CHC NEWS

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

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NEWS

Doctors must inform on incompetent colleagues

A hospital consultant has been found guilty of serious professional misconduct by the General Medical Council for failing to take action over the incompetence of a colleague. A locum anaesthetist, Dr Behrooz Irani, had made a number of serious errors which had been brought to the attention of the chairman of the anaesthetic division at East Yorkshire NHS Trust, Dr Sean Dunn. However, Dr Dunn had failed to trigger procedures for dealing with dangerous and incompetent doctors. Last year Dr Irani was struck off by the GMC after an incident in which he showed a "deliberate and culpable" disregard for professional duties and a 33 year old patient suffered massive and permanent brain damage.

The GMC's ruling in Dr Dunn's case reinforces its earlier written advice to NHS managers and the medical royal colleges that doctors have a duty to report incompetent colleagues. In its judgement, the first of its kind, the GMC commented that "at all times patient safety must take precedence over all other concerns" including the possibility of putting a colleague's career at risk.

Independent 24 March

Midwives lose appeal over water birth

Two midwives have lost their appeals against being disciplined for helping a mother to give birth in a birthing pool, against the policy of the East Hertfordshire NHS Trust. The hospital's policy allows mothers to undergo labour in a birthing pool, but not to deliver underwater. In the case for which the midwives were disciplined, the mother refused to get out of the birthing pool. The midwives say in the face of the mother's refusal they were faced with the option of leaving (in which case they risked being struck off), emptying the pool or dragging the mother out of the pool (which they say might have put the child at risk). The trust says that the midwives faced disciplinary action because they undertook the procedure when they had been specifically instructed not to do so and because they failed to seek advice.

The Royal College of Midwives has called on Virginia Bottomley to stop NHS trusts from imposing policies which counter midwives' professional responsibilities. However Mrs Bottomley has declined to become involved in this individual case. Last year the Department of Health commissioned a study into the safety of water delivery (see *CHC News* No 88) – the report is expected in November.

Independent 16 March

Drug firms found guilty of bribery

Four British drug companies have been fined by the Association of the British Pharmaceutical Industry for bribing GPs and consultants to prescribe their products.

- Fisons was found guilty on three charges. A *Sunday Times* report accuses the company of offering cash payments in return for prescribing the asthma drug Tilade and of offering over 100 foreign holidays to doctors on the understanding that they would prescribe Aerocrom. The company was suspended from membership of ABPI, but has since been reinstated.
- Duphar Laboratories had offered gifts worth more than £1000 to dozens of consultant psychiatrists as an inducement to prescribe the drug Faverin. The drug, used to treat depression, has been linked to adverse reactions. The company has been fined and suspended from ABPI membership.
- Glaxo and Allen & Hanbury's were also found guilty of many breaches of the industry code.

Sunday Times 13 March

More support for checks on GPs

NAHAT has added its voice to calls for GPs to be required to pass periodic "MOTs" to ensure that they keep up to date with developments in practice (see *CHC News* No 87). In its report NAHAT also recommends that GP training should be extended from three to five years.

Times 23 March

CONTINUING RESISTANCE TO REFORMS AMONG DOCTORS

Fundholding: believers and dissidents

From this month, 36% of the population will be patients of fundholding GPs. The further extension of fundholding is now a key policy of the Secretary of State for Health.

The unspent surpluses made by GP fundholders in England rose from £14 million in 1991/92 to £32 million in 1992/93 and are expected to be about £30 million in 1993/94 according to RHA estimates (representing about 1.8% of total fundholding budgets for the year). Labour health spokeswoman, Dawn Primarolo, takes the figures as evidence of the inefficiency and waste caused by fundholding. In the House of Commons she complained that it was "obscene" that fundholders can hold on to money intended for patient care when some people are unable to obtain hospital treatment. In contrast, the Secretary of State for Health claimed that the surpluses provide evidence that fundholding GPs "steward ... resources more carefully and invest in better patient care for others".

Virginia Bottomley remains firm in her view that extending fundholding is the key priority for continued reform in the health service. Addressing a conference organised by the National Association of Fundholding Practices and the Royal College of Nursing she dismissed the conclusion she ascribed to her critics – that fundholding is "too disruptive". In contrast she expressed her enthusiasm for the scheme: "When you have found something that works, you build on it, extend it and amplify it, so that its benefits can flow to everybody". She said that she wants more small practices to group together to become fundholders. Since some GPs are "nervous about wider responsibilities" one option may be to have more than one level of fundholding. A menu system whereby practices could select elements of fundholding might enable less experienced or smaller practices to avoid taking on responsibility for such a large budget.

However, not all GPs who oppose fundholding would agree that they are motivated by "nervousness". At a conference held in March, GPs from around the country agreed that non-fundholders need to "speak with one voice" to oppose the imposition of 100% fundholding. They are to form a national organisation to represent their views. One of the organisation's early activities will be to come up with proposals for establishing commissioning practices in which groups of surgeries will advise on buying health care, but will not hold their own budgets. They believe that, among other benefits, such an approach would counter the growth preferential access to treatment for the patients of fundholders.

Hospital doctors

Dissatisfaction with Government policy has also been expressed by a representative of hospital doctors. Saying that it is obvious to everyone except ministers that there is huge dissatisfaction in the health services, the chairman of the BMA's consultants committee, John Chawner, has claimed that senior doctors are threatening to resign from NHS employment to escape management diktat. They could establish themselves as independent contractors and could provide services to hospitals on terms which they find acceptable. According to Mr Chawner, consultants believe that this would give them more freedom than they are granted at present to determine treatment according to patients' clinical needs.

A report in the BMA's *News Review* confirms that there is a good deal of unhappiness among doctors with the effects of the NHS reforms. Of 150 doctors responding to a survey, 85% believed that the reforms have failed to improve patient choice, 69% do not agree that NHS resources are being used more efficiently and 80% believe that the NHS is not in better shape than when the reforms were introduced in April 1991.

Sunday Telegraph 13 March, Guardian 23&25 March, Times 28 March

PARLIAMENTARY NEWS

Hospital closures

Alan Milburn, Labour MP for Darlington, has been showing exemplary persistence in trying to winkle out of health ministers information on hospital closures. The exchanges are quoted almost in full in order to get across just how reluctant ministers were to release the information.

Mr Milburn: To ask the Secretary of State for Health if she will list by region and name each proposed hospital closure notified to her Department for each year since 1988; whether the hospital closed, merged, changed its function or was downsized; and what was the number of beds each hospital had at its closure date.

Mr Sackville: The Department requires formal notification only where proposed closures are contested by the community health councils. The detailed information requested could be provided only at disproportionate cost.

Hansard WA, col 165, 8 March

Mr Milburn: To ask the Secretary of State for Health ... if she will list by region and name each proposed hospital closure which was contested by the community health councils since 1988; whether the hospital closed, merged, changed its function or was downsized; and what was the number of beds each hospital had at its closure date.

Mr Sackville: The details requested are not routinely provided to the Department during the process for dealing with contested closures. The information requested by the hon. Member could be provided only at disproportionate cost.

Hansard WA, col 447, 11 March

Mr Milburn: To ask the Secretary of State for Health ... if she will list by region hospital closures which have been contested by community health councils in each year since 1988.

Mr Sackville: The following known hospital closures were initially contested by community health councils and remained contested through the consultation period. More detailed information could be provided only at disproportionate cost. Hospital closures which have been contested in this way since 1988 are:

Northern Region
Ponteland & Lemington Hospitals, Newcastle

Yorkshire Region
Grove Hospital, Ilkley
Brandesburton Long Stay, Hull

Trent Region
Balderton Hospital, Newark
Scarsdale Hospital, Chesterfield

East Anglian Region
Newmarket Hospital, Suffolk

North East Thames Region
Rush Green Hospital

South East Thames Region
Sydenham Children's Hospital

North West Thames Region
Clapham Hospital
South Middlesex Hospital
Westminster Hospital
West London Hospital
Westminster Children's Hospital
St Mary Abbots Hospital
St Stephen's Hospital

South West Thames Region
St James' Hospital

Wessex Region
None

Oxford Region
Iver Cottage Hospital, Berkshire

South Western Region
Almondsbury Hospital, Almondsbury
Standish Hospital, Stonehouse

West Midlands Region
Mill Street Hospital, Kidderminster
Birmingham Accident Hospital

Mersey Region
St Paul's Eye Hospital

North Western Region
Whittingham Hospital, Preston

(Given the limited criteria quoted by the minister, CHCs may be interested in checking that the list tallies with their local experience of opposition to closures)

Hansard WA, cols 231-2, 23 March

Question from Simon Hughes asking for a list of London hospitals closed since 1978 and from Mr Milburn on closures between 1979 and 1988 elicited no further information. All this official ignorance of hospital closures prompted a question from Gordon Prentice: whether the Secretary of State would make it her policy to collect centrally information on hospital closures in England. The response was that, except where statutory objections are raised, "these are matters for local decision" and that to "streamline and simplify central management" central reports should be kept to a minimum.

Hansard WA, col 464 25 March and col 595, 28 March

All of which points to the important role of CHCs in officially registering objections to closures. Without statutory (and sustained) objections, opposition to closures (and the closures themselves) will go officially unnoticed by the Department of Health.

NHSME pamphlets

In answer to a question from David Blunkett, the Labour health spokesman, on NHSME pamphlets, Dr Mawhinney listed 15 titles of "pamphlets, leaflets and brochures" that have been published since October 1993 (some in more than one edition) at a cost of £619,839.

Hansard WA, Col 599, 28 March

STOP PRESS: Patient's Charter

The following are the changes to the Patient's Charter announced by Virginia Bottomley:

- Setting a national target for the length of time patients have to wait for their first out-patients appointments; the aim is to do this from 1 April 1995.
- Setting a new target so that patients waiting for Coronary Artery Bypass Grafts are admitted from the waiting list within 12 months. The aim is to translate this target into a guarantee.
- In June, publishing hospital league tables under six main headings based on Patient's Charter information and using this information to level up to the standards of the best.
- Publishing over the coming months a series of leaflets showing how the Patient's Charter is being applied to maternity services, long-term NHS care services and health services for children.
- Consulting shortly on proposals to simplify and speed up the NHS complaints system.
- New standards to improve patient choice of hospital food.
- Introducing timed appointments for community nurse visits.

Department of Health Press Release 13 April

FROM THE JOURNALS

A research project in Milton Keynes and Aylesbury Vale aims to find out what members of ethnic groups think of local NHS provision. Respondents were contacted through English for Speakers of Other Languages (ESOL) classes (mainly long-term residents in Britain), English as a Foreign Language classes (mainly short-term residents) and community groups. The use of ESOL classes, in particular, has enabled the researchers to make contact with women from ethnic groups. In further stages of the research they intend to build on the initial contacts made through the ESOL classes to establish a wider range of contacts. Most of the findings concern barriers to understanding and communication, though they also touch on cultural barriers.

Respondents were asked about the help they receive and would prefer to help them understand health staff. Many respondents have difficulty in understanding GPs (61%) and hospital staff (47%), and most were inclined to take someone with them when they visited a GP (73%) or a hospital (67%). This is likely to place constraints on what can be discussed between patient and health staff.

Methods of helping people to understand were grouped into language-based help (speaking in a language understood by the patient or using an interpreter) and other methods (non-verbal communication and leaflets). Most would prefer language-based help, but more received "other help". (In practice most received neither kind of help – instead the main method used was for health staff to speak slowly and clearly.) The authors conclude that more language-based help should be provided to overcome barriers to communication.

Nursing Times, 30 March, pp 31-33

AROUND THE CHCs

Barnet CHC staff felt they needed training to help them respond to the considerable number of their clients who have been bereaved. Their local Bereavement Project set up a training day for the CHC's staff and staff from another seven CHCs. The participants found the day useful. The facilitators of the training were very surprised by the amount of this stressful work that faces CHC staff and by the lack of support and supervision they receive in carrying it out. The CHC's Chief Officer comments that CHCs should be arguing at a local and national level for more support in terms of health and safety as well as resources.

CHC PUBLICATIONS

Maternity services liaison committees: a forum for change

Helen Lewison for the Greater London Association of CHCs, 356 Holloway Road, London N7 6PA and the National Childbirth Trust, 15 pages, £5

This briefing paper opens by welcoming the adoption of *Changing childbirth* as official Government policy and the NHSME's executive letter *Women-centred maternity services* which requires NHS managers to implement the report's recommendations. *Changing childbirth* recommends that maternity services liaison committees (MSLCs) should be strengthened, but it is disappointing that neither the NHSME's executive letter nor *Changing childbirth* assigns a role to MSLCs in the implementation of the report's recommendations. Helen Lewison believes that MSLCs could provide an ideal multi-disciplinary forum for the planning and monitoring of maternity services at DHA level and that the targets, action points and indicators recommended in *Changing childbirth* could easily form part of every MSLC's agenda. The NHS reforms introduced uncertainty about the role of MSLCs since the Department of Health did not initially issue guidance about how MSLCs should relate to purchasers and providers. The paper traces developments in attitudes to their role. The Government has yet to complete a review of how this should change in the light of the purchaser/provider split, though *Changing childbirth* indicates that MSLCs should be strengthened and should report primarily to purchasers. Nevertheless, Helen Lewison detects a degree of unease about the ability of MSLCs to enable users effectively to influence maternity services, reflected in the omission of MSLCs from *Changing childbirth*'s chapter "Action for Change" and the report's encouragement of the use of *Local voices* as a guide to consumer involvement. She argues that, while initiatives such as *Local voices* have a vital role in obtaining information, "the work of discussing and agreeing strategic plans, proposals for development, service specifications, business plans and quality standards is most effectively carried out in the formal setting of the MSLC".

She goes on to outline ways of ensuring effective user representation on MSLCs: having a lay chairperson of sufficient standing to lead the committee effectively and support other user representatives, having at least three other user representatives on the committee and in various ways ensuring that the MSLC is accessible to lay representatives. Lay representation is not the whole story, however. All interested groups need to "own" the process of change. The paper goes on to discuss how the MSLC can provide a forum for debate and resolution of conflict between professional groups. It closes with a summary of the action CHCs should take if they are to take advantage of the opportunities offered by *Changing childbirth* by contributing to the strengthening of MSLCs.

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.

FOR THE RECORD

An audit of premises managed by the King's Lynn and Wisbech Hospitals NHS Trusts to assess accessibility for people with a physical or sensory disability
North West Anglia CHC, ca 50 pages, £2.50

Well prepared? Women's views and experiences of ante-natal education in the Bath health district.
Bath CHC, 16 pages

Survey of general medical practices in south Devon
Torbay and District CHC, 21 pages

Accessibility of Newham's hospitals to disabled people
Newham CHC, Action and Rights of Disabled People in Newham and Students from Queen Mary Westfield College, London, 32 pages

Having your baby at North Manchester General Hospital? A survey of the maternity services and views of women giving birth at North Manchester General Hospital, September 1993
Manchester North CHC, 37 pages

Patient satisfaction survey (with GP fundholders and non-fundholders)
Gateshead CHC, 32 pages

The special needs of black and minority ethnic women in connection with health care
Brighton CHC, 8 pages

Counselling project
Brighton CHC, Working Group on Services for women and children, 18 pages

Equal opportunities outreach project (concerned with dialogue with and services for people from ethnic minority groups)
Wandsworth CHC, 26 pages

Public consultation by the Gwynedd CHCs in response to Gwynedd's Local Strategy for Health
Gwynedd CHCs (Aberconwy, Arfon/Dwyfor, Meirionnydd, Ynys Mon)

A survey of community psychiatric nursing services in Hillingdon

Mental Health Services Working Group, Hillingdon CHC, 21 pages

Questionnaires were sent to half the users of the CPN services in Hillingdon (as listed on the CPN index file). Despite a reminder letter, only 29% responded, which makes the interpretation of some responses uncertain. For example, it is not quite clear why most respondents were relatively short-term users of the service, but this result highlights the need to monitor the percentage of service users who have long-term mental health problems. Almost a fifth of respondents felt they needed more time with the CPN and fewer than one in three of those who used the emergency on call system were contacted within the recommended two hours. Both of these suggest that staffing levels need review, though again there are alternative possible interpretations. Other concerns raised were about the accuracy of the CPN index, students being present during counselling sessions and communicating with CPNs of the opposite sex. The recommendations for improvements in these areas are made in a context of a generally positive response to the services provided.

London hospitals: discharging their responsibility?
Nikki Joule, Greater London Association of CHCs, 45 pages

Recommendations for CHCs coming out of this report on discharge policies and practices in London are that:

- CHCs should join with the DHA, hospitals, local authorities and user and carer groups to devise a charter for people being discharged from hospital
- CHCs should devise a scheme for monitoring discharge from hospital
- CHCs should consider undertaking commissions from the DHA to carry out specific discharge surveys
- CHCs should enable user and carer groups to participate in planning.

The Gardener Unit (Adolescent Forensic Service), Prestwich Hospital: visit report
Salford CHC, 11 pages

Last month Salford CHC drew the attention of CHCs to the National Centre for Mental Health and Deafness. This report is on another unit in the Salford area which provides a national service. The Gardener Unit is the only NHS adolescent forensic service in the UK. It provides a consultative, assessment and treatment service to young people aged from 11 to 18. As well as its work with in-patients, the service offers advice and assistance to professional bodies, referral agencies and other establishments caring for seriously disordered adolescents and to the criminal justice system in dealing with mentally abnormal adolescent offenders. Salford CHC is keen that other CHCs should know about this service and highlight it to their health authorities and GPs. Please contact Salford CHC if you would like a copy of the visit report.

Health checks for child-care workers
Catherine Hayes for North East Essex CHC, 44 pages

People wishing to work with children under eight years old have to undergo a health check (to judge whether people are unsuitable to work with children because of their health), a police check and an assessment by social services. This report on the procedures used in the health check is based on surveys of public health offices and social services departments. The author concludes that, given the lack of an established correlation between types of illness and inability to care for children, the health check is very unlikely to identify dangerous people.

OFFICIAL PUBLICATIONS

Eat Well! An action plan from the Nutrition Task Force to achieve the Health of the Nation targets on diet and nutrition
Department of Health, 44 pages. Available from: BAPS, Health Publications Unit, DSS Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs OL10 2PZ

AIDS/HIV-infected health care workers: guidance on the management of infected health care workers. Recommendations of the Expert Advisory Group on AIDS. (HSG (94) 16)
UK Health Departments, 27 pages. Copies have been sent to CHCs. Available from: BAPS as above.

A study of minor injury services
NHS Management Executive, 24 pages. Copies have been sent to CHCs. Further copies from: Heywood Stores, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ

Just for the medical record
Patient's Charter Primary Care Initiative. A pack on transfer of medical records.
NHS Management Executive. Available from: Heywood Stores as above.

Caring for the future. The NHS Wales plan for improving quality
Welsh Office, 20 pages. Copies have been sent to Welsh CHCs.

GENERAL PUBLICATIONS

Evaluating the NHS reforms

Edited by Ray Robinson and Julian Le Grand, King's Fund Institute, 288 pages

Giving evidence to the House of Commons Select Committee for Health in 1989, the then Secretary of State for Health, Kenneth Clarke, denied the need for formal monitoring and evaluation of the proposed NHS reforms, saying that calling on the advice of academics would be a sign of weakness. The King's Fund begged to differ and selected seven research proposals each on the evaluation of a different aspect of the impact of the reforms. The studies were carried out over the period 1990–93. Accounts of the research have been pulled together for this book and are supplemented by a chapter on the events leading up to the reforms, a review of the equity implications of the reforms and a closing chapter offering reflections on evaluation and the NHS reforms.

A theme that runs through the book is the difficulty of establishing the causes of any particular observed changes. As well as the NHS reforms *per se*, there were changes to GP contracts, the Patient's Charter, reforms to community care and real funding increases of 6.1% in 1991/92 and 5.5% in 1992/93. Moreover, it is early days. Nevertheless, it has been possible to come to some tentative conclusions about the progress of reforms.

A study on non-clinical aspects of quality found little significant improvement in services to elderly hospital patients. Some improvements were identified at the primary level, but were attributed to the GP contract and the Patient's Charter. A survey of GPs and patients sought to find out what effect the reforms had had on choices of hospital for elective surgery. Patient involvement in the choice was low (9.9% in 1991 and 10.9% in 1992) and nearly 44% of patients (in both the 1991 and 1992 samples) wanted more information about other hospitals. However, 89.9% (1991) and 90.7% (1992) were happy with the way choice of hospital was made. Willingness to travel further for treatment varied considerably between patient groups. Overall, just over a third of patients would not be prepared to travel any further to be seen more quickly. About 40% would travel up to 10 miles, but not up to 30. When GPs were asked about choice of hospital, fundholders were more willing to refer their patients some distance from home. The authors suggest that there may be a discrepancy between patient choice and decision making based on other criteria such as efficiency. They call for more investigation of the extent to which fundholders' and patients' choices coincide. They also call for a move away from normative definitions of quality and efficiency and the development of a broader definition of consumerism.

In another study, fundholders were found to have improved the quality of their services (communications with providers, consultant input at general practices and more practice staff). Again, the causes are not certain: early fundholders were probably already among the most innovative GPs and they received considerable financial support. The authors conclude that fundholding is probably having efficiency effects on hospitals. They acknowledge that the scheme has introduced some inequity, but favour extending "bottom up funding and negotiation" to non-fundholders to overcome this. The issue of equity is taken up in more detail in a review by Margaret Whitehead. While there is little well-designed research on the effects of fundholding, there is growing if fragmentary evidence of a two-tier service. She warns that while extending fundholding (or a more robust approach from DHAs) might reduce the two tier effect, it is difficult to see how it could do so unless funding is increased – not the most likely scenario. This discussion is part of an interesting chapter which analyses those elements of the pre-reform NHS which fostered or were intended to foster equity and the possible theoretical impact of the reforms. The chapter also looks at evidence that needs assessment might have improved aspects of equity and at the effects on equity of blurring the boundary between free and means tested provision for those needing non-acute care.

Other studies are on monitoring managed competition, medical audit, the NHS personnel function and the performance of trusts.

Beyond the Patient's Charter: working with users

Christine Hogg for Health Rights, Unit 405, Brixton Small Business Centre, 444 Brixton Road, London SW9 8EJ, phone: 071 274 4000 x326, 102 pages, £13.50 full price, £8.50 concessionary price to CHCs/voluntary organisations

In this practical guide, Christine Hogg argues for moving beyond the production by the Government and managers of a list of "rights" and "standards", which may bring about improvements in some areas, but not necessarily those considered most important by users. The real value of charters lies in the process of negotiating between service providers and users – a process which was neglected in the development of the Patient's Charter.

An opening section discusses the development of charters in health care and draws out some differences between charters produced *for* people as consumers and charters produced *by* people themselves. An example is the emphasis in the Patient's Charter on standards for waiting times, which may be achieved at the expense of other important, but less readily measurable, criteria such as quality.

The second section discusses areas identified as important by two groups of users: people living with chronic or recurrent pain and women with HIV infections. These two groups were chosen in the belief that good practices identified as important for them would, if introduced more widely, also improve services for other users. The main concerns of most users were about the attitudes and expertise of GPs. The most important priority was to be treated with "reasonable skill and care". Although this is a right in common law, "safety" in health care is not included in the Patient's Charter. In addition, although health services may seek the views of patients on organisational issues, they rarely ask patients for their views on clinical issues despite the fact that people with long-term conditions often have useful expertise. The second most important area is to be treated with respect, privacy and dignity. Although this is a Charter standard, examples are given of patients being met with disbelief, a failure to listen and a lack of awareness of their needs. If the standard of treating people with respect was genuinely adhered to, then others would follow: for patients to be given the information they want and services appropriate to their needs. Other chapters in this section concern access, information, informed decisions, choice, confidentiality, continuity of care and complaints. Although many of these may feature in official charters, the wording of particular standards does not necessarily match the priorities of users.

The third section of the guide deals with developing partnerships between users and providers in developing and monitoring charters. This is seen as more important than the actual words which make up charters. In line with this view, Christine Hogg suggests that a national charter should focus on setting a framework for the *process* of developing local charters, rather than on setting and monitoring specific standards. The principles underpinning the process need to be that charters are part of an overall quality programme and part of an overall strategy for the involvement of patients and local people; that clinical audit and patients' surveys should be integrated; and that patients' and carers' perceptions of effectiveness should be central to clinical audit. The process itself would involve finding out users' priorities; developing achievable standards; monitoring which involves users; and using experience to redefine standards and move beyond the charter.

Each chapter in the guide ends with a list of action points which health workers could use in involving patients and meeting their needs and priorities and the third section includes tables of suggested action for GPs, FHSAs, hospitals and DHAs.

Consumer Audit Guidelines

College of Health, St Margaret's House, 21 Old Ford Road, London E2 9PL, phone: 081 983 1225, fax: 081 983 1553, 142 pages, £24 (inc p&p)

Despite the declared emphasis on making health services responsive to the needs of users, there has been little lay input to either clinical or organisational reviews, with patient satisfaction surveys tending to restrict themselves to "hotel services". Since the mid-1980s, the College of Health has been developing ways of investigating and

presenting the views of health service users on a wider range of issues. These guidelines describe the methods they have developed with the aim of providing an insight into how some of the methods may be used, discussing when they may be appropriate and giving training guidance for undertaking some of the Consumer Audit processes. They are aimed at a wide range of people in the health services (and elsewhere), and are not restricted to those involved in quality assurance and patient satisfaction work. As well as enabling in-house staff to use some of the methods, the information in the document should help those in the health services to assess when they need expert or outside help.

Nine sections cover: What is consumer audit?; Getting started; Involving all client groups; Training staff; In-depth interviews; Focus groups; Observations; Analysing the results and writing the report; and Achieving change. Alongside explanatory text there are bulleted checklists and highlighted examples of good and bad practice. Advice is given on developing appropriate skills, on choice of methods, the use of the different methods, and stages of audit. Although the guidelines are aimed at purchaser and provider staff, they are clearly relevant to the work of CHCs. In addition, the report advises readers that, given the important role of CHCs in representing the interests of patients and local communities and their experience, it is often appropriate for a CHC representative to be a member of the Consumer Audit steering group.

Deadline

If you have any items for the next issue of CHC News could you please get them to ACHCEW by 11 May.

INFORMATION WANTED

The Campaign for Freedom of Information is researching **"confidentiality clauses" in out of court settlements** involving medical negligence and other matters. These are clauses which prevent a plaintiff from talking to a third party about the terms of his/her financial settlement or about the facts of the case. If you have any experience of this type of clause, please contact The Campaign for Freedom of Information, 88 Old Street, London EC1V 9AR. Phone: 071 253 2445.

Waltham Forest CHC has become aware of a case which has implications for the care of mental health patients in the community. A local **private nursing home has been refused insurance cover** if it provides a home for any Section 37/41 patients (under the 1983 Mental Health Act, Section 37: Hospital and guardianship orders or Section 41: Restriction orders). This is despite the fact that the home has had such residents in the past, and this has caused no problems. The CHC has written to the Secretary of State for Health asking what action her Department could take over the issue. The CHC would be interested to hear from any other CHCs who are aware of similar problems.

South Cumbria CHC would like to hear from any CHCs which have come across cases in which, when a patient changes GP, the new GP has received only a summary of the **patient's health records** from the previous GP, rather than the full records.

Bath & District CHC would like to see copies of questionnaires/surveys specially developed to measure **user perceptions of maternity services.**

Blackpool, Wyre and Fylde CHC is a member of a focus group looking at chiropody services for children (specifically **orthotics**). Parents are reporting difficulty in obtaining shoes which can be worn with inserts. Is this an issue in other parts of the country? The CHC will be approaching manufacturers. Please contact the CHC if you are interested in this topic.

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.

FORTHCOMING EVENTS

Managing to listen: practical user involvement for mental health service managers

- two one-day conferences
- organised by the King's Fund Centre
- at Crest Hotel, Swindon on 18 May 1994 and
- West Yorkshire Playhouse, Leeds on 20 June 1994
- £65 for first ten applicants from CHCs/voluntary organisations
  free for first ten applicants from unwaged service users applying as part of a team
  £85 others

Further info from:
Rose Echlin, Project Manager, or
Melanie Kornitzer, Project Secretary
King's Fund Centre
071 267 6111

Building the consumer agenda into local health services

- one-day conference
- organised by the College of Health to explore the findings on its South Bedfordshire Consumer Audit project
- at Regent's College, London
- on 16 June 1994
- £50 voluntary organisations, £90 others
- conference report is available for £7.50
- cheques payable to College of Health

Further info from:
Francesca Avbara, College of Health
St Margaret's House, 21 Old Ford Road
Bethnal Green, London E2 9PL
Phone: 081 983 1225, Fax: 081 983 1553

Water poverty

- one-day conference on proposed changes in water charging and the implications of future options
- organised by Age Concern England and the Public Utilities Access Forum
- at Edgbaston County Cricket Ground, Birmingham
- on 24 May 1994
- £115 plus VAT. Concessionary rates available.

Further info from:
Claire Brook, Conference Unit
Age Concern England
Phone: 081 679 8000

Advanced legal and medical issues

- AVMA Medical Negligence Conference 1994
- at the Brighton Metropole Hotel and Conference Centre
- on 27-28 May 1994
- £539 residential
  £504.12 non-residential, two days
  £252.06 non-residential one day
  (all inclusive of VAT)

Further info from:
Penny Moore or Pat Osinaike
Action for Victims of Medical Accidents
Bank Chambers, 1 London Road
Forest Hill, London SE23 3TP
Phone: 081 291 2793, Fax: 081 699 0632

Donated ovarian tissue

- one-day conference
- organised by the BMA
- at BMA House, London WC1
- on 12 July 1994
- £62 (inc VAT)

Further info from:
Gillian Romano
Professional and Scientific Division
British Medical Association
BMA House, Tavistock Square
London WC1H 9JP

DIRECTORY AMENDMENTS

In view of the large number of amendments/additions received for inclusion in the revised Directory, these are not being listed in this issue. They will, of course, be included in the revised Directory which will be sent out to all CHCs within the next few weeks.

Correction

Last month (page 8, para 4) we put in the wrong fax number for the Coordinator of Assessors at the Appointment of CHC Staff, Gordon Tollefson. The number should be 0977 600859.