CHC NEWS

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

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NEWS

Treats in store

In her party conference speech, Virginia Bottomley set out her agenda for next year:

- all operations to be subject to a maximum 18-month wait
- legislation to allow the return of "dangerous mental health patients" to hospital
- tougher checks on those who say they are exempt from prescription charges
- fundholding status available to GP practices with as few as 5000 patients
- a "community fundholding scheme" for practices with as few as 3000 patients
- the 20 or so first wave fundholders will be given total purchasing freedom including accident and emergency cover and all hospital and community health service care
- new standards for outpatient appointments
- all trusts to set out in annual reports how much is being spent on management.

The form this last item will take has been the subject of some speculation. The *Health Service Journal* has suggested that the scheme will involve two separate calculations. The published figure will be the sum of all salaries of managers earning over £20,000 annually. A second, confidential, figure will include the costs of all non-managerial support staff.

NAHAT seems to have developed a sudden aversion to league tables. NAHAT director, Philip Hunt, had welcomed this summer's hospital league tables on waiting times and day cases: "Comparing performance is the touchstone of the NHS and it is important that we develop the indicators". However, he is "very nervous about the idea of league tables on this [i.e. management costs]" – "We will not be comparing like with like." NAHAT's preference is that each trust should present its management costs "in its own way", otherwise national comparisons will be used to undermine the role of management. Ray Rowden, the director of the IHSM, is in favour of the publication of total management costs, but not of partial disclosure. (A £20,000 threshold might well be unpopular with NHS managers since it would provide NHS trusts with an incentive to keep some salaries below £20,000 in order to keep the published costs to a minimum.)

Daily Telegraph 13 October; Guardian 8 October

Organ donation

Opinion divided on computerised register

The Government has launched a computerised register of organ donors which will make information on such donors immediately available to hospitals and bereaved families. People will be recruited to the register when they apply for or renew driving licences.

The president of the British Kidney Patient Association, Elizabeth Ward, has predicted that the scheme will be ineffectual and will deprive thousands of patients of life-saving operations. Instead she would like to see an *opt-out* scheme which presumes that everyone is an organ donor unless they register otherwise. The main argument for this is that surveys have indicated that 75% of the public is in favour of organ donation (15% against), while only 20% of the population has picked up a donor card. Last year 3,000 organs were donated, but 5,600 people were still waiting for a donated organ. She added that pilot schemes of voluntary computerised registers in Manchester and Wales had been failures.

Tom Sackville has rejected these arguments, saying that the voluntary tradition of donating should be maintained.

Times 7 October

Surgeons warned over elective ventilation

Transplant surgeons have been warned by Tom Sackville that it is illegal to keep patients alive artificially in order to make use of their organs. Patients may be kept alive only when, in the opinion of doctors, this would benefit the patients themselves. In a few hospitals, such as the Royal Devon and Exeter Hospitals, there has been a policy of putting some patients on "elective ventilation" for a few hours after brain death in order to save organs for transplant – with the approval of the patients' relatives.

A study of deaths in South Wales hospitals showed that elective ventilation could be used to save organs from over 100 people each year. Few hospitals have adopted the practice, but transplant organisations are calling for the law to be changed to allow elective ventilation.

Times 10 October

Protocol and propriety

Sir Duncan Nichol has joined the board of BUPA within six months of leaving his post as NHS chief executive. He will earn about £14,000 for an estimated 18 days' work a year. The propriety of the move has been questioned by the shadow health secretary, David Blunkett. Civil service guidelines say that senior civil servants must be scrutinised if they take another post within two years where the individual concerned "could be, or could be thought to be, significantly helpful to the employer in dealing with matters where policy is developing". It is understood that the Cabinet Office cleared Sir Duncan's move. Tom Sackville, junior health minister, has said that there has been no breach of protocol.

Relations between the NHS and the private sector as *providers* of care have clearly changed in recent years: health authorities now spend some £300 million annually for care in independent hospitals. David Blunkett has produced leaked internal NHS guidance which says that health authorities have "a central role" in promoting entry to the NHS market by new suppliers and should consider lending suppliers funds. Sir Duncan has said that he has "no problem" with the private provision of care sourced from public funds. Policy development in relation to private *financing* of care is less clear, though many would argue that the private insurance market is benefiting from public perceptions of developments in the NHS.

Daily Telegraph 24 September, Independent 7 October

GP strikes off three year old with defective heart

A Sheffield GP has "struck off" a three year old girl because her parents have asked for too many visits for her. The girl is due to have open heart surgery next year. Her parents say they have had to call out doctors because she is very ill and that at times her breathing is so bad that she turns blue. They say that they have asked for a home visit on average once a month, though in September they called for three visits. The GP says that many of the calls were for complaints unrelated to the girl's heart condition and that they could easily be treated at the surgery. He denied that she is at present suffering any symptoms from her heart defect.

Daily Telegraph 5 October

Fiddling the figures?

> *"You are on a waiting list for the outpatient appointment, although this does not show in official figures as you are not actually recorded on the administration system. This happens when you receive your appointment."*

And you are wondering how long that might that be?

> *"[Patients with similar conditions] are waiting approximately 15 months from the receipt of the letter to the appointment being given. The wait to treatment after that appointment is, I believe ... six months."*

So says a letter from the surgical clinical centre of the Oxford Radcliffe Hospital.

One might think along with Labour health spokesman, David Blunkett, that the hospital, anxious to do well in league tables once they include waits for outpatient appointments, has an unofficial and an official waiting list. But no, we are assured, that would be "a misunderstanding". The figures given for waiting times were "a mistake". The "official" figures refer to the waiting list for treatment once a consultant has decided an operation is necessary. The director of planning denied "categorically" that there were any hidden lists for outpatient appointments.

Independent 10 October

Flu vaccine selectively withheld

It has emerged that some elderly patients are not being given flu vaccinations because they are senile. Last winter doctors at Knowle Hospital in Hampshire decided not to vaccinate 17 long-stay mentally disturbed patients. Eight of the patients subsequently died of flu. Critics of the policy say that it is discriminatory, and in effect a policy of euthanasia. Others have defended the policy, saying that a rapid death from flu was a "blessed relief" for some patients.

It seems that the families of long-term patients at Knowle Hospital were not routinely asked about flu protection, though some families defended the decision which was made. The hospital says that in future families will be consulted where possible. It may be possible for patients themselves to set down their preferences over treatment in advance in a "living will", a blueprint for

which is shortly to be published by the Alzheimer's Disease Society.

There have been calls for guidance to clinicians who are faced with decisions of this kind, but since the Knowle Hospital cases came to light the Health Department has said that it is the responsibility of doctors to decide who should be given flu vaccinations.

Sunday Times 9 October, Times 10 October

New evidence in case of hepatitis-carrying surgeon

The police are considering reopening their investigation into the case of a heart surgeon who has been jailed for operating on patients although he knew that he was carrying hepatitis B. The move follows the disclosure that one of Umesh Gaud's patients died of hepatitis seven months after a heart valve operation in which Mr Gaud assisted. Apparently, the police were unhappy that their original investigation was hampered by several hospitals claiming professional confidentiality. Scotland Yard is to consult with the Crown Prosecution Service over whether there are grounds for a new prosecution.

The issue identifying health professionals who are unfit to practise was the subject of heated debate at ACHCEW's conference in July. A motion from South Lincs calling for professional confidentiality to be waived for some individuals was heavily defeated at the conference, and some delegates talked of the need for adequate confidential health screening. An item in ACHCEW's latest Work Programme is to "consider work on the ethics of testing health (physical and mental) of NHS personnel."

Daily Telegraph 11 October, ACHCEW Work Programme September 1994

FOCUS ON ... RATIONING AND PUBLIC PRIORITIES

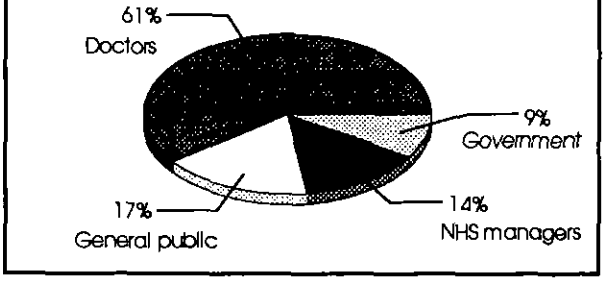
What is being rationed, and who decides?

A *Daily Telegraph* survey (see Figure 1) showed that most of the public do not want the Government to decide what should be prioritised for treatment. However, individuals and the public at large feel that it is unfair when treatments are available to some people but not to others, simply because of where they live or because of which GP they are registered with.

A House of Commons select committee survey of health authorities has highlighted the variations in services available on the NHS. Examples of treatments restricted by some purchasers are:

- in vitro fertilisation
- cochlear implants
- homoeopathy
- tattoo removal
- reversal of sterilisation
- alcohol detoxification
- non-medical circumcision
- sex changes

Figure 1.
Who should establish the necessary priorities?



Figures from Daily Telegraph 12 September, more results on pages 5 and 6.

Some health authorities, such as Coventry, have a policy of not excluding any specific services, while others have completely excluded some treatments.

Independent 26 September

In vitro fertilisation

Feelings run particularly high about rationing IVF treatment. In Bradford, for example, the health authority is reviewing its exclusion of IVF because of public outcry. The policy in Sheffield has also been in the news. A childless couple, the Searles, have been refused leave to seek judicial review of Sheffield Health Authority's refusal to give Mrs Searle IVF treatment because she is over 35. The health authority limits IVF treatment because of funding constraints. Since effectiveness of the treatment falls off with age, it believes that it is justifiable to use age as a criterion. The Searles believe that the cut-off point is unfair on a number of counts:

- if Mrs Searle were treated privately, she would be accepted for treatment. In the same envelope as the letter refusing her treatment, she was sent a price list for private treatment at the same clinic for women up to the age of 42.
- if Mrs Searle lived in neighbouring Doncaster, she could be accepted for treatment up to the age of 40, and would be treated at the same clinic in Sheffield
- Mrs Searle has been undergoing fertility treatment for 7 years. She is now 37 years old, so had there been fewer delays in treatment and decision-making, she could have been given IVF treatment before the 35 year cut off point.

Guardian 18 October, Radio 4 News 17 October

GP involvement in rationing

In Wiltshire & Bath, Dr Stephen Henry, a fundholder who has funded IVF treatment for one of his patients, says he has been criticised by a member of the local health commission for doing so. The health commission does not purchase IVF treatment, although it is to review the policy. Criticisms of this kind place fundholding GPs in an invidious position. On the one hand, they are deemed to be "rocking the boat" if they step outside the policies of local health commissions. On the other hand they are expected to do what they judge is best for individual patients. Dr Henry commented that the health commission and local GPs need a strategic view to which they can all sign up, and that in the mean time "I pray that we do not get anybody else in the next few months coming to ask for IVF".

Pulse 8 October

That GPs are being expected to make rationing decisions can be seen in the recent case of a woman with an ambition to be a model who asked for breast implants on the NHS. In newspaper reports it was the GP who was the focus for criticism. Initial reports said that he was a fundholder and that his patient had been "fast-tracked", being treated within eight weeks of referral. As it turned out, he is not a fundholder, and his patient had waited eight months for treatment. The GP, Dr Moor, said that the case was "complex" and that he had taken into account "the patient's social, medical and psychological background". He decided that there was a clinical need for the operation and accordingly had referred her to a consultant. The consultant could have over-ridden the GP's decision, but did not do so.

Independent 26&27 September

A survey of GPs carried out by *Doctor* magazine (510 GPs returned the questionnaire) found that 97% thought that rationing was taking place, 75% thought that it was inevitable and 84% believed it was harming patients. The responses confirmed that GPs themselves are making rationing decisions: only 4% said their decisions were not affected by costs and 55% said cost influenced their decisions either very much or quite a lot. The survey found that doctors are influenced by judgements of their patients' usefulness to society and their lifestyles in deciding what priority to give them. GPs want more advice on how to take rationing decisions, with 64% wanting guidance from the Government, the royal medical colleges or health authorities.

Guardian 30 September

Age discrimination

Two cardiac consultants have claimed that budgetary constraints are forcing surgeons to discriminate against elderly patients who need pacemakers. Most patients needing pacemakers are given a simple version which costs £1350. A more sophisticated, dual chamber version is available. It more closely replicates the heart's action and gives a better quality of life, but costs £3000. According to Dr Douglas Skehan and Dr Gillian Payne, younger patients are much more likely than older ones to be given the more expensive pacemaker.

Daily Telegraph 13 September

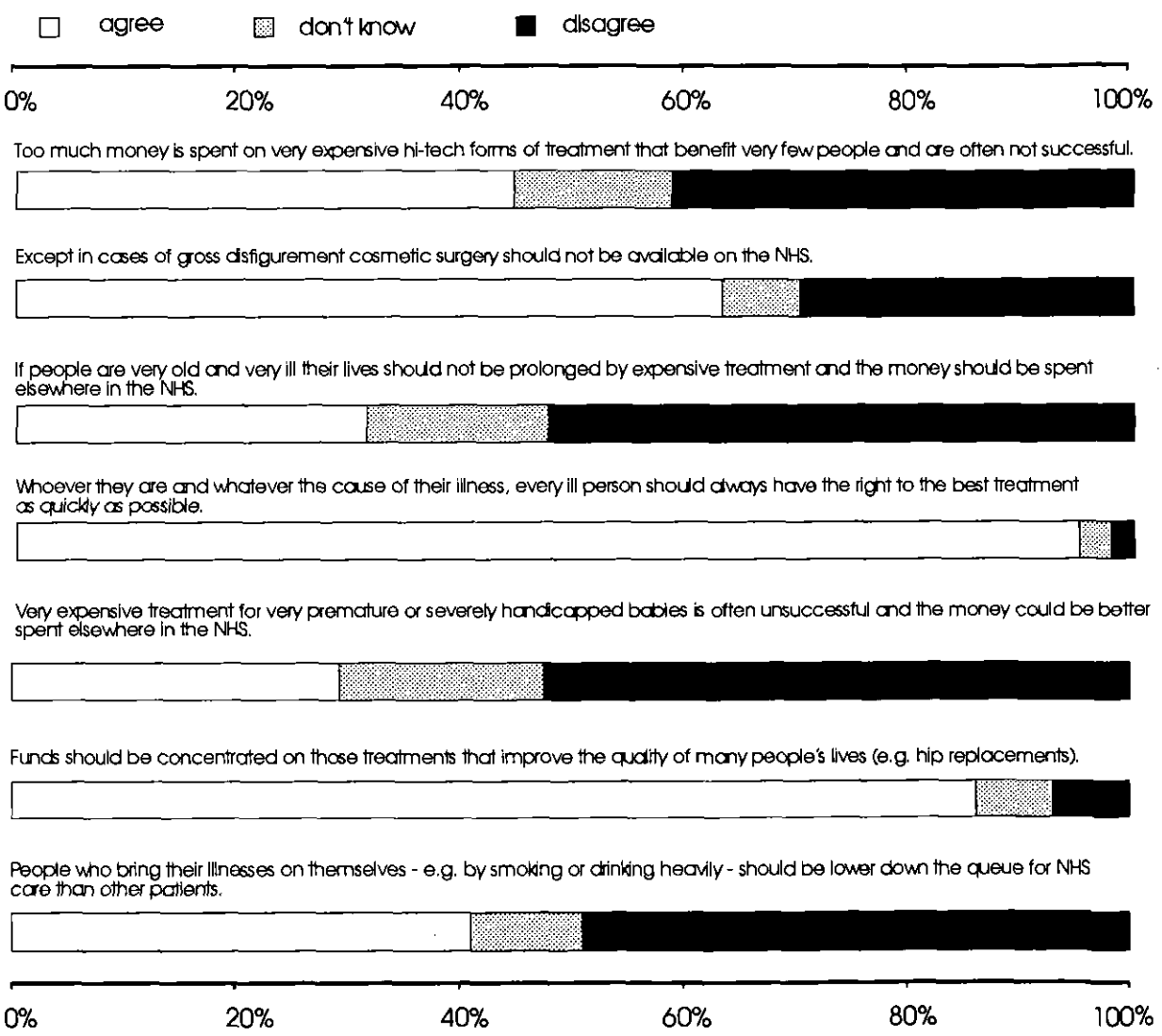
Public opinions on rationing

The *Daily Telegraph* published the results of a Gallup survey in which 1027 adults were interviewed to find out their views on rationing in the NHS.

The answers on priorities showed that respondents differed between each other, and also that individual respondents often gave apparently incompatible answers. For example, 96% thought that everyone should have the right to the best treatment (see Figure 2), yet very few people were prepared to say that all groups of people and all treatments should be given equal priority (see Lists 1 and 2 overleaf).

Figure 2. Who should the NHS spend its money on?

Respondents were asked whether they agreed or disagreed with statements about the NHS. The percentages giving each response are shown in the bar below each statement.



The following two lists show the percentages giving priority to each option (each respondent was invited to name three priority groups of people and three priority treatments).

List 1:
Who should have priority for treatment?

People with family responsibilities . . . 64%
Small babies 59%
Previously healthy young and middle-aged people 54%
Retired people 23%
Mentally ill people 22%
Terminally ill people 21%
People with self-inflicted illness or injuries 1%
None/all equal 3%
Don't Know 14%

List 2:
Which treatments should have priority?

Care offered by GPs for everyday illnesses 51%
Childhood immunisation 46%
Screening for breast cancer 39%
Support for those caring for elderly people in the community 32%
Intensive care for premature babies . . 26%
Education programmes to prevent children and young people from starting to smoke 23%
Heart transplants 23%
Hip replacements for elderly people . . 11%
Cancer treatment for smokers 5%
Treatment for patients with schizophrenia 4%
None/all equal 1%
Don't know 9%

The discrepancies between these lists of priorities and the proportions agreeing with the statements listed on page 5 are interesting. They may show how different answers can be elicited by asking questions in different ways. For example, in Lists 1 and 2 is not clear whether people were offered the option of saying that all people/treatments should be given equal priority, or whether some respondents simply refused to name three priorities.

A related problem is that respondents may not be clear exactly what is meant by some questions: does "treatment for terminally ill patients" mean all active interventions including, say, surgery, or could it mean hospice and nursing care?

Do you know what it costs?

Another difficulty with this sort of exercise is that people are not given enough information to be certain in their judgements. The relative priority given to options would be greatly influenced by a knowledge of how much those options are likely to cost. Yet, not surprisingly given the lack of hard information the public is given, respondents didn't do particularly well at guessing the costs of NHS treatments. Nor did I ... Perhaps readers of *CHC News* will get them all right. Answers on page 15.

	Treatment	How much does it cost?	% choosing each option
A	A week's intensive care for a premature baby	£2000 £4000 £6000 Don't know	19 42 25 13
B	Six half-hour physiotherapy sessions	£60 £95 £150 Don't know	14 32 42 13
C	Hip replacement	£2,500 £4,000 £6,000 Don't know	23 44 21 11
D	Heart by-pass surgery	£6,000 £10,000 £14,000 Don't know	15 40 34 11
E	One course of penicillin	£3 £6 £9 Don't know	35 37 15 13
F	Average cost to NHS of GP prescriptions	£2 £5 £8 Don't know	23 39 24 14
G	Average cost of a week in NHS hospital	£1,200 £1,750 £2,500 Don't know	36 37 14 13

All results from Daily Telegraph 12 September

FROM THE JOURNALS

Sight tests and glaucoma detection

An article in the BMJ suggests that because of the deterrent effect of charges for eye tests, many people with glaucoma may not have the condition recognised, and so may be at risk of losing their sight. Glaucoma can lead to blindness, but early treatment can slow its effects. Since 1989 adults have been charged for eye tests unless they are income support claimants, have diabetes or glaucoma or are aged over 40 and are closely related to someone with glaucoma.

Researchers at the Bristol Eye Hospital looked at the numbers of ophthalmic referrals to the hospital from 1984 to 1992. They examined in more detail a sample of the referrals from 1987 to 1991 to determine whether the patients were "true positive glaucoma referrals". Analysis of the numbers of referrals showed that referrals increased between 1984 and 1988. This trend was extrapolated to predict how many referrals would have been expected from 1989 to 1992. Actual referrals fell sharply in 1989. Referrals have since risen, but have remained below predicted levels. There has been no significant variation in the proportion of referrals which are found to be true positives.

These results suggest that at the Bristol Hospital, 438 cases of glaucoma would have been identified in 1992 had the pre-1989 trend continued, whereas the estimated number identified in the year is 356. This represents a shortfall in detection of one case of glaucoma a year in 10,000 population.

The Health Minister, Gerald Malone, has rejected the report on two main grounds:

- the Bristol Hospital findings do not reflect the national pattern – he says that referrals nationally are back to pre-1989 levels;
- the figures are out of date.

In reply, a spokeswoman for the researchers pointed out that one would expect referrals to be rising (as they are at Bristol), since the population is ageing. The point is that referrals are below those predicted on the basis of earlier trends. One of the authors has also said that on preliminary examination, 1993 figures seem to support their findings for earlier years.

BMJ/Guardian/Times 10 September

Children and adolescents in hospital

An article in October's *Which? Way to Health* looks at the needs of children in hospital. It found a big gap between DoH guidelines and Audit Commission recommendations on the one hand and reality on the other. For example only a third of hospitals with children's wards had two Registered Sick Children's Nurses on duty on those wards at all times. Only 34% had no children on adult wards. The article also looks at separate outpatient clinics and A&E facilities, leaving hospital, support for parents with low income and pain management. Practice in all cases is patchy.

There are also comments from parents and teenagers. Many parents felt they were being used as surrogate staff. One commented that she was being thrown in at the deep end when she had to take in her baby son for a few days due to asthma. Teenagers were happiest when they felt they had been kept fully informed and had been involved in decisions. They disliked being put on wards with young children.

A *Nursing Times* review (21 September) looks specifically at the needs of adolescents. It points out how the normal stresses of adolescence can be exacerbated by being in hospital. Disrupted schooling (and fear of this), isolation from your peer group, a feeling of loss of control at a time when you are trying to assert your identity, being put with younger children when you are trying to become an adult, lack of privacy at a stage when you may be very self-conscious, and fear of surgery when you may be very concerned with body image. All these stresses and others can make hospitalisation very upsetting to adolescents.

A survey of 85 children aged 11–13 years shows some interesting results. Offered the choice of an adolescent or children's ward, 81% of 11 year olds would prefer a children's ward, but 82% of 12 year olds and 100% of 13 year olds would prefer an adolescent ward. If no adolescent ward were available, 45% of 13 year olds would prefer an adult ward to a children's ward. The children were unanimous in saying that they should have a voice in decisions about their care in hospital.

AROUND THE CHCs

Liverpool Central & Southern CHC has conducted a satisfaction survey among members of the public who have used the CHC's service to help them make a complaint about NHS services. The results were heartening, in that the vast majority of respondents were very positive about the service provided. The area of highest dissatisfaction was in the outcome of the complaint, though a number of respondents pointed out that the CHC was not responsible for this. The survey was also useful in confirming the importance of the CHC's city-centre shop front premises to public awareness of the CHC. The few negative comments about the service have identified some specific problems individual clients experienced, and the CHC is currently following them up.

Hastings CHC has challenged the right of the Hastings and Rother NHS Trust to demand a £5 deposit from patients who borrow crutches, unless they are in "financial hardship". It has been making such charges for some five months. The CHC believes that the charging of a deposit contravenes the 1977 NHS Act – a view which appears to have been backed up by the NHS Executive. Responding to a request from ACHCEW to clarify the legal position, the NHSE said that "If the item is medically required, it must be supplied without charge under the NHS, and such charge would include the taking of a deposit." The trust however has argued that a refundable deposit can be levied as the "aids are not part of the medical treatment for a particular condition. They are an aid to mobility." The trust says that it is seeking clarification from the Department of Health. According to the local *Evening Argus*, a DoH spokesperson commented: "It sounds as though Hastings and Rother NHS Trust has slightly overstepped the mark."

Deadline

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

The Estates Division of the North West Regional Health Authority has produced an ***Accessibility checklist* for CHC premises**. It aims to help Chief Officers in carrying out a broad assessment of their premises. It is to be used for all new premises being acquired for use as CHC offices and as a standard for the improvement of existing offices. The checklist is divided into the following sections: location, entrance, reception, internal circulation and rooms.

Southampton CHC was concerned at a local GP's claim that patients of fundholding GPs were getting faster access to patient care. It decided to conduct a study into waiting times for patients of fundholding and non fundholding GPs to see if there was any truth in the claim, which had been denied by Southampton Health Commission. It took snapshots of the waiting list (i.e. after a decision to admit) at monthly intervals between December 1993 and June 1994, and listed those who had been waiting for 0–2 months, 3–5 months and so on. The CHC found no evidence of GP fundholder patients being given preferential treatment. It suggests that the perception that this is the case may be caused by some people's use of private health insurance to jump the queue.

Last month Tom Richardson, the CHC Development Officer at Anglia and Oxford RHA, presented a **Discussion paper on the way ahead for CHCs and purchasers** to the Steering Group for CHC and Purchaser Development. His paper was based on 26 meetings with CHCs as well as more informal contacts, and on attendance at a number of conferences.

The paper looks at the strengths and weaknesses of the NHS internal market and at "The public and purchasing and commissioning". It discusses possible ground rules for CHCs in their dealings with purchasers, including purchasers which see themselves as "champions of the people" and purchasers which act as "traditionalist health authorities".

CHC PUBLICATIONS

From here to equality: CHCs, race and ethnicity
Mandana Hendessi for GLACHC, £10

GLACHC surveyed all CHCs in the Thames Regions as the basis for this report, which should be of wide interest (36 CHCs responded out of a total of 56). The project aimed to find the level of Black and ethnic minority membership of CHCs and to identify factors which encourage or discourage the involvement of Black people in the work of CHCs.

There is a review of relevant topics, including GLACHC's own experience of starting to take positive steps in this area; the institutional context; the development of CHCs' practice with regard to race issues; and the participation of Black people in public life beyond the health sector. This sets the context for the qualitative and quantitative findings of GLACHC's research project.

Information from the questionnaire survey includes figures on membership and staffing. An interesting finding is that where local authorities and RHAs nominate ethnic minority people as CHC members, they are twice as likely to nominate men than women. By contrast, voluntary organisations nominate ethnic minority men and women in equal numbers. In general, ethnic minority women are much more likely to be co-opted than to be nominated to full membership. Black and ethnic minority people were under-represented among CHC staff. There was only one Chief Officer (acting) from an ethnic background in *all* the responding CHCs.

The presence of Black or ethnic minority members appears to have a marked impact on the projects undertaken by CHCs (and/or the projects undertaken influence the membership profile). Among CHCs with Black members and an equal opportunities policy, 93% worked on one race-related project or more. Of the 15 CHCs without any Black or ethnic minority members, only six mentioned any work on race-related issues.

Interviews and seminars were used to get qualitative information on Black and ethnic minority people's perceptions and experiences of CHCs. Many respondents mentioned the quality of representation. These people felt that under-representation was mainly related to the quality: not simply to the number of black faces at meetings. They stressed the need for minority ethnic members to be active in their communities and in touch with them. Another important issue was the sense of isolation described by many members, which could lead to sporadic attendance at meetings. There was a feeling that CHC members need more awareness of the broad range of issues that concern Black and ethnic minority communities – they should not simply concentrate on language and interpreting.

The report includes many other observations and comments, leading to a discussion of "ways forward" and a summary list of recommendations.

The quality of primary care for the mentally ill in Hillingdon
Patricia Miller, Hillingdon CHC, 155 pages

This substantial report contains much more than can be reported here. Information was gathered from GPs, practice staff, users, carers, self-help groups and staff of mental health organisations.

There were a few exceptional GPs who met patients' needs for support. Most users however had very little involvement with GPs. Consultations were usually very brief. Despite this, about three-quarters rated their GPs highly. Expectations were low, and, asked about specific details, the picture most users gave was of little input from GPs. (Many GPs recognised these shortcomings, though a few responses show a rather shocking readiness to offload problems.) A specific area of low expectations was among Asian women. Many would be prepared to talk about mental health problems with GPs if they were asked, but they did not know that GPs had a role in this area.

Obtaining 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.

IN BRIEF

London CHCs: A wealth of ideas and activity
GLACHC, 356 Holloway Road, London N7 6PA; phone: 071 700 0100; fax: 071 700 8126

A booklet to celebrate 10 years of the Greater London Association of CHCs, with contributions from 25 CHCs, each writing about one facet of its work.

Report of the general survey
Health Watch Project, Warrington CHC, 33 pages

This is the fourth in a series of surveys carried out by Warrington's Health Watch Project. It sought views on: services for elderly people; informal discussion groups; mixed sex wards; services for carers; dental services and NHS charges. It comes with a separate 40-page booklet setting out all the comments made in reply to questions.

Charter Standards Report No. 5
Patient's Charter Monitoring Unit, Bury CHC, 7 pages

Report into Patient's Charter Standard No. 6: that out-patients should be given a specific appointment time and be seen within 30 minutes of that time.

Dovecot: a profile of the community's perceptions regarding problems encountered and the quality of service provided within the area
Liverpool Eastern CHC with help from students of the Liverpool School of Tropical Medicine, 42 pages

This report presents mainly the views of women aged 20–39 and 60–79. The study recognised the broad range of influences on health. The report identifies issues for health services; housing; policing and environmental services. It makes recommendations to relevant agencies. This reflects the major problems identified: stress of unemployment and financial problems; intimidation older people feel from young people; crime and joyriding; lack of leisure facilities; loneliness among older people; dirty environment; and access to contraceptives and teenage pregnancy.

Community Health Councils – Your voice in the Health Service
Video produce by the former Yorkshire Regional Council of CHCs

This video aims to provide basic information about the role of CHCs and the broad range of work they undertake. It is suitable for viewing in any part of the country, though the examples given relate to Yorkshire and Humberside CHCs. Suggested audiences include the general public, voluntary or community groups, potential CHC members and NHS staff. It is accompanied by notes for presenters, a poster (with a space for CHCs to personalise) and a leaflet.

IN BRIEF

FOR THE RECORD

Preparing for parenthood: an evaluation of parentcraft classes in North Tyneside *North Tyneside CHC, 15 pages*

Report following visits made to GP fundholders, *Milton Keynes CHC, 3 pages*

Community care one year on: report of a day conference, *West Essex CHC, 21 pages*

Guide for members 1994–96, *Northumberland CHC, 103 pages*

Disabled people's perceptions of services in the Newry and Mourne Area Quantitative findings, 107 pages; Qualitative findings, 29 pages
Southern Health & Social Services Council, 16 Church Street, Portadown, Craigavon, Co Armagh BT62 3LQ; phone: 0762 351165; fax: 0762 351493

OFFICIAL PUBLICATIONS

Feet first: Report of the Joint Department of Health and NHS Chiropody Task Force
NHS Executive, 28 pages, CHCs should have received copies

Age Concern's worries that this report calls for an end to simple nail cutting as part of the chiropody service may well be justified. Many people in contact with Age Concern need nail cutting as a result of immobility, yet the report appears to hope that this role may be carried out by "others" – "e.g. a carer".

Among the report's recommendations are that:

> *"Basic foot care should be taught, where appropriate – after consultation with local authority social service departments – to those who provide care for elderly people and others who are unable to care for their own feet, but do not require the skilled care of a state registered chiropodist."*

The report emphasises the need for health purchasers to have policies for specialised services and for those most at risk, such as people with diabetes. However, many people who do not have diseases or disabilities which put their feet "at risk" cannot cut their own nails, and many of these people will not have relatives who can do it for them. The nail cutting could be done by foot care assistants [FCAs], but the report states that the FCA is:

> *"often tending patients who require simple foot care .. that could be provided by someone else..... The more appropriate use of [an FCA] is to provide support to the state registered chiropodist. This can be done most effectively where there are two surgeries or two chairs within one clinic."*

It is not clear whether the Task Force hopes that Social Services Departments (SSDs) will fill the gap, and even less clear that they would. It is telling that the 24-strong membership of the Task force included just one representative from an SSD. It had ten members from NHS purchasers/providers, seven from the Department of Health and six from professional organisations, but none from other Government departments or from voluntary organisations. None of the information accessed by the Task Force came from the social services sector (unless one counts the North Health and Social Service Board – N Ireland), or from voluntary or user organisations. It is ironic, therefore, that the Task Force states that "basic foot care should be considered in partnership with local authority SSDs".

The recommendations also state that a reduction in the need for domiciliary skilled foot care "could be achieved by promoting basic foot care in others and by helping people to reach centres where chiropody is provided". However, the report comments that "Ambulance services are expensive to use, but there examples of voluntary car schemes working well." Besides "in rural areas people expect to travel". One has a vision of elderly people who find it difficult to get about having to beg yet another favour of neighbours, asking them to cut their nails or to drive them to the nearest centre (at a specific time, of course) and wait for them to re-emerge from a foot clinic and then to complete their shopping and a visit to the Post Office. The glossy photo of the couple walking in idyllic surroundings on the cover of the report begins to look just a tad like window-dressing.

Local systems of support: a framework for purchasing for people with severe mental health problems

Mental Health Task Force, NHS Executive, 15 pages, no availability details given. DoH phone number: 071 210 3000

Since the Task Force sub-group preparing this guidance last met, the document has been substantially slimmed down and "refined" in the light of "practical experiences ... in London and elsewhere" and "comments and suggestions within the Department". The final version has been approved by Ministers and is to be published on 18 October.

The accompanying letter remains silent on what changes were made to the document. However, it is interesting that the *Mental illness* handbook listed below refers to *Local systems of support for people with severe mental health problems: a framework for purchasing* ***and provision*** (our emphasis). It has been clear for more than a year that central policy initiatives have focused on purchasing, but it is of some concern if the Task Force's comments on provision of care have been "refined" out of existence. And does anyone have any suggestions as to why they didn't do the same to the chiropody report (see page 11)?

Mental illness
Health of the Nation Key Area Handbook, 2nd edition

Department of Health
Available from HMSO, £15, 179 pages

How you can help to improve the Health of the Nation: an introductory booklet for the primary health care team

A 21-page, four colour booklet produced by the Health Promotion (Medical) Division of the Department of Health. Available from Health Strategy Unit, Department of Health, Room LG04, Wellington House, 133–155 Waterloo Road, London SE1 8UG

Managing contracts: examples of further good practice and innovation in contracting

NHS Executive, 76 pages
Available free of charge from 0532 545313 (answerphone). Copies should be sent out within 2 days of message being left.

On the State of the Public Health for the year 1993
Introduction to the Chief Medical Officer's Annual Report, 28 pages

Full report from HMSO Books, PO Box 276, London SW8 5DT; phone: 071 873 9090, £16.25

CHCs should have received copies of:

Health promoting hospitals

Published as part of the Health of the Nation strategy by the NHS Executive, 17 pages

and

Supporting research and development in the NHS

A report to the Minister for Health produced by an R&D task force, 87 pages

GENERAL PUBLICATIONS

Caring in a Crisis from Age Concern

This series of four books is aimed at someone facing the responsibility of caring for the first time:

Going home from hospital by Sheila White, £5.95

Finding and paying for residential and nursing home care by Marina Lewycka, £5.95

Caring for someone who is dying by Penny Mares, £6.95

What to do and who to turn to by Marina Lewycka (dealing with the first hours and days of an elderly person being taken ill), £6.95

All available from bookshops and from Publications Unit, Age Concern England, 1268 London Road, London SW16 4ER; phone 081 679 8000.

RCN Research

The Royal College of Nursing has recently published three research reports:

The changing face of community care for older people: Year 1, setting the scene
133 pages, £10, (4-page Briefing on the report available. Report on Year 2 to be published soon)

The morale of nurses working in the community: a study of three NHS trusts. 3rd & final report, £10 (6-page Research Briefing available)

The care and treatment of people with HIV disease and AIDS: a nursing perspective, 184 pages, £10 (6-page Research Briefing available).

In addition, there are two further Research Briefings:

The specialist nursing care of children with diabetes. 4-page Research Briefing on a doctoral thesis by Alwyn Moyer

The morale of nurses working in the community: a study of four NHS trusts. Year 1. 4 pages.

All available from: the Daphne Heald Research Unit, Royal College of Nursing, 20 Cavendish Square, London W1M 0AB; phone 0171 409 3333, ext 325 (Note: you can already dial the new "01" phone numbers, but they are not yet compulsory).

Secrecy and medicines in Europe
National Consumer Council, 20 Grosvenor Gardens, London SW1W 0DH, phone: 071 730 3469
61 pages, £10

A report urging the Government to tackle unnecessary drug secrecy before the European Medicines Evaluation Agency (EMEA) starts operations on 1 January 1995. It highlights what the NCC believes are flaws in the agreed framework for the EMEA, in particular the lack of consumer representation.

FROM THE VOLUNTARY SECTOR

Out of sight, out of mind

The National Childbirth Trust recently asked all its branches to visit GP practices, health centres and antenatal clinics to check on the availability of the Government's Maternity Services Charter leaflet. The Trust received feedback from 77 branches, whose members had visited a total of 271 locations. Of these:

- 41 locations had the leaflet on display on a first visit (up to 66 by the second visit)
- in 64 locations, the leaflet was available but not on display
- in 151 locations, the leaflet was not available
- in 96 locations, staff said **they did not know about the Charter.**

The NCT is writing to the Health Minister, Baroness Cumberlege, pointing out that the Charter will remain ineffective unless it is readily available to pregnant women.

Overcoming fear of dentistry

The Behaviour Science in Dentistry Group (BSDG) is working to promote the application of psychology to the practice of dentistry. The group is trying to improve the care of patients who are terrified of dentistry and whose dental health is suffering as a result. As part of this activity, the BSDG is compiling a list of dentists who have a special interest in helping nervous patients. It has sought names through the dental press, but would also like to have recommendations from patients.

If CHCs know of dentists who have helped nervous patients to overcome their fear of dentistry, could they contact Dr Stan Lindsay, Department of Psychology, De Crespigny Park, Denmark Hill, London SE5 8AF; phone 071 919 3242; fax: 071 708 3497.

Toxoplasmosis Awareness Week, 20–27 November 1994

Toxoplasmosis is a parasitic infection which can cause serious damage to an unborn baby if caught by a woman during pregnancy. it is preventable, testable and treatable. All pregnant women should know about it. The Awareness Week aims to raise the profile of the infection through a series of events including:

- distribution of leaflets to employees of major companies
- press advertising
- leaflets and posters in antenatal clinics, health centres and women's centres.

The Toxoplasmosis Trust is asking all CHCs to raise the issue of toxoplasmosis at their November meeting, with a view to ensuring that their local health authority has this health issue on its agenda.

Leaflets, posters and a video are available. Contact: Christine Asbury, The Toxoplasmosis Trust, 61–71 Collier Street, London N1 9BE; phone: 071 713 0663; fax: 071 713 0611.

INFORMATION WANTED

Southend CHC has been approached by someone who has been recommended for **gender reassignment surgery**. The health authority has not placed a contract for gender reassignment and is refusing to approve an extra-contractual referral. Southend would like to hear from any CHCs with clients who have experienced similar problems and would particularly like to hear about the outcome.

Christie Hospital would like to hear from any **CHCs involved in clinical/medical audit.** Please contact Anne Eardley, Centre for Cancer Epidemiology, Christie Hospital, Kinnaird Rd, Manchester M20 4QL; phone: 061 446 3580.

Hastings CHC would like to hear from any CHCs which have been **involved in the process of tendering for services** by DHAs. They would particularly like to find out about the extent of any such involvement.

Predatory Trusts: South East Staffs CHC is seeking information about the activities of trusts:

- which have taken over services from other trusts in their own areas or from other trusts outside their own areas or
- which are known to be planning to do so, and
- whether such arrangements were predatory /hostile or came about by mutual agreement.

To keep our information up to date, ACHCEW would like to hear from CHCs that have set up **consumer panels.**

Following the change to GPs' Terms of Service allowing the immediate removal of violent patients from GP lists, Guidance has been issued to FHSAs suggesting that they "consider developing **local policies for handling violent patients**". CHCs were included among the agencies which could be involved in this policy formulation. ACHCEW would like to hear from any CHCs which have been involved, or which have unsuccessfully asked to be involved.

Hampstead CHC would like information on the following:

1 As a result of **weighted capitation**, the DHA has lost £30m. It cannot now implement its primary care plan. In addition, hospital provision has been reduced and hospital waiting lists have increased. How have losses through weighted capitation affected the plans of other DHAs?
2 There has been an increase in the **transfer of prisoners** to secure mental health units in the district. The DHA is now liable for the costs of their treatment. Has this happened elsewhere?
3 There has been a marked increase in the number of **babies requiring special care.** Has this happened elsewhere? And what mechanisms are used to pay for additional care?

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

From the margins to the mainstream

- conference to stimulate good practice, particularly within the statutory sector
- organised by Good Practices in Mental Health
- on 30 November 1994
- in York
- £100; £50 users/small voluntary organis'ns; £20 extra if invoiced before payment

Further info from:
Caroline Harding
Good Practices in Mental Health
380–384 Harrow Road
London W9 2HU

Inequalities in health

- two-day conference
- organised by UK Health for All Network
- on 10–11 November 1994
- at Hopcrosts Holt Hotel, Steeple Aston, Oxfordshire
- £100 members; £125 non-members inc. accommodation and food (£9.60 extra for Friday lunch)

Further info from:
UK Health for All Network
PO Box 101
Liverpool L69 5BE
Phone/fax: 051 231 1009

Sharing health and welfare choices with old people

- conference on new approaches to consent
- organised by Social Science Research Unit
- on 24 November 1994
- at Friends House, Euston Road, London NW1
- £30; unwaged/students/pensioners £5

Further info from:
Jackie Lee
SSRU
18 Woburn Square
London WC1H 0NS
Phone: 071 612 6397

DIRECTORY AMENDMENTS

Page 3 **Association of West Midlands CHCs**
c/o Solihull CHC
Warwick House
87 Warwick Road
Olton
Solihull, West Midlands B92 7HP
Phone 021 706 9500
Administrative Secretary:
Ms Margaret Coleman

Page 7 **South Tyneside CHC**
Fax: 091 427 6905

Page 8 **North Lincolnshire CHC**
Chief Officer: Mrs Sally Scott
wef 28 November 1994

Page 12 **Barnet CHC**
Chief Officer: Ms Denise Schulte

Page 16 **Brighton CHC**
Chief Officer to be announced early 1995

Page 17 **Kingston & Esher CHC**
New address
UMI House
9–13 St James Road
Surbiton, Surrey KT6 4QH
Chief Officer: Mrs June Haswell
Phone, fax and answerphone unchanged

Page 24 **South Birmingham CHC**
Chief Officer: Ms Louise Kilbride

Page 29 **Tameside & Glossop CHC**
Fax: 061 343 5795

Page 30 **Aberconwy CHC**
Fax: 0492 860878

Costs of treatment (see page 6)
A: £4,000; B: £95; C: £4,000; D: £6,000; E: £3; F: £8; G: £1,200