While there seem to remain some areas of disagreement, or at least difference of emphasis, between FHSAs and CHCs, the discussions reported here have uncovered much common ground, clarified areas of difference and produced plenty of constructive suggestions for the future.

Caring for the carers? The primary health care teams and carers needs
South Tees CHC for Cleveland FHSA, 79 pages

Having set out to look at the interaction between carers and primary health care teams (PHCTs), the authors of this study consider that their most important findings concerned the desperate situations very many carers have to cope with. Receiving inadequate support, excluded from decision making about such support and faced with such a daunting range of agencies that they do not know where to turn, they soldier on largely unnoticed.

The study is based on interviews with 40 carers. The average length of time spent caring by the time of the interviews was eight years – in many cases the care had continued for decades. In view of this long-term care, regular review of people's situations is vital.

One section of the report deals with information. Very few carers had received any written information and 80% reported having received no information (written or verbal) on how to care for their dependant. Most wanted more information on how to cope with the dependant's moods and mood swings and there was a clear need for supportive counselling. Carers need various types of information (information on benefit entitlement, for example, often comes very late in the day) and the wide range of sources of information is confusing and difficult to access. Just over half the carers thought that the GP or the PHCT should provide information. The CHC recommends that one person (ideally GP or named member of PHCT) should be responsible for providing carers with *all* the information (both medical and non-medical) or to ensure that it is provided. This should include all the information which carers are likely to need, not just information they already know they need.

Most carers had not been shown how to do the practical things for their dependants although 43% said they did not need such training (this may be partly because they felt their competence was being called into question). Those who had not received training but felt they needed it showed that their needs were serious: one wanted to know how to cope with fits, another what to do if her husband had another heart attack.

As with information, in the area of communications, help and support, it is the GP or the PHCT who would appear to be the most useful focal point for *all* services to users. It was clear that carers needed an easily identifiable point of contact.

Contrary to common assumptions, quite a number of carers received little or no informal help and support from other family members (only 58% of those caring for a child with special needs got help or support from a partner or spouse). A very clear message was that carers need much more structured help rather than having to rely on friends and family. The CHC calls for the resources to provide such help in view both of the very difficult positions many carers are in and the consequences if they are pushed so hard that they can no longer cope.

Flexible friends:
a survey of transport to out-patient clinics
Salford CHC, 46 pages

A survey at Hope Hospital in Salford investigated what transport is used by and is available to out-patients and what problems they experience with transport. The report presents overall results, and then breaks them down in three ways: male/female, Salford/ non-Salford residents, gynaecology/rheumatology patients. The findings lead to recommendations for purchasers, providers and transport operators which cover issues such as the timing of clinics, appointment systems and child care facilities as well as directly improving access through the appropriate transport provision.

Have you ever asked me?
The experiences of carers in
North West Surrey
Rachael Frost and Justin Dix,
North West Surrey CHC & Woking Carers Project
16 pages

This report challenges artificial divisions between the health and social care which carers need and aims at putting the health needs of carers on the local agenda. It presents the experiences of carers as they were expressed in group discussions. While acknowledging that the agencies concerned are well intentioned, the report concludes that the system is not working well and makes many suggestions of how the agencies could improve what they offer.

IN BRIEF

Terminal and palliative care in North Staffordshire
North Staffordshire CHC, 16 pages

This report, based on a programme of visits and discussions with service providers and users, calls for a District-wide strategy for the care of people needing terminal or palliative care. At present there is a serious lack of appropriate services for non-cancer patients and those needing care over long periods, and a strategy should urgently address their needs.

Report on the survey on the pharmacy service
Warrington CHC, 33 pages

By using its Health Watch panel and excluding members who had not replied to previous questionnaires, Warrington CHC achieved an 87% response rate on this survey. The report covers satisfaction with and preferences for services delivered. With responses from 410 people, it has been feasible to break down some responses by ward, providing useful local information on the need for more pharmacies.

Report on a survey into the views of the public of mixed-sex wards in Maidstone hospitals
Maidstone CHC, 8 pages

Overall, a majority of patients did not mind whether they were on mixed-sex wards, but almost a half of female respondents would prefer to be in a single-sex ward or bay.

The patient's friend: the counselling work of CHCs
Jane Dunkley, North Staffordshire CHC, 14 pages

This paper examines the counselling skills that CHC staff need if they are to be effective in their role as 'the patient's friend'. It draws on models of counselling and counselling skills described in the literature and on the practical experience gained by CHC staff during their work.

Cross-infection control dentistry: results of a postal survey into public awareness
North West Herts CHC, 52 pages, £3

With the help of CHCs around the country, and especially Durham, NW Herts CHC has completed its survey on this topic (see *CHC News* 81) . The report presents results from 288 members of the public (broken down by region) and 91 dentists. While many dentists are undertaking proper infection control procedures , it is worrying that some are not, especially since many patients reported that they could not pluck up the courage to ask dentists what procedures they used. NW Herts CHC is to hold another **seminar** on the subject on 16 April. For details, please contact the CHC asap.

IN BRIEF

CHC PUBLICATIONS LIST

Having a baby in Wandsworth
Wandsworth CHC, 8 page information booklet for service users

Queen Elizabeth II Hospital A&E Department Survey 1993
East Herts CHC, 26 pages

GPs' out-of-hours arrangements: a short report
North West Surrey CHC, 7 pages, report of a survey of local GPs

The tranquilliser legacy:
an exploration of the issues concerning people who have taken minor tranquillisers
Vanessa Stone for Haringey CHC, 22 pages, focusing on the experiences of four people who had taken tranquillisers

The role of the consumer in health needs assessment
Scottish Association of Health Councils, 20 pages, report of a conference

Buckland Hospital survey: main findings from survey investigating public reaction to proposed changes to local hospital services
Pat Sloss, South East Kent CHC, 55 pages, final report to the health authority

ACHCEW did not receive copies of **West Cumbria CHC**'s numerous reports during 1993, so they have not been listed in *CHC News* or in the bibliography of CHC publications. The list of the CHC's publications is:

- **Cumbria Ambulance Service: report on patients' perceptions of the ambulance service in West Cumbria**
- **Report on research undertaken by West Cumbria CHC during 1993**
- **Report on women's perceptions of the maternity services in West Cumbria. Part 1: Quantitative report. Part 2: Qualitative report**
- **Report on the in-patient questionnaire results during the period February to May 1993**
- **Results of in-patient satisfaction survey July 1993**
- **Report of in-patient satisfaction survey for October 1993**
- **Local health forums: progress in 1993/94**
- **Report on women and children's services in West Cumbria**
- **Report on the Regional Health Strategy survey for West Cumbria**

CHC publications

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

OFFICIAL PUBLICATIONS

CHCs should have been sent copies of the following:

A prescription for improvement: towards more rational prescribing in general practice
Audit Commission, 102 pages, £11

Across the divide: building community partnerships to tackle drug misuse
Roger Howard Associates for the Department of Health, 62 pages

INFORMATION WANTED

Bristol & District CHC would welcome any examples from other CHCs of **delays in the work of the Appeals Unit in Harrogate.** The CHC has experienced unacceptable delays in the Unit's administration. Two recent complaints were given oral appeal hearings in Spring 1992, but neither the CHC nor the parties involved have yet been informed of the outcome of the appeal. In another case no decision has yet been made on whether the Unit will accept the grounds for an appeal six months after the FHSA decision on the case. Bristol & District CHC considers that these cases should be referred to the NHSME to investigate the effective breaching of the Patient's Charter Right 3: *to have a full and prompt written reply to complaints* – or to the Health Service Commissioner to investigate mal-administation by an NHS service.

Stockport CHC would like to hear from any CHC where the **DHA gives funds to individuals** to enable them to purchase services of their choice.

Lambeth CHC is interested to hear from other CHCs with experience of providing **mental health advocacy services** – particularly where an advocate is based at the CHC.

Any CHCs recently looking at **poverty and its effect on health**, please contact Jenny Crabb at the Manchester CHCs.

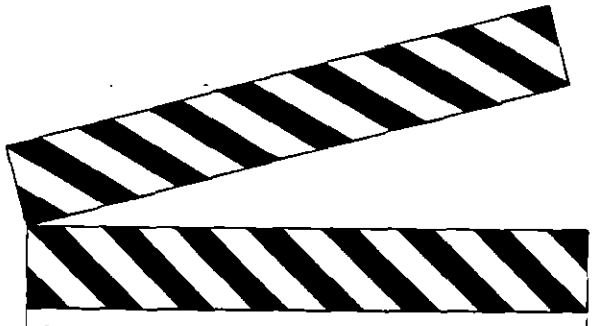
Is anyone aware of **guidance** for dealing with **allegations of sexual assault** on patients by medical professionals? Southwark CHC would like advice on the best way to advise patients making such allegations and to ensure that health providers receive good advice so that assaults and abuse can be prevented.

Could any CHCs which have been involved in the development of **alcohol policies** please contact ACHCEW.

Any CHCs with knowledge of side-effects or any other problems which have been linked to the use of **'Sensodyne' disclosing tablets,** please contact East Suffolk CHC.

Have any CHCs recently developed written **guidance** or 'methodologies' on the **design and analysis of survey questionnaires** and on the compilation of subsequent reports? ACHCEW would be grateful to receive any examples.

Have any CHCs been involved in discussions about the **appointment of hospital chaplains**? If so, please contact South Gwent CHC (Chief Officer: Roger Coakham).



A new Channel 4 programme is looking for viewers with strong topical stories to tell. *Speak Out* is to be broadcast live on Sunday nights, 8-9 p.m. during May and June. The production company, Filmit, will offer viewers the opportunity to work alongside the *Speak Out* team to make films, mount studio events or set up debates.

If you are involved in a campaign, have a story you want to investigate or reveal, then Mary-Anne Thompson would like to hear from you on freephone: 0800 220815.

For our files

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

Age Concern England has produced a new leaflet, *Looking after your money in hospital* which deals with:

- benefits and how they change while you are in hospital
- getting hold of and spending your money
- asking the hospital or relatives to look after your money
- what happens when you leave hospital

Copies are available free from:

Donna Pearce
Age Concern England
Astral House
1268 London Road
London SW16 4ER

Please enclosed an A5 stamped addressed envelope.

FORTHCOMING EVENTS

Community care – one year on

- health promotion day conference
- at Alexandra Social Centre, Princes Alexandra Hospital, Hamstel Road, Harlow, Essex
- on 12 May 1994 from 10 a.m. to 4 p.m.
- £12

The aim of the day is to examine whether Community Care is working effectively in meeting the needs of people in the community and whether the joint working relationships of the various agencies of social services, health authorities and the voluntary sector are working in practice. It will also look at purchasing arrangements and ask whether services provided are the best possible within available resources and most appropriate to the needs of carers.

Applications to:

West Essex CHC
Herts & Essex Hospital
Haymeads Lane
Bishop's Stortford
Herts CM23 5JH
Phone: 0279 655863

DIRECTORY AMENDMENTS

Page iii **South East Thames Regional Association of CHCs**
Administrative Officer:
Miss Elizabeth Nuttall
c/o Hastings and Rother CHC
Thrift House
Collington Avenue
Bexhill-on-Sea
East Sussex TN39 3NQ
Phone: 0424 730073
Fax: 0424 733763

North West Regional Association of CHCs
Secretary: William Cawley
c/o Wigan & Leigh CHC
1 Bishopsgate Walk
Hallgate
Wigan
Lancs WN1 1NL
Phone: 0942 39631
Fax: 0942 826127

Page 4 **Scarborough & North East Yorkshire CHC**
Change of address:
62 Roscoe Street
Scarborough
North Yorkshire YO12 7BY
Phone and fax unchanged

Page 17 **Bath & District CHC**
Change of address:
Kelso Villa
Upper Bristol Road
Bath BA1 3AU
Phone: 0225 465292
Fax: 0225 311454

Page 19 **Kettering & District CHC**
Change of name to:
North Northamptonshire CHC
w.e.f. 1 April

Bromsgrove & Redditch CHC
Chief Officer: Ms Susan Bright
Fax: 0527 595674

Coventry CHC
Chief Officer: Sandra Hill

Page 25 **Liverpool Central & Southern CHC**
Chief Officer: Elizabeth Powell