CHC NEWS

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

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NEWS

The Wilson Committee Report

Being Heard, the report of the independent committee set up under the chairmanship of Professor Alan Wilson to look at NHS complaints, was made public on 11 May. Among its 67 recommendations are many that will be welcome to CHCs if they are accepted. Recommendations for a common system across the NHS, the separation of disciplining practitioners from the resolution of complaints, the separate filing of complaints from medical records and requirements on GPs, dentists and pharmacists to introduce practice procedures should all remove some of the present obstacles experienced by patients.

As many complaints as possible should be resolved informally by front-line staff. Conciliation should be made more widely available. The degree of investigation should relate to the level of response required by the complainant. "Internal" investigation or conciliation should be completed within three weeks and all stages within three months. If a complaint cannot be handled by investigation/conciliation, action should be taken by an FHSA complaints officer or a trust chief executive. Complaints which are still unresolved should go to a Stage 2 panel with three members.

CHCs

Two recommendations mention CHCs:

- that appropriate training is offered jointly to health council staff and others who may be asked to support complainants; and
- that specific resources, including staff, are provided to health councils for their role in supporting complainants, accompanied by guidance from the Health Departments as to the use of these resources and monitoring arrangements.

Communication

Some recommendations deal with communicating with the public, including the dissemination of information leaflets and "establishing what their users think about their handling of complaints". The complaint respondent should check with complainants whether they are satisfied with the response and inform them of further action they could take.

Widening complaints systems

Complaints systems should encompass non-NHS providers (through contract terms) and integration with local authority procedures should be considered. Purchasers should also give "proper consideration" to complainants' views on their *policies*, and complainants should have recourse to the Health Service Ombudsman on policy and purchasing issues. The Ombudsman's jurisdiction should also be extended to GPs and FHSA service committee procedures.

Impartiality

This is the area in which the recommendations fall short of what CHCs might have hoped for. Although the committee says impartiality is a key principle, ACHCEW is not convinced that the envisaged system will guarantee full independence. The recommendation headed "impartiality" states: "We recommend that NHS complaints procedures include the possibility of impartial consideration by lay people". Health authorities and boards responsible for family health services should *employ* complaints executives to deal with complaints in Stage 1. The complaints executive or trust chief executive should have a full range of options at their discretion. This *might* include obtaining independent advice or establishing an independent inquiry. On a positive note, it is recommend that Stage 2 panels (when "internal" procedures have not resolved the complaint) should always have a lay majority and a lay chair. It remains to be decided who would appoint the panels.

The broad thrust of the report has been supported by Secretary of State for Health, Virginia Bottomley. She hopes to introduce legislation on its principles in the autumn, after a period of consultation. Please send any comments on the report by 15 August to: Elizabeth Connell, NHSE, GN35C, Quarry House, Quarry Hill, Leeds LS2 7UE.

Note: All CHCs should by now have received a copy of the committee's report. Let ACHCEW know if you have not.

Report's list of recommendations, Independent 12 May, Guardian 15 May

HOSPITAL CLOSURES

Another London hospital looks certain to lose its casualty department after a judicial review rejected objections to the decision to close the A&E department at St Bartholomew's Hospital. The ruling comes just as a confidential NHS Executive study concludes that the inner cities are receiving too small a share of NHS funding and another study warns that a number of hospitals are facing financial crisis.

Funding formula flawed

The formula used to determine the distribution of NHS funds around the country is flawed, according to both the King's Fund and a confidential study carried out by the NHS Executive. It is understood that the NHSE study shows that the inner cities should be allocated more resources to take account of social deprivation. The effects are particularly marked in London, which the King's Fund estimates is underfunded by £200m. The Department of Health has been arguing that a £70m overspend on London's health services justified hospital closures in the capital. The King's Fund accepts that there should be a shift from hospital provision to community-based care, but argues that the new services must be established before old services are closed. This can only be achieved with substantial new investment. Apparently the NHSE survey concludes that the big conurbations outside London should be receiving an extra £35m rather than losing £70m, though ministers might soften the impact of the conclusion by changing the weightings within the new funding formula.

Independent 29 April

Barts battle lost

The reports on the NHSE study come shortly after a High Court ruling that the Health Secretary, Virginia Bottomley, had acted properly in deciding to close the casualty department at St Bartholomew's hospital in London (a decision which will trigger the rundown of most of the hospital's departments). The boroughs of Islington and Hackney and a local out-patient had brought the application for judicial review, arguing that Mrs Bottomley had acted "unfairly, unlawfully and unreasonably" after a consultation exercise in which the vast majority of respondents were opposed to the closure and that NE Thames RHA had issued misleading or inadequate consultation materials. Two judges rejected the argument that Mrs Bottomley had prejudged the outcome, saying that she was answerable to Parliament and the electorate, not the courts, for an unpopular decision. They also rejected a call that the Department of Health disclose documents showing how the decision on closure had been taken.

Guardian & Daily Telegraph 26 April

'Merger' warning

The *Fourth Newchurch Guide to NHS Trusts* has been published, with now-familiar warnings of financial crises and possibly inappropriate mergers. The study looked at the financial performance of the 157 first and second wave trusts (there are now 400 trusts, accounting for 96% of hospitals and community units). It found that nearly half had failed to meet Health Department financial targets: to achieve a 6% return on capital, to break even and to operate within external financing limits. Of these 18 have severe problems. There are likely to be mergers or take-overs, motivated by financial survival rather than an assessment of the needs of the local population. Since 1991 about 20 mergers have taken place – others are under discussion,

Speaking to a NAHAT conference, the managing director of Newchurch said that, given the wide-ranging restructuring of the NHS, the lack of disasters had been notable. However, he added that there is no evidence as yet that trusts are delivering higher quality or lower cost health care. He also predicted that some trusts are simply not going to be financially viable.

Guardian 12 April

Looking the other way

A report by Professor Liam Donaldson, director of public health and regional general manager of Northern & Yorkshire Region, says that it is difficult to sack consultants who are dishonest, incompetent, abusive or guilty of sexually harassing patients. Since taking disciplinary action is difficult, acrimonious work and because of the vagueness of disciplinary rules, there is a tendency to look the other way. Prof. Donaldson reviewed 49 cases in which there had been a possibility of disciplinary action (involving 6% of the senior medical staff in the region). The most common complaint was of aggression and rudeness to patients or staff. Others involved lack of commitment to duties, poor skills, dishonesty and sexual behaviour. Of the 49 doctors involved, 21 remained after counselling, 19 retired or took non-NHS jobs and 9 left to work elsewhere in the health service.

Guardian 13 May

Value for drugs money: who calls the tune?

Health Secretary, Virginia Bottomley has been placed in the uncomfortable position of shelving moves to increase the use of lower cost generic drugs just as GPs have agreed to back such a scheme. In a reversal of its previous policy, the BMA's family doctors' committee voted overwhelmingly to enable pharmacists to substitute generic drugs for prescribed branded drugs, unless the prescription states that they should not. GPs say that there is less concern than a decade ago about the quality of generic drugs. It is estimated that substitution would save £50m per year – a saving which Health Minister, Brian Mawhinney, is keen to make. Last month he told the House of Commons Health Select Committee that Health Department officials were to open talks with the BMA on the details of such a scheme. Furious at Dr Mawhinney's support for the idea, the Association of the British Pharmaceutical Industry wrote to Michael Heseltine, President of the Board of Trade, and to Mrs Bottomley complaining of a breach of faith and threatening that drug companies would leave Britain if generic substitution went ahead. At a subsequent pharmaceutical conference, Mrs Bottomley said that having considered generic substitution for a decade, the Government had "never been convinced that it was the right way to tackle the problem" and that ministers remained to be convinced.

Independent 2 May

Over 1 million on waiting lists

Over a million people are now waiting for hospital treatment. At the end of March there were 1,065,349 people waiting for treatment, a rise of 7.1% on the 1993 figure, which itself was up 8.3% on the 1992 figure. The highest rises last year (using old regional boundaries) were in South West Thames (14.3%), North East Thames (14.2%) and North Western (13.7%). Lists in South Western region fell by 5.2% and in Wessex by 3.7%.

Nationally, the number waiting more than a year rose by 14.2% during the year 1993/94 (this category had fallen by 28.8% in 1992/93). At 31 March 1994 there were 64,323 people who had been waiting between one and two years, and 428 people who had been waiting over two years.

An extra £12m was allocated to bringing down waiting lists in the last six weeks of the 1993/94 financial year. Waiting lists rose by 1047 during the last quarter, though the one-year-plus list fell by 13.2%.

Guardian 7 May

Patient's Charter

A Royal College of Nursing survey has revealed widespread ignorance of the standards set out in the Patient's Charter. A telephone survey of 2000 people found that, although 69% of respondents had heard of the Charter, only 28% could name any of its guarantees or aims. The highest rating (13%) was for a maximum 30 minute wait at out-patients. Only 1% could identify the named-nurse provision. However, of 927 respondents who had been treated by a nurse in the previous year, 43% knew they had been given a named nurse.

The freephone Patient's Charter helpline costs almost £16 a call, the Labour party has claimed. The help line, which was set up two years ago, had cost £3.7 million and receives around 500 calls a day – 2.2 per hour for each operator. Health Minister, Dr Mawhinney, has said that the number of calls is rising sharply, bringing down average costs.

Guardian, Daily Telegraph 25 April, Guardian 2 May

Health inequalities on the agenda

The Government has set up an inter-departmental working group to examine health inequalities. The work will cover variations in health between different socio-economic and ethnic groups and between geographical areas. The setting up of the group (a sub-group of the Chief Medical Officer's standing group on the *Health of the Nation* targets) marks a notable reversal of policy. Ministers have consistently avoided the issue since the publication of the Black report in 1980 which showed that the health gap between social classes had been widening. At that time, Sir Douglas Black was not permitted to hold a departmental press conference, and the Government produced only 260 copies of the report. The Government move has been warmly welcomed by the British Medical Association.

The announcement of the setting up of the group came in the wake of considerable publicity generated by a series of articles in the 30 April edition of the *BMJ* which explored various aspects of the link between socio-economic factors and health. There are articles on relative poverty and mortality, differential immunisation uptake, eczema and social class, the impact of unemployment on mortality, and the wider European experience of inequalities in health and strategies to address them. The issue is headed by an editorial on the topic by Richard Wilkinson, a specialist in health inequalities.

Over the years many studies have shown that lower social status is associated with higher mortality rates. One of the *BMJ* articles, by Peter Phillimore and colleagues, shows that mortality among those aged 0–64 years is four times higher in the six poorest electoral wards of the Northern Region than it is in the six most affluent. Mortality rates among 15–44 year old men in poorer electoral wards actually rose during the 1980s, reversing a long-term trend and in contrast to more affluent wards. The authors challenge the preoccupation with behavioural explanations for health differentials, arguing that material conditions must be re-emphasised.

The argument developed in the editorial goes further than associating measures of health and absolute wealth. It is suggested that in richer developed countries (Britain among them) relative, rather than material, deprivation is the problem. In developed countries mortality rates for the country as a whole are related to income distribution. In an article comparing the experience European countries Chris Power argues that whereas among relatively poor countries (less than $5000 GDP per head per year) there is a strong link between the GDP per head and life expectancy, this is not the case for the richer countries of the OECD. In these countries, there is a strong association between income *inequalities* within a country and its average life expectancy. Those with the smallest gap between the highest and lowest income groups have the most favourable rates for the country as a whole. Similar effects are seen with infant mortality rates.

This analysis may be supported by looking at changes over time in Britain. The 1980s saw an unprecedented widening of income differentials in the UK. The Phillimore study shows that the decade also saw a widening in the death rates of the wealthy and the deprived in the Northern region.

Summing up the implications of the various articles, Richard Wilkinson concludes that reducing the burden of excess mortality attributable to relative deprivation depends on reducing social and economic inequalities themselves. In the meantime, the more deprived sections of the population pay a heavy price for the official failure to take the social causes of disease seriously. While Dr Wilkinson welcomed the Government decision to set up a working party, he added that we already know that to tackle health inequalities is a matter of taxes and benefits in the short term, and education and the economy in the long term. The inter-departmental nature of the working group at least should make it possible to address the issues over a wide range of policy areas, as these arguments suggest is necessary.

BMJ 30 April, Independent 4 May

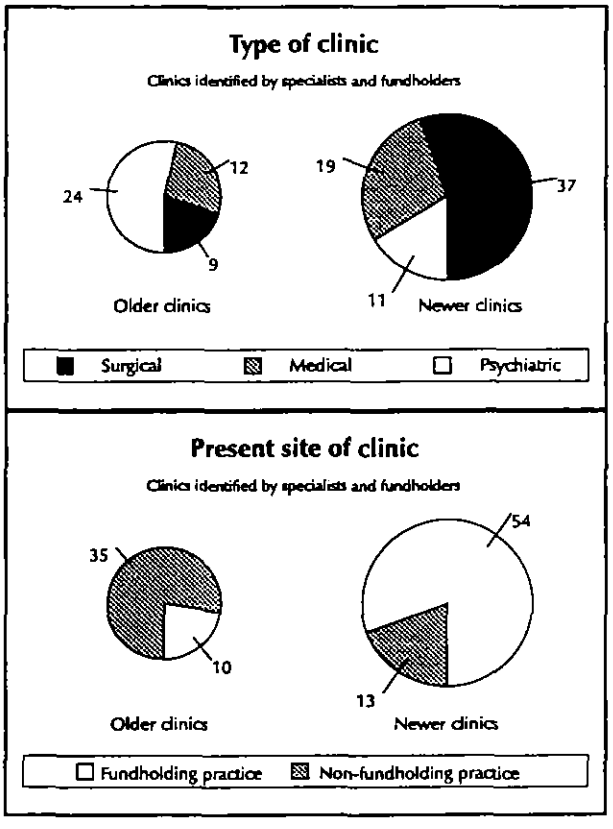
FROM THE JOURNALS

Outreach clinics

Outreach clinics, in which specialists provide services in GP surgeries and health centres, are on the increase, especially in fundholder practices and for non-psychiatric services, according to a survey reported in the *BMJ*.

A study of outreach clinics surveyed managers at 22 district general hospitals and 28 NHS hospital trusts, specialists attending the clinics identified, GPs using the clinics and (separately) GP fundholders in the districts of the 50 hospitals included in the study. A total of 157 clinics were identified. (Apparent inconsistencies in some of the figures below are caused by the use of different elements of the survey.)

A comparison of older clinics (established before 1990) and newer ones (established 1990 onwards) shows up some interesting shifts:



Clinics held at fundholder and non-fundholder practices also show significant differences (GP survey):

- Of 54 clinics in fundholding practices, 44 had been initiated by the fundholder, whereas of 18 clinics in non-fundholder practices, 15 had been initiated by the specialist. Fundholders were also much more likely to have plans to increase outreach clinics.
- Clinics at fundholding practices were much less likely to be for psychiatry (9% of newer clinics, 17% of all) than were clinics at non-fundholding practices (46% of newer, 50% of all).
- Referrals from other practices were accepted at 22% of clinics held at fundholding practices and at 61% of clinics at non-fundholding practices.

In neither fundholding practices nor non-fundholding practices was there much GP involvement in the running of the clinics, although many advocates of clinics see improved specialist–GP communication as one of their benefits.

The study did not investigate the views of patients on the clinics. The great majority of doctors (especially specialists) thought that the main benefit to patients is ease of access (many specialists reported improved attendance at outreach clinics). Familiarity with surroundings was also frequently mentioned. The only disadvantage to patients that was mentioned was that in some cases patients have to go to the hospital for further tests.

One of the (many) points of controversy about outreach clinics has been that, while they may improve access for some patients, they may diminish it for others. This study found little evidence that this was yet happening. A number of hospital psychiatric clinics have been cancelled because of outreach clinics. However, since these outreach clinics tend to be specialist-initiated and held at non-fundholding practices (which are less likely to restrict referrals), this may merely mean that services have been shifted to a more convenient location. The authors point out that if outreach clinics continue to grow in number there may be serious resource implications for hospital-based care. If hospital services are run down and new clinics restrict referrals, then there could be reduced access for some patients.

BMJ 23 April

Community mental health services

It is hardly surprising that in a recent MIND/*Community Care* survey 91% of Social Services directors wanted more Government funding for mental health services. Social Services Departments (SSDs) are allocating a higher proportion of their funds to mental health (58% now devote more than 3%, compared to 38% three years ago), but half believe that their 1994/95 mental health budgets are insufficient (23% say they are sufficient). The extra resources allocated to the field have been used to develop community services: primary day care, counselling, home care, benefits advice and some form of 24-hour help.

More surprising are some of the policy preferences expressed by directors. On issues that might require legislation, 83% favour statutory rights to community support for mentally ill people and 83% want national minimum standards of care. On service provision, 89% want guaranteed access to 24-hour specialist care (limited types of 24-hour cover are currently provided by over half the SSDs) and 74% would like a right of access to counselling through GPs. Almost all want more public education/information on mental health.

A rather worrying aspect of the report of this survey is a potential division of interests between the different 'Cinderella' services. Both Elaine Murphy, vice-chair of the Mental Health Act Commission, and Tad Kubisa, junior vice-president of the Association of Directors of Social Services, are quoted as arguing that too much of the money generated by the sell-off of mental health hospitals has been diverted towards elderly people in long-stay beds. While undoubtedly mental health services need higher priority, it is surely not elderly people in need of long-term care who should be expected to pay the price.

Community Care 30 April

Nurse prescribing pilots

Bids for pilot nurse prescribing schemes have now been submitted. There will be eight pilots – one in each region. Under the 1992 legislation, community nurses (health visitors and district nurses) are authorised to prescribe in the schemes. Nurses in the pilots will complete a 15-day distance learning package and attend a two-day course.

Although bids have been submitted by GP fundholders, the nurses' employers will retain the line of professional responsibility. The reason given for basing the pilots at GP fundholder sites is that, since fundholders have their own budgets and patient lists, data collection and evaluation will be more straightforward. This aspect of the pilots has, however, been criticised by the Health Visitors Association and the District Nursing Association. They believe it would be useful to evaluate more innovative work, especially since nurse prescribing might prove most useful for working with clients who are not registered with GPs.

Nursing Times 13 April

NEWS FROM ACHCEW

Rose Walter

Members and staff of CHCs will be saddened to hear of the death of Rose Walter. Rose had worked at ACHCEW for a number of years and was a familiar figure at ACHCEW conferences and seminars. She had finally retired last autumn, but sadly died a few months later after a short illness. An obituary of her appeared in the Guardian on 30 April 1994. Copies are available from the ACHCEW office.

ACHCEW events

Places are rapidly filling up for the ACHCEW seminar on *Being Heard*, the report of the review of NHS complaints procedures. The seminar is being held on 14 June 1994 and will be addressed by the Right Honourable Dr Brian Mawhinney MP, Minister for Heath, and by Professor Alan Wilson, who chaired the review committee.

Dr Mawhinney has now also been confirmed as the Ministerial speaker (reshuffles permitting) at the ACHCEW AGM Conference which is being held in Eastbourne from 12 to 14 July 1994. Details of both events are available from CHC offices or from ACHCEW.

CALL FOR VOLUNTEERS

We are looking for volunteers to help with the AGM newsletter at Eastbourne.

If you would like to write a formal piece on one of the plenary sessions, describe any of the conference activities or ferret out news and gossip, please let us know at ACHCEW.

We would also be grateful to anyone willing to help with tasks such as collating and distributing copies.

ACHCEW reports

Two ACHCEW reports have been published in the last few weeks and have attracted considerable press and broadcasting interest. The first was *Fundholding and access to hospital care*, which looked at the extent to which patients of GP fundholders enjoy priority access to NHS hospital care. The second was *Access to Health Records Act 1990: the concerns of community health councils*, which looked at the workings of the legislation allowing patients to see their medical records.

The reports have been sent to individual CHCs.

New *Patients' Rights* leaflet

A new version of ACHCEW's highly popular leaflet, *Patients' Rights*, has just been published. An initial supply was sent to CHCs and reference copies are being provided to CABx. Single copies are available from ACHCEW on receipt of a stamped addressed envelope.

The leaflet is also being translated into Arabic, Bengali, Cantonese, Greek, Gujarati, Hindi, Punjabi, Somali, Turkish, Urdu and Vietnamese. There will be taped and large print versions for people with sight impairments.

CHC PUBLICATIONS

Changing childbirth in Newcastle upon Tyne: user views of a maternity service
Jacqueline Calder for Newcastle CHC, 44 pages

A survey of women resident in Newcastle who gave birth during September 1992, achieving a 76% response rate. By using community midwives to distribute the questionnaires, it was possible to identify and exclude women who should not be troubled with the survey because of a traumatic experience. There were also focus group sessions with six Bangladeshi women, eight Chinese women (with interpreters present) and ten women who use a local community centre. The report presents qualitative and quantitative results (on 308 variables).

As is often the case, most women expressed overall satisfaction, but many were dissatisfied with particular aspects of their care. Among the more striking results were: rather high levels of dissatisfaction with information about ultrasound scans (reaching 57% at one of the two hospitals for information after the scan); that while 28% of women said they would prefer a female doctor, this rose to 47% for women aged 19 or under; and that 40% of first time mothers said they had received conflicting advice about something while on the postnatal ward.

FOR THE RECORD

A project into genito-urinary medicine services for Salford people
Salford CHC, 24 pages
Survey to obtain the views of users of the drug dependence clinic
Warrington CHC, 36 pages
Survey of the quality of meals served at Warrington Hospital NHS Trust
Warrington CHC, 17 pages
Survey of patient opinions at Royal Berkshire and Battle Hospitals NHS Trust
West Berkshire CHC, 12 pages
Chiropody services in North Tyneside
North Tyneside CHC, 5 pages
1994 Mental Health Services Directory: where to go for help in Wyre Forest and Kidderminster areas
Community Resource Development Group and Kidderminster & District CHC, 51 pages

Five publications have recently been published by *Southern Health and Social Services Council*, 16 Church Street, Portadown, Craigavon, Co. Armagh, BT62 3LQ, phone: 0762 351165, fax: 0762 351493
Health and social care in Kilkeel – the consumer viewpoint
Are GPs practising good practice?
Caring for children in hospital
Mental handicap/learning disability in the Craigavon and Banbridge Community Unit of Management
Women's experience of maternity services

Going home: the discharge of elderly frail people from hospitals in North Tyneside

North Tyneside CHC, 82 pages, summary available

A report based on interviews with 39 people discharged from hospital and with health and social service professionals and a review of the literature on elderly people's perceptions of discharge. Despite all the attention discharge arrangements have received in the literature, and despite the high levels of appreciation of hospital staff, discharge arrangements are still not sufficiently co-ordinated or comprehensive. Several of the people identified as not needing community care assessment (so that they did not see a hospital-based social worker) did have questions about care in the community – they were left not knowing how to get the help or information they felt they needed. Hospital social workers felt that they were asked to assess some patients who clearly did not need an assessment. In general, many elderly people wanted to be given more information about aftercare. The lack of written information was seen as a problem by both the patients themselves and ward sisters. Work is currently under way to establish a unified discharge policy for North Tyneside.

A survey of the Accident and Emergency Departments of the Hillingdon Hospital and Mount Vernon Hospital

Hillingdon CHC, 39 pages

A survey based on a questionnaire administered by interviewers. In both hospitals, the triage system worked well while there was a Triage Nurse in the department. At some times of day, however, other nurses had to undertake these duties, and the target of 90% of assessments within 5 minutes was not being met. Almost half of the patients thought they "would be better at A&E" than seeing their GP/dentist, and a third believed that their GP/dentist would not be available. When patients were asked what was important in an A&E service, the response was overwhelmingly "a 24-hours service".

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.

Contributing to health care: the CHC role in the 1990s

Malcolm Spencer and Sarah Gee

A research project commissioned by the Northern Regional Association of CHCs, 32 pages

This project, undertaken by external consultants, aimed to establish the extent of work being undertaken by CHCs, identify good practice, evaluate the impact of CHC activity, make recommendations for future developments and disseminate the project's findings. Questionnaires were completed by all CHCs in the region. There were follow-up interviews with CHC chief officers and chairs and with the chief executives of three purchasing authorities in the region.

Relationships with NHS bodies

All CHCs have regular contact with the DHA and directly managed units. Most have regular contact with NHS trusts and FHSAs. Contact with other authorities and providers is more variable – only one of the 15 CHCs has no contact with non-fundholding GPs, but six have no contact with fundholding GPs. Despite the contact with DHAs and FHSAs, reflecting the statutory requirements, CHCs felt that decision making was increasingly taking place outside the statutory meetings which CHCs can attend. In some areas this problem has been partially addressed by setting up regular informal meetings between the CHC chief officer and/or chair and the chief executive and/or chair of the commissioning authority. Relationships with NHS trusts are variable, and it is recommended that good practice is disseminated across the region. All these relationships impinge on CHC independence. Again, more debate and sharing of good practice is needed.

Community care

Nine CHCs have either no contact or only occasional contact with the local authority. In the context of community care, CHCs see a need to form better working relationships with local social services departments. This has happened in some areas, North Tyneside for example, but in others social services staff seem to be disinclined to acknowledge that CHCs could have a relevant input. It is recommended that the regional CHC liaison officer should take a lead in organising a workshop between CHC representatives, social services departments, NHS and non-NHS providers and NHS purchasers to clarify roles and relationships in the context of community care provision.

Workloads and skills

With ever-increasing workloads and low staffing levels, CHCs are hard pushed to cope with existing core functions, let alone to develop new areas of work. CHCs must ensure the availability of skills and expertise within the CHC if they are to respond to the changes within the NHS and maintain their profile in the local community. One of the issues in this area is that many CHCs are supplementing core staffing by the use of non-recurring funds, particularly "White Paper" moneys. This enables them to appoint staff with specialist expertise on fixed term contracts. However, such skills can be lost when the non-recurring funding is exhausted. CHC members are a potentially valuable resource for CHCs, but the researchers found that they are often overlooked or undervalued (although "representation of views via CHC members" was ranked first as the method of obtaining the views of the public). One of the recommendations of the report is that each CHC should audit the skills, knowledge and experience of its members in order to maximise their input. Others are that the training and development needs of CHC staff and members should be reviewed and that there should be a formal review of CHC arrangements, including regional support, CHC funding and staffing.

Deadline

If you have any items for the next issue of *CHC News* could you please get them to ACHCEW by 8 June.

OFFICIAL PUBLICATIONS

Code of Conduct and Code of Accountability, Department of Health, 12 pages
Associated Guidance (EL (94) 40)

Queries relating to the codes should be addressed to: Corporate Governance Task Force, NHS Executive Headquarters, Room 5E59, Quarry House, Quarry Hill, Leeds LS2 7UE.

These two Codes are bound into one volume. The Guidance has been distributed separately to NHS purchasers and providers. All board members of NHS trusts and authorities are required to subscribe to the new Code of Conduct. This Code asserts three crucial public service values which must underpin NHS work: accountability, probity and openness.

On openness, the Code of Conduct states that NHS trusts and authorities should "forge an open relationship with the local community and should conduct a dialogue about the services provided". The Code of Accountability adds that plans and performance should be responsive to the community's needs. Annual and other key reports should be issued in good time to allow full consideration by those wishing to attend public meetings on local health issues. Although it is not detailed in the Code, the Health Secretary has decided that DHAs and FHSAs should be required to publish annual reports. Statutory measures to enforce this requirement are being considered. The Guidance sets out matters annual reports should cover. These include the extent and nature of consultation with local people, GPs and local statutory and voluntary organisations, and the action taken as a result of consultation. Authorities should ensure that reports are readily accessible to local people.

In January this year the Department of Health called for comments on the draft Codes. As a result of the consultation, to which ACHCEW contributed, a requirement has been added that all NHS boards should maintain a formal register of board members' interests, i.e. "business interests, positions of authority in a charity or voluntary body in the field of health and social care and any connection with a voluntary or other body contracting for NHS services". The guidance further explains that "relevant and material" interests include "majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS." ACHCEW had argued that even minority shareholdings constitute a pecuniary interest. The Code of Accountability states that the register should be available to the public – the guidance adds that NHS authorities and trusts should "take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it".

In its submission to the Department of Health, ACHCEW commented that the response often given to Parliamentary Questions, that "this information is not available centrally", reflects poorly on the accountability of the NHS to Parliament. The Code of Accountability says nothing about reporting systems that would ensure accountability in this sense. The NHS Executive says that this is one of the issues that is being taken forward as part of the *Open Government* White Paper. This exercise will involve drawing up an NHS code of practice, which may also cover the frequency of authority meetings and public consultation.

One minor, but welcome, change is that "Fair and open competition should be the basis for appointments to posts in the NHS". The original draft had said "... should normally be the basis ...". The guidance also says that "the pay of [NHS] employees, must be publicly defensible".

National Health Service: hospital catering in England

National Audit Office, HMSO, 30 pages, £7.40

A general conclusion to this report is that many hospitals could go further towards achieving economies in catering without prejudicing quality. It also concludes that many hospitals have been successful in delivering high quality food within a tight budget, but recognises that there are significant variations in the extent to which patients are satisfied. The report lists actions required by hospitals, health authorities and the NHS Executive.

FOR THE RECORD

CHCs should have received copies of the following publications:

The Patient's Charter: Maternity Services
8 page public information booklet, Department of Health
Further copies from Maternity Services, FREEPOST, (SE2851), London SE99 7XU

Trusting in the future: towards an audit agenda for NHS providers
Audit Commission, HMSO, 37 pages, £8.50

Clinical audit of suicide and other unexpected deaths
Professor H G Morgan, University of Bristol for NHS Executive, 27 pages
Further copies available from: BAPS, Health Publications Unit, DSS Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs OL10 2PZ.Quote reference HSG(94)21

Information to support Health of the Nation
NHS Executive, 32 pages
Further copies available from: BAPS, Health Publications Unit, DSS Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs OL10 2PZ.Quote reference HSG(94)19

Priority setting for health gain
Chris Ham, Frank Honigsbaum and David Thompson, Health Services Management Centre, University of Birmingham
Commissioned by the NHS Executive, 36 pages (report dated January 1993, but recently distributed). Further copies available from: the Research and Development Directorate, NHSE, Department of Health, Room GW59, Quarry House, Quarry Hill, Leeds LS2 7UE.

Hospital discharge workbook: a manual on hospital discharge practice
Department of Health, 17 pages, Workbook and separate leaflets available free of charge from: BAPS, Health Publications Unit, Storage and Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs OL10 2PZ

A workbook addressing different stages of the discharge process. The four stakeholders – senior strategic managers, purchasing; hospital and social services managers, providers; community-based health and social services; and hospital based practitioners – can identify the parts relevant to them by looking for their own symbol (an empty bed for hospital-based practitioners). The workbook lists "key questions", with spaces left for readers to fill in action points. Sample leaflets providing checklists for action are included.

GENERAL PUBLICATIONS

Refugees (political asylum seekers): service provision and access to the NHS
College of Health, St Margaret's House, 21 Old Ford Road, London E2 9PL, phone: 081 983 1225, fax: 081 983 1553, for Newham Health Authority and Newham Health Care, 187 pages

This substantial piece of work looks at a range of demographic data, patterns of health, health service availability and use and health service needs of the diverse refugee communities living in Newham. The picture which emerges is one of communities at the bottom of the socio-economic league and having, in addition, to cope with disruption in their lives, separation from family and friends and uncertainty about the future. Large numbers reported depression and it is shocking that the perceived health of refugees seems to deteriorate over a period of time in this country. The findings will undoubtedly be useful in Newham in identifying the needs of part of the local population. The methods and many of the conclusions would be of use elsewhere.

IN BRIEF

Involving older people in planning and evaluating community care: a review of initiatives

Patricia Thornton and Rosemary Tozer, Social Policy Research Unit, Univ'y of York

Single copies available free to CHCs and other local community, voluntary or older people's organisations which send a self-addressed A4 envelope to: Publications Office, SPRU, University of York, Heslington, York YO1 4DD; phone: 0904 433608. Further copies, £7.50.

Last year we circulated a request for information about initiatives involving older people in planning and evaluating community care. SPRU have now published this report based on that work, bringing together information from organisations throughout the UK. The review discusses the origins and aims of initiatives and outlines a range of practical approaches. It includes a directory which describes the funding, purposes and activities of local projects, giving contact names and addresses.

Help us to Help you

Trent RHA has produced three leaflets as part of the Help us to Help you campaign.

Copies are available from Trent RHA, Primary Care, Fulwood House, Old Fulwood Road, Sheffield, S10 3TH; phone: 0742 630300; fax: 0742 306956.

Working Together advises patients on how to find out more about their practice team, surgery opening hours, what to do at other times and how to prepare what they will say to their doctor.

You and your medicines covers the safe use, storage and disposal of medicines. It advises on useful medicines to keep in the home and explains medicine labelling.

Minor illness: how to treat it at home advises patients on how to cope with minor complaints. For each of the common complaints it deals with, it describes usual symptoms and advises on when patients should see the doctor.

IN BRIEF

Public participation in health care

Involving the public in health care decision making: a critical review of the issues and methods

Ben Hamilton Gurney, Health Services Research group, University of Cambridge, 99 pages, and

Framework for public involvement, *16 pages*

both published by East Anglian Regional Health Authority

Public participation in health care is a literature review of all the major initiatives and evaluations of public involvement work published to date in the UK. The first of its main conclusions is familiar – that the challenge of public participation suffers from too much rhetoric. Another conclusion highlights the tension between the desire to involve the public in decision making and seeking endorsement for politically determined priority setting. There are risks of misrepresentation and under-representation in public involvement. Clarifying the motives for public participation is vital – possibly even more important than the choice of method. Lastly the author concludes that the outlook for participation is good, with a positive commitment to the process gaining ground within the NHS.

The first two sections of the report look at what public participation is, and why it is on the agenda. CHCs are briefly mentioned in the second section. The author comments that CHCs are under-resourced and have no "power" in decision making – mere presence is no substitute for participation. Given that CHCs are inadequately resourced to establish the views of the local community, their role is perhaps individual rather than collective and could be seen as reactive rather than proactive. This judgement seems

a little unfair given the considerable efforts that CHCs make to find out what the public thinks, though few would deny that more funds would help. But it is, perhaps, not a surprising judgement from a literature review based on formally published documents, rather than the copious "grey literature" produced by CHCs.

The third section of the report looks in details at methodological issues, assessing the strengths and weakness of different methods commonly used. Little link is found between public input and decision making output, nor has there been any thing like adequate evaluation of the process of public participation.

Framework for public involvement sets out an outline of a strategy for moving forward. Based on interviews with chief executives of all health authorities in East Anglia, it presents a SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) of public involvement in the region. It then sets out categories for development such as "the learning organisation" and "special needs, special groups". The framework is rounded off with an 11-point action plan for health authorities.

INFORMATION WANTED

Mark Griffiths, Rotherham CHC, would like to hear from CHCs which have done work on the **views of drug misusers** about the services available to them.

Bassetlaw CHC would like to hear from any CHCs which know of instances of **doctors prescribing privately for patients of slimming clinics or health clubs.**

Mid-Essex CHC has heard of concerns about self-funded **nursing home residents who have been threatened with eviction** when they have run out of money. It would like to hear from CHCs with any *information on such evictions.*

Chris Dabbs, Salford CHC, would like to hear from CHCs involved in, or aware of, **patient participation projects involving people with HIV or AIDS.**

North Tyneside CHC would like to hear from anyone who has information about research into **patients' perceptions of day surgery**, or who has *information on* **good practices in day surgery.**

World in Action would like to hear from CHCs which have knowledge of **complaints about private residential care homes**. Please contact: Giovanni Ulleri, *World in Action*, 071 734 8080 ext 2262.

Could any CHCs with experience of **monitoring the work of Health Promotion Departments**, or developing models of **good practice** for HPDs, please send details to ACHCEW.

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

Consumer audit training workshops

- organised by the College of Health
- each workshop has a morning session and in the afternoon an option of detailed training in a specific method or a general overview of consumer audit methods
- £85 per person per day or £300 for all four sessions (inc. VAT)

22 June 1994
a.m. Hear from experts about involving users
p.m. option: **Observations**

14 September 1994
a.m. User involvement made simple
p.m. option: **Focus groups**

9 November 1994
a.m. Local voices
p.m. option: **Semi-structured interviewing**

8 February 1995
a.m. Latest thinking in consumer involvement
p.m. option **Questionnaires**

Further info from
Dominique Freire, Training Manager, or Francesca Avbara, Administrative Officer
College of Health, St Margaret's House
21 Old Ford Road, London E2 9PL
Phone: 081 983 1225

Building the consumer agenda into local health services

- one-day conference to share the findings of South Bedfordshire consumer audit
- organised by the College of Health
- on 16 June 1994
- at Regent's College, London
- £90 (£50 voluntary groups and CHCs)

Further info from:
Francesca Avbara
College of Health, as above (on page 13)

Women influencing policy in health and social care

- two-day seminar
- organised by School for Advanced Urban Studies, University of Bristol, and NHSE Women's Unit
- on 13–14 June 1994
- at SAUS, Bristol
- £289 (some bursary places available at £89 – enquiries to Deborah Marriott at SAUS)

Further info from:
Lyn Harrison or Linda Martin
SAUS
Phone: 0272 741117

Research with children with HIV and AZT trials

- public discussion
- organised by Consumers for Ethics in Research
- 5.30 – 8.00 p.m. on 22 June 1994
- Friends House, Euston Road, London NW1
- admission free

Further info from:
Consumers for Ethics in Research
Phone: 081 802 8231 or 0732 458021

Community care for older people – the next steps

- one-day conference on how to create the highest standards of care, examining issues and problems and how they can be tackled
- organised by Age Concern England
- at Purcell Room, South Bank, London SE1
- on 20 July 1994
- £80 + VAT, concessions for voluntary groups and pensioners

Further info from:
Nick Hayes or Ben Furner
Conference Unit, Age Concern England
Phone: 081 679 8000

Developing Managers for Community Care

The NHS Executive has been running a programme called *Developing Managers for Community Care*, which brings together participants from health and social services and the voluntary sector to explore the contribution management development can make to Community Care.

If you want to join the DMCC network or want more information, please telephone the DMCC Helpline on 0225 723077.

DIRECTORY AMENDMENTS

Page 9 **South Lincolnshire CHC**
Fax: 0529 304361

Page 14 **Riverside CHC**
Fax: 081 741 1865

Page 24 **South Birmingham CHC**
Change of address:
1802 Pershore Road, Cotteridge,
Birmingham B30 3AU
Phone: 021 458 2888
Fax: 021 458 2898
Chief Officer: to be advised

Page 26 **Bolton CHC**
Change of address w.e.f. 1 June:
St Peter's House, Silverwell Street,
Bolton BL1 1PP
Phone/fax: unchanged.

Burnley, Pendle & Rossendale CHC
Fax: 0282 414944

Page 29 **Wirral CHC**
Joint Chief Officers: Judith Edwards & Richard Hindley