CHC NEWS

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

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NEWS

Winners and losers in funding allocation

Better-off areas will be protected from the full impact of changes to the allocation of NHS funding following a Government decision to limit the application of a new funding formula and to phase it in over a long period.

At present, £18 billion of NHS funding is allocated according to the age profile of local populations and standard mortality ratios. This system, introduced in the early 1990s, has resulted in a shift of resources from the North to the South, and away from poorer and sicker areas. Last year the Government commissioned York University to improve the allocation model. The York model has two separate elements: acute care and psychiatric care. Between them they take into account standardised death rates for people aged under 75 years, self-reported illness, level of permanent sickness among the adult population, the unemployment rate, the proportions of elderly people living alone, dependants with only one carer and people living in lone-parent households and the proportion born in the New Commonwealth. This formula was designed to reflect more closely the need for health care. Its application would be of greatest benefit to inner cities.

The Government has decided to apply the formula to 76% of total funding. The remaining 24% will be allocated without any weighting. The NHS finance director has explained that the formula is not to be used for services such as chiropody, for patients with learning disabilities or for administration. One of the economists who devised the formula, Roy Carr-Hill, welcomed the fact that the formula has been accepted, but expressed disappointment that it is not to be applied in full. The changes will apply to the funding of both district health authorities and GP fundholders and will be phased in over a number of years. An NHS circular has said that the impact in 1995–96 will be "minimal".

University of York press release 22 October, Guardian 24 October

Commission on Social Justice proposals

The Commission on Social Justice, set up by the former Labour Party leader John Smith, proposes maintaining the divide between means-tested social care and free health care. Everyone should make provision for their own long-term care insurance, which would cover care in residential homes and help at home with daily living. The options for achieving this would be social insurance policies, private insurance policies or increased taxation, with the state paying for those who cannot pay the premiums or whose insurance runs out. Of course, a crucial question here is what constitutes health care and what social care. The commission comments that the divide between health care (treatment needed for illness or injury) and social care (assistance in performing the routine tasks of daily living) needs to be more clearly defined. One possibility would be the creation of a universal health care guarantee, setting out the treatment which would be available as of right and within a specified time.

Within the NHS, the commission proposes a focus on health promotion and the reduction of health inequalities. The commission would like to see all health authorities placed under a statutory obligation to reduce inequalities in health care. The thrust of health policy should be the narrowing of the health gap through economic and social strategies concerned with employment policies, income distribution, education and child care and environmental policies.

On private health care, the report recommends that tax relief to elderly people who take out health insurance should be abolished and that private hospitals should reimburse the NHS for some of the cost of training staff, possibly through the imposition of VAT on private medical treatment.

Independent 25 October

Stirring up bad blood

Tempers are running high among staff of the national blood transfusion service, hospitals and the public about plans to reorganise the service. The National Blood Authority (NBA) has proposed the closure ("amalgamation") of five transfusion centres according to the following timetable:

1995 Lancaster with Manchester
Plymouth with Bristol

1996 Liverpool with Manchester
Birmingham and Oxford with Bristol

1997 Brentwood with Colindale

There would be administrative centres at Colindale, Bristol and Leeds. It is claimed that the changes would make the service more efficient and cost effective. The service would have the target of being able to supply blood to all hospitals within two hours. Health Minister, Tom Sackville, has defended the proposals saying that, at present, some hospitals have to wait over two hours for blood. Under the new system, he says, the service would be "maintained and improved", partly with the help of stockholding bloodbanks in Lancaster and Liverpool. He also said that the NBA is undertaking a "thorough and widespread" consultation on its proposals.

Letter-writers to the *Guardian* remain unconvinced by his arguments. Staff from the Liverpool Transfusion Centre and the Chair of the Oxford BTS Campaign Support Group both point out that the NBA has never described what a stockholding bloodbank is, where they will be or what products they will hold. The Oxford Chair suggests that stockholding units might be an appropriate response in those areas which are currently badly served, and claims that in the great majority of areas, emergency deliveries can currently be made in under an hour.

There is also scepticism about the "consultation" process, particularly since, before the end of the consultation period, executive directors of the three administrative zones have been appointed and nine senior management posts advertised. Blood transfusion staff claim to have been told that it would take an earthquake to stop the changes going ahead – but then an earthquake would seem rather a drastic way of proving the point.

Guardian 7, 10, 14 November

Cost saving in Wales

John Redwood, Secretary of State for Wales, has ordered health authorities in the principality to cut the paperwork and time spent in meetings by a quarter. At a meeting of the Welsh Association of Health Authorities and Trusts he called on authorities and trusts to reduce the number of forms they use and the form filling imposed on family doctors. Last year Mr Redwood declared a three-year freeze on management numbers and instructed that management costs should be kept below 1% of total budgets. He also called on the conference to dispel the all-enveloping fog of jargon.

In a further move to reduce costs (by an estimated £3 million annually) Mr Redwood has announced the merger of 17 DHAs and FHSAs into five large authorities. Subject to legislation, the new areas will be:

North Wales	Gwynedd Clwyd
Mid Wales	Powys Dyfed Pembrokeshire
West Glamorgan	(to include the new unitary authority area of Bridgend)
Gwent	(to include the new unitary area of Caerphilly)
Mid and South Glamorgan	(present South Glamorgan area with remainder of Mid Glamorgan)

The changes will take effect from 1 April 1996, though East Dyfed and Pembrokeshire are to be merged a year earlier. Liaison committees with DHA and FHSA representation are to be established to take forward the plans.

Mr Redwood hopes shortly to announce a decision on the structure of Welsh CHCs.

Earlier this summer, ACHCEW responded to a consultation paper on proposals for restructuring health authorities in Wales. Its view is that there need to be enough CHCs in each health authority to allow ready access to CHC offices and to allow members to cover the population. CHCs should be merged only where it is clear that local communities would be more effectively represented by merged CHCs and where the CHCs concerned agree. The Association called for consultation before CHC boundaries are changed.

Welsh Office press release 3 November
Guardian 5 November

Doctors and pharmacists reject policing role

GPs and pharmacists have both indicated that they will not cooperate with checking on patients who claim to be exempt from prescription charges. At the Conservative Party conference this autumn the Health Secretary Mrs Bottomley announced tough checks on prescriptions. However the BMA's GP committee is to tell Health Minister Gerry Malone that they believe that providing information on patients could destroy the doctor–patient relationship. The pharmacist's negotiating body has said that pharmacists are too busy to cross-question customers. Other systems for checking would be costly. At present the system is policed through random checks of prescription forms, but even where possible fraud is uncovered little is done because of the likely costs of prosecution.

Independent on Sunday 30 October.

Local authorities failing to inspect

Two-fifths of local authorities are failing in their duties to inspect residential homes, if a survey by the *Independent* is representative. Councils are required by law to inspect each home for children, elderly people and handicapped people twice a year. However, the survey of 54 councils found that 22 were not achieving this. Five could not say how many homes had been visited. In Buckinghamshire, where there have been allegations of abuse at two private homes for people with learning difficulties, 12% of homes had not been visited even once. Private home owners in the county carried out a survey and found that at least three homes had not been inspected for nearly two years. In Bury, only 53% of homes had been inspected at all last year. Councils blame staff vacancies and funding shortages for their failure to meet their obligations. The vice-chairman of the National Association for Inspection and Registration Officers blamed the Government for giving inspection units new responsibilities with no additional funds. The Health Secretary can appoint an independent commissioner to run a social services department which is not meeting its statutory obligations, but has not so far exercised this right.

Independent 17 October

Pay-as-you-go television

Patients at Northwick Park Hospital are to be asked to pay to watch television. At present each ward has four television sets available and patients are free to bring in portable TVs. Under the new arrangement, there will be one communal set. Other sets will be provided by the bedside, together with an answerphone, video and radio. Patients will have to pay to use the system. Charges have not yet been set, but the chief executive of Patientline, which runs the scheme, said that they are looking at charges "starting from" £1.50 per day. Patients will not be allowed to bring in portable TVs. The scheme has been condemned by London Health Emergency and by ACHCEW, which commented that it was a "denial of basic creature comforts" for poorer patients.

Responding to the criticisms, the hospital's "director of operations", Martin Lerner, displayed the confusion between "want to use" and "able to pay for" common among the comfortably off. He said that "While we know that not every patient will want to use the new services, especially those which they have to pay for, we are confident that most of our patients will want to use some of the services". He also commented that many patients are disturbed by the noise of TVs which other patients have brought into the hospital. One might have thought it would not be beyond the wit of the hospital to insist that patients use portable TVs only with earphones.

Daily Express, Guardian 2 November

And finally ... Takeaway culture

Hospitals in Southend have announced an amnesty for the return of 200 pairs of pyjamas, 270 nighties, 650 towels and 2500 pillow cases.

Times 7 November

FOCUS ON ... THE DENTAL GREEN PAPER

ACHCEW's response to the Government Green Paper *Improving NHS Dentistry* (see *CHC News* No 95) expresses concern about three recent trends in dental services: the increase in NHS charges, the growing number of people purchasing private care and the difficulties of finding NHS dentists in some parts of the country. While it agrees that major change is needed to improve NHS dentistry, ACHCEW does not believe that the Green Paper proposals address any of these issues. The British Dental Association (BDA), if sometimes for different reasons, has also "emphatically rejected" the proposals following a consultation exercise among 18,000 practitioners.

In ACHCEW's view, the key tasks are:

- to move UK dentistry away from a fee-for-service system, since it provides the wrong incentives;
- to focus and prioritise dentistry along the lines set out in the *Oral Health Strategy;*
- to ensure accessibility to all NHS services by reducing charges and restoring services where they have disappeared;
- to improve the quality of NHS care so that people do not feel they must go private to receive first-rate treatment.

NHS charges

The Green Paper proposes to reduce (or abolish) charges for check-ups, but to charge the full cost of "advanced" treatments. ACHCEW endorses the former proposal, but not the latter, believing that the high costs of NHS treatment have a deterrent effect for some patients. Many people on Family Credit do not claim the exemptions to which they are entitled and the people just above benefit levels will "think twice" before paying for services they need. ACHCEW believes that this contravenes the Patient's Charter commitment to giving *every* citizen the right to receive health care on the basis of clinical need, regardless of ability to pay.

A *Daily Telegraph* article outlines what the Green Paper could mean in terms of charges for "advanced" treatments. Crowns, already £59.32 would rise to £74.15. Dentures would go up from £81.36 to £101.70.

Gaps in the service

The Green Paper declares that the Government is committed to an accessible dental health service. Statistics from the Dental Data Service are not much help in assessing the difficulty which patients have at present in accessing NHS treatment. However, ACHCEW points out that there is evidence of serious problems in this regard, especially in the South East, the South West and Wales. With people experiencing difficulty in getting NHS care, they may visit an NHS dentist further from home, turn to private care or forgo treatment.

An example from Devon is reported in the *Independent*. Two pensioners have been told by the FHSA that they must travel at least 12 miles to receive NHS treatment because dentists in the town of Kingsbridge have stopped taking NHS patients. A spokesman from the local FHSA said that the FHSA has been trying to encourage a new dentist to practise in the town. He reckoned that the FHSA received 100 calls a week from people looking for an NHS dentist. Most of these have been directed to NHS dentists (as the Government claims is the case generally), but this raises the question of how readily accessible these dentists are and of whether patients are offered any choice. In any case, many people will turn to private care or give up without contacting the FHSA. A survey from North Beds CHC last year found that among patients who had gone private in order to stay with their dentist, two-thirds said they preferred NHS treatment.

Charges – BDA response:
Dentists can see no benefit in reduced check-up charges and higher fees for advanced work.

Gaps – BDA response:
If the proposals are introduced, patients will find it increasingly difficult to obtain NHS treatment.

Private care

While ACHCEW welcomes choice in health care, it has concerns about the growth in private dentistry. As influential sections of the population turn to the private sector, they will be less concerned to defend NHS dentistry. In any case, the growth of private dentistry is not necessarily indicative of choice. People may go to private dentists because they perceive the NHS care as inaccessible or second-rate. Once in the private sector, patients do not have the protection of established complaints procedures and CHCs do not have a remit to support or represent these patients. Lastly, the larger the private sector, the more difficult it will be to adopt a strategic approach to dental services or to develop audit. In the long-term, the Government wants to move away from the wrong incentives offered by a fee-for-service system in the NHS, yet this is the very system of incentives which operates in the private sector.

The *Daily Telegraph* gives examples of the extremely high charges that can face people who take up private care: from £150 to £300 for a crown and from £200 to £400 for dentures. In parts of the South East private charges are often four times NHS charges.

Purchaser/provider split

In the long term, the Government would like to introduce a purchaser/provider split in dentistry. ACHCEW sees some possible advantages to this. For example, purchasers could be required to take action where gaps in the service appear. However, since the Green Paper does not recognise a serious accessibility problem, this hardly seems to be the intention of the purchaser/provider model.

Purchaser/provider split – BDA response:
"No great enthusiasm", but a third of districts might be prepared to enter a trial. Would increase bureaucracy and if there is no commitment to redress underfunding, no improvements would result. NHS treatment will be rationed and there will be waiting lists.

A passage in the Green Paper reads: "Within their overall health budgets, local NHS managers would target resources to meet these variations". This, ACHCEW fears, implies that resources could be moved out of dentistry. ACHCEW also commented that, if a purchaser/provider split is introduced, access should not be delayed by the development of waiting lists.

Sessional fees

The preferred medium-term option in the Green Paper is a sessional fee model. ACHCEW sees some advantages in this, but comments that levels of remuneration would need to be high enough to tempt dentists back into the NHS, especially given the acrimony and lack of trust caused when the Government clawed back 7% of payments for work done in 1991. The Green Paper gave no indication of what such dentists might be paid.

Sessional fees – BDA response:
"Almost universally rejected".
Might mean that patients would not see the dentist of their choice.
In some areas, dentists would not get enough sessions to stay in business.

Community Dental Service (CDS)

The Government proposes to strengthen the function of the CDS and to bring it together with salaried dentists employed by FHSAs. However, there are concerns that this might be used as a fall-back service where general dental services are allowed to wither away. Also, the CDS has a valuable role in bringing services to people who face a variety of barriers to using general dental practitioners. Having acknowledged the importance of the service as a safety net, in the next breath the Green Paper recommends that charges should be levied for its services.

People in glass houses

Responding to the BDA's rejection of the proposals, Health Minister, Gerry Malone, commented "I had hoped for an argued case rather than mere assertions. It looks as if the profession has no clear idea of the way forward".

Daily Telegraph 21 October, Independent 1 November, ACHCEW letter of response 31 October

For all her pains ...

Mrs Bottomley's recent attempt to win over GPs to cheaper prescribing seems to have backfired. She told *Pulse* how she had consulted her GP about toothache. He first gave her the cheaper of two antibiotics. When she returned the next day still in pain, he prescribed her the more expensive option. This little anecdote, presumably supposed to promote the virtues of cheaper prescribing practices, did Mrs Bottomley few favours. Furious GPs have contacted *Pulse* asking why she didn't see a dentist anyway? Did she expect an antibiotic to work in one day? And was the fact that she received two prescriptions merely an example of how cheaper drugs may be more expensive in the end?

Pulse 22 October

FROM THE JOURNALS

Disappearing statistics

An article by Alison Macfarlane in *Radical Statistics* discusses the difficulties of interpreting the statistics deployed by Government ministers when they make claims about the NHS. It discusses how changes and reductions in the data collated, the incompleteness and poor quality of some data returns and changes in administrative practice limit the ability of published statistics to reveal the facts of what is really happening.

One example is the oft-repeated claim that the number of patients treated has risen. One element of this statistic is "finished consultant episodes" for in-patients. Until 1987/88 people were counted each time they were discharged from hospital. From 1988/89 they have been counted each time they change consultant within a hospital stay. This change in itself increased apparent activity rates in that year. In addition, shorter hospital stays may have increased readmission rates, but published statistics do not provide information on this (although the computer systems used could generate the information). There is evidence that the introduction of the internal market has made hospitals more likely to record changes in consultant, but again it is impossible to use published data to quantify the extent of this.

Other areas considered include waiting lists, staffing, facilities and league tables. The author concludes that the statistics repeatedly quoted in defence of changes in the NHS are quite inadequate to enable an assessment of the impact of those changes and do not even support the interpretations Government politicians place on them.

Radical Statistics Summer 1994

Empires of the future?

The community care system is increasingly putting social services departments under pressure, but some local authorities are positively looking for ways to expand their areas of responsibility.

An article in *Community Care* discusses the problems SSDs are trying to grapple with, the most widespread of which are charges for home care and time spent on assessments. Despite these problems, some local authorities are looking to the day when they can add purchasing health care to their responsibilities. What some view as "town hall fundamentalism" is seen by others as an opportunity to "ensure a holistic approach to health care".

Harrow and Wandsworth are already exploring ways of bringing health and social services purchasing together – under local government. They believe that it would encourage investment in health gain in areas such as housing and environmental health. It would also ensure local accountability through elected members. It is also argued that bringing purchasing together would remove the confusion between health and social care (though it is not explained how this would be achieved if the former remains free and the latter means-tested).

Critics are less sanguine about local government's ability to cope with commissioning health services. They predict that the health operation would in effect become a separate body, with outside consultants running the show and setting priorities. Others fear that NHS money might be channelled into other council activities. (A proponent of combined purchasing responsibility, Gerald

Wistow of the Nuffield Institute, argues that, because of the public's interest in health, cash would be more likely to flow towards the health function.) There is also the worry that the transfer of health purchasing would provide the central government with an opportunity to shift bad publicity for NHS funding to local government.

Between the supporters and critics of such schemes are those who advocate selective purchasing, in which social services would buy some services from NHS providers and sell others to health commissioners and GP fundholders. Other compromise suggestions would involve setting up regional purchasers with representation from both the NHS and local government or a split system, in which NHS purchasers keep responsibility for acute care, while local government takes on responsibility for chronic services.

Community Care 3–9 November

Overcoming language barriers

The results of a survey in Bradford suggest that providing translated written materials for non-English speakers would not meet the needs of many NHS patients. Respondents to the survey included 824 non-English speaking patients. Of these, 588 could not read or write in any language, including their first language. The department of obstetrics in Bradford Royal Infirmary is trying to develop more effective ways of overcoming language barriers. They have produced audio tapes and are working on video tapes in different languages. However, this may not meet patients' needs in acute settings. The authors therefore call on purchasers to recognise the value of interpreting services in areas such as labour suites and casualty units.

BMJ 15 October

A focus group study among ethnic minority women living in east London challenges some of the assumptions about why there is a low take up of cervical cytology among some groups of ethnic minority women. The women (speaking seven different languages and meeting in 11 focus groups) did not appear to be avoiding cervical cytology because of attitudinal barriers such as fear of cancer, although there were concerns about surgery hygiene. Most women wanted facilities for children at surgeries so that they did not have to be in the same room during a smear test. Many had misunderstandings about the purposes of a smear test (in one translated leaflet "smear test" had been translated into "fat test") and procedures of the cervical cytology system (the need for laboratory analysis and the call, recall and results arrangements). Language barriers affected both understanding and the likelihood of women being aware of a written invitation to attend a test. These administrative and language barriers apart, women were generally enthusiastic about having cervical cytology screening once its purpose had been explained.

BMJ 29 October

NEWS FROM ACHCEW

New staff at ACHCEW

Three new staff are joining the ACHCEW team in December. They are:

Elizabeth Rickerby, who will be ACHCEW's Training Organiser with the task of putting together a portfolio of training events for CHCs which will be available during 1995 in a variety of venues around the country. She is at present the Training Officer in the Advice Work Department at *Counsel and Care.*

Helen Richardson, who will be ACHCEW's Publicity Officer. She will be working with CHCs to raise the profile of CHCs, will help liaise with the media for ACHCEW and will be improving the appearance of ACHCEW publications. She currently works at the London Implementation Group as Communications Assistant and has done voluntary work on public relations with the charity, *Crisis.*

Roselyn Wilkinson, who will be joining ACHCEW's Research, Information and Development Team as Information Officer (Development). She is currently Census Research Officer at the King's Fund Institute.

AROUND THE CHCs

Sale of paracetamol to children

A report from **Pontefract and District CHC** has stimulated wide interest in both local and national newspapers, from local MPs and from the local commissioning authority. The report on the sale of paracetamol to children has been largely due to the efforts of the CHC's Development Officer, Louise Bentley.

The CHC sent a 12-year-old child into 31 outlets, including 11 pharmacies. In the pharmacies the child asked for at least 100 tablets; in the other shops she asked for at least 50 (a dose of 40 tablets can be lethal to adults). Few of the outlets took any steps to ensure that the paracetamol would be used safely:

- in only 2 pharmacies and 2 other shops did the retailer ask the child if the paracetamol was for her parents;
- in 3 pharmacies and 2 other shops the vendor checked with another member of staff before selling the paracetamol to the child (the pharmacists concerned did not question the child);
- no advice was given on the safe use of the drug;
- in 8 cases the child was sold more than one pack of tablets.

None of the vendors were breaking the law, but the pharmacists appeared not to be conforming to their own Code of Ethics.

Among the suggestions made by the CHC is that the sale of paracetamol could be restricted to pharmacies; that the number of tablets in a packet should be reduced and that the number of packets bought at one time should be restricted. The legal age for purchase of paracetamol should be set at 16 years. The CHC has written to the Pharmaceutical Society of Great Britain with suggestions for improved labelling: more prominent information on dosage and the dangers of overdose; the amount of paracetamol in the product; and the action to take in cases of overdose.

The response to the report has been swift and very largely positive: local MPs are taking up the matter, Wakefield Healthcare (purchasers) have instituted immediate discussions with pharmacists and others. The Pharmaceutical Society has written to express its concern and asked for the details of the pharmacies concerned so that it can take the matter up. It, too, would like to see sale of paracetamol restricted to pharmacies since it believes that widespread availability of the drug is one of the reasons that people underestimate the dangers of overdose. The *Pharmaceutical Journal* however, has been a little more prickly. While the Journal did decide to report the survey and presented the results in a straightforward way, the questions it raised are telling. Its reporter was concerned to know "how a survey of this type fitted in with the remit of the CHC" and how the CHC justified "the use of public money to investigate private health care transactions" – the reporter even asked what budget coding had been used for the money spent on the survey!

The CHC has passed copies of the report to local MPs asking them to support a call for statutory restrictions on the sale of paracetamol to children. **It would welcome support from any other CHC in petitioning MPs.**

The 12-page report is available from the CHC.

Deadline

The newsletter takes its Christmas holidays next month. If you have items for inclusion in the next issue, could you please get them to ACHCEW by 11 January.

CHC PUBLICATIONS

For your information...
A report of a project to look at information on DHA contracts
Nikki Joule for GLACHC, phone: 0171 700 0100, 36 pages

This research project was designed to establish whether the information needs of CHCs, voluntary organisations and NHS users were being met. Do the reams of paper landing on CHC, and other, desks provide information which they need? The project looked at information about DHA contracts. Although the intention was not to limit research to acute sector contracts, this emerged as the main focus since DHA respondents (Directors of Purchasing) themselves had very limited knowledge of their contracts for priority and community services. Information was gathered from questionnaires completed by CHCs and DHAs and submissions from five Councils for Voluntary Services. It proved difficult to canvass the views of GPs on the subject. The results are presented in three sections: information available to the public, information CHCs would like to have, and how information about contracts is conveyed.

As ever, there are wide discrepancies between areas. There are also gaps between what is provided to CHCs and to GPs. While CHCs are often involved in purchasing *plans*, many receive little information about what DHAs eventually do *and do not* commission (or why) or about quality measures. It is important for DHAs to be open with both CHCs and with GPs, since both can act as conduits for supplying information to NHS users. There is a particular issue about information on GP fundholder contracts. The report concludes that information on these contracts must be communicated to the practice population and, arguably, more widely. Only then will patients have a genuine opportunity to exercise choice about GPs and will the population be able to see how GP contracts are affecting the patterns and quality of services available locally.

Both DHAs and CHCs need to clarify their information strategies. Most of the recommendations in the report are for DHAs. Five recommendations are for CHCs, among them that CHCs need to agree with DHAs and others how quality standards are to be articulated, since this information is often unavailable, or is available only in a form that is not meaningful to the local population. Another recommendation is that CHCs need to define what information they require from the DHA. An appendix to the report provides a checklist which may help CHCs in achieving this.

The influence of the public in the NHS internal market with particular reference to purchasing in the Oxford Region for 1994–95.
Tom Richardson, CHC Development Officer Oxford RHA, 10 pages

This report to the Steering Group for CHC and Purchaser Development in Oxford Region discusses the involvement of users, carers and the general public in the planning of services. Much of the report is made up of examples of good practice in the Region, followed by recommendations for the CHCs in each county on how they could take their work forward. A more general section makes suggestions for involving the public. One danger it identifies is that a gap may develop between CHC members and staff, with the former concentrating on provision of services, while the latter become involved in planning and purchasing. It looks at various opportunities for cooperation between CHCs, DHAs, FHSAs and GP fundholders and comments that support is needed at a Regional level to encourage the work of those health service managers who are attempting to involve the public, often with little support from their colleagues.

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

The Patient's Charter: A manual on monitoring privacy dignity and respect
Worcester District CHC, 21 pages

Patients on four wards were asked to recall situations and aspects of service and care in which they felt embarrassed or where they felt that their feelings had not been considered. Recommendations are drawn from an analysis of their responses, recorded verbatim. The recommendations identify the need for privacy at the pre-admission clinic, during consultations and when a patient is dying. Patients appreciated being treated with consideration and politeness, and equally did not like being discussed in their hearing without being consulted or left without attention when they needed it or had reason to expect it.

Survey of accidental injuries and near misses
Sharon Parsons , West Essex CHC 43 pages

This survey used three sources of information: a sample of individuals (school children, local employees and elderly people), a sample of GPs and two focus groups of elderly women. The individuals were asked to keep a diary for a week recording any accidental injuries and any near miss accidental injuries. GPs were asked to keep a diary of people presenting (in person or by phone) with an accidental injury. Results are broken down in various ways, including types of accident, type of injury and part of the body and where, when and why the incident took place.

A ten point check list survey of the public toilets of Withington and Wythenshawe Hospital
South Manchester CHC, 42 pages

Mental health services: managing change in community care. Report of a seminar
MIND in St Albans and North West Herts CHC, 25 pages

Withington Hospital food survey
South Manchester CHC, 22 pages

Study of the quality of care for elderly people in hospital
Sharon Parsons, West Essex CHC, 19 pages

Minor injuries services in East Yorkshire
East Yorkshire CHC, 13 pages

Survey analysis of local opinion on mixed sex wards
Harrow CHC, 10 pages

IN BRIEF

OFFICIAL PUBLICATIONS

STANDARDS FOR LOCAL RESEARCH ETHICS COMMITTEES (LRECs)

Three documents have been circulated to LRECs, commissioning authorities, FHSAs and trusts:

Standards for Research Ethics Committees: a framework for ethical review
Produced for the NHS Training Division on behalf of the Department of Health, 39 pages

Each of 17 modules refers to a distinct activity of an LREC. Each module starts with a brief commentary on the activity, followed by what the LREC is required to ensure, what members need to know to meet these requirements and a list of further reading.

Standard Operating Procedures for Local Research Ethics Committees: comments and examples
by Christine Bendall, 87 pages, (Disk copies in WordPerfect 5.1 are available from Ms C Bendall, McKenna and Co, 160 Aldersgate Street, London EC1A 4DD, £10)

Presents a set of sample Standard Operating Procedures (SOPs) with notes. They cover: constitution and terms of reference of an LREC; standardised application forms; notification of LREC decisions; assessment of applications (including a list of relevant guidelines and summaries of selected guidance); and the drafting of SOPs.

Using Standards for Local Research Ethics Committees
by Christine Bendall (McKenna & Co) and Jane Riddell (NHS Training Division), 15 pages

Explains the purpose of the above two documents with guidance on how they complement each other.

Queries about the documents (other than to order disk copies of the SOPs) to Mr S Goulding, DoH, Wellington House, 133–155 Waterloo Road, London SE1 8UG; phone 071 972 4925.

Local systems of support:
a framework for purchasing for people with severe mental health problems
NHS Executive, 18 pages

This document, mentioned in last month's newsletter (Number 97, page 12), has now been published. It is available from: BAPS, Health Publications Unit, Storage and Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs OL10 2PZ.

CHCs should be receiving (or have already received) copies of the following:

A framework for local community care charters in England
Department of Health, 33 pages
Further free copies available from: BAPS, Health Publications Unit, DSS Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs OL10 2PZ

Mental illness: what you can do about it
Department of Health, 16 pages
Further free copies available from Mental Illness, PO Box 643, Bristol, BS99 1UU

Finding a place: a review of mental health services for adults
Audit Commission, 94 pages, available from HMSO, £11

GENERAL PUBLICATIONS

Housing, homelessness and health
Working Group Report from the Standing Conference of Public Health, 52 pages
Available from the Nuffield Provincial Hospital Trust, 59 New Cavendish Street, London W1M 7RD, phone: 071 485 6632, £7

The Standing Conference on Public Health is an umbrella body for 18 health and social care organisations, including ACHCEW. This report reviews the evidence for links between bad housing and poor health. As well as taking a personal toll on the health of occupants, poor housing is estimated to impose costs on the NHS alone of between £800 million and £2,400 million a year. There is a persistent gap of about 100,000 units between the need for and the supply of affordable rented housing, yet current policies are doing little to decrease the shortfall. Recommendations are made for changes to policy which would increase the stock of decent, affordable accommodation. Among these are that the Treasury should take a cross-departmental view: policies should be changed to permit and encourage the collaborative responsibility between health, social services and social security providers in order to identify vulnerable people and take action to support them.

The asthma generation
A National Asthma Campaign report on childhood asthma
NAC, Providence House, Providence Place, London N1 0NT, phone 071 226 2260; £5

Published during National Asthma Week as part of a campaign aimed at improving the quality of life for children with asthma and to promote the need for more research funding. The focus of this report is on the management of asthma and treatment of children who already have the condition.

Report from the National Task Force on Chronic Fatigue Syndrome, Post Viral Fatigue Syndrome, Myalgic Encephalomyelitis
Report from an independent task force with support from the Department of Health
Available from Westcare, 155 Whiteladies Road, Clifton, Bristol, BS8 2RE, phone 0117 923 9341; 133 pages, £6.95

Intended to act as a "springboard" for further action to improve the help available to patients from this overlapping group of conditions, this report assembles much of what is known about the conditions, and thus is fairly technical. It is being considered by the medical Royal Colleges and the Department of Health.

Being cared for: a discussion document about older people with depression living at home
Counsel and Care, Twyman House, 16 Bonny Street, London NW1 9PG; phone 071 485 1550, 40 pages, £6.

A report looking at the needs of the estimated million and a half older people in the UK who have depression. Considers issues of how carers and care agencies can help preserve rights, promote good standards of assessment and care, and help older people attain a higher quality of life.

Learning disability nursing in the contract culture: a guide for purchasers

Commissioned by the Royal College of Nursing from the Nuffield Institute for Health

15 page booklet. For availability details contact Alan Parrish RCN, 20 Cavendish Square, London W1M 0AB, Phone: 071 872 0840. Re-order number 000 374

Fold-out summary available free of charge. Send an A4 SAE to RCN (as above). Re-order number 000 417

Race relations: code of practice in maternity services

Public information leaflet summarising the code of practice for the elimination of racial discrimination and the promotion of equal opportunities

Commission for Racial Equality, Free Publications, Elliot House, 10/12 Allington St, London SW1E 5EH

P&P charges: for 1 copy send SAE; 5 copies 80p; 10 copies £1; 25 copies £1.50; 50 copies £2.50

Geriatric day hospitals: their role and guidelines for good practice, 31 pages, £10
Clinical audit scheme for geriatric day hospitals, 49 pages, £10

Both from Research Unit of the Royal College of Physicians of London, 11 St Andrews Place, NW1 4LE

Building confidence: advice for alcohol and drug services on confidentiality policies

SCODA (Standing Conference on Drug Abuse) and Alcohol Concern

Available from SCODA, Waterbridge House, 32–36 Loman Street, London SE1 0EE; phone 071 928 9500, 47 pages, £9 (£6 members of SCODA or Alcohol Concern)

INFORMATION WANTED

Three requests from Salford CHC:

1. The CHC is concerned to make sure patients are offered and have a real opportunity to make **fully informed decisions about ECT**. Chris Dabbs would be grateful for any information about the information given to patients about ECT and about the processes used to gain patient consent for its use.

2. *Performance Standards for CHCs* (page 24) recommended that CHCs within a region should adopt a recording system for enquiries with:
   - common definitions of enquiries and complaints;
   - common classification for types of enquiries.

   Salford CHC would like to hear from CHCs with **recording systems for enquiries** along these lines and whether they are shared with other CHCs in the same region.

3. Could any CHCs which produce leaflets, information, guidance etc. for complainants about **how to write letters of complaint** please send copies to Chris Dabbs.

Aberconwy CHC and North Tyneside CHC would like to receive copies of **equal opportunities policies** developed by CHCs.

North Tyneside CHC would also like copies of procedures developed for **handling internal CHC complaints**.

Leeds CHC would be grateful for details of any **information tapes or videos in Urdu about epilepsy**. Please contact Jacqué Pitts.

We have heard of a case of a child being given a measles/rubella **vaccination after the child's parents had refused permission** for it to be given. Have any CHCs heard of similar cases? If so, please contact ACHCEW.

For our files

ACHCEW would be grateful if any CHCs sending information direct to another CHC in response to a request for information could also send a copy to ACHCEW.

FROM THE VOLUNTARY SECTOR

"Palpable nonsense"

The Muscular Dystrophy Group (MDG) has accused the Government's financial advisors of deliberately inflating cost estimates for providing indoor/outdoor powered wheelchairs to severely disabled people. When he presented a 100,000 strong petition calling for specific funding for such wheelchairs to Downing Street last month, Lord Richard Attenborough described Department of Health estimates as "palpable nonsense".

As part of its *Batteries Not Included* campaign, the MDG has published the result of its Wheelchair Survey. It is perhaps a measure of how strongly Wheelchair Service staff feel about what they *could* achieve that 95% of Wheelchair Services Centres in the UK responded to the survey. The survey shows that 93% of centres cannot provide indoor/outdoor powered wheelchairs, with 81% saying that lack of finance is the primary reason for this. The MDG is angry that the Government claims that providing indoor/outdoor powered wheelchairs through the state system would cost an additional £70 million annually – trebling the cost of the Wheelchair Service. Using estimates from senior management within the service, the MDG arrives at an annual cost estimate of £13.5 million. Evidence from Scotland (where funding of indoor/outdoor wheelchairs does exist) supports the MDG's much lower figure. Adjusting the Scottish figures for population size produces a figure of £12.25 million for the rest of the UK.

Overcoming the fear of injections

Action for Sick Children has produced a 12-page Family Information Booklet *Needles: helping to take away the fear*. It describes a range of relaxation techniques which parents can learn and use with their children. It also describes techniques, such as counting games, jokes and storytelling, to distract children while they are having an injection.

The booklet can be ordered from: Action for Sick Children, Argyle House, 29–31 Euston Road, London NW1 2SD. 1 copy: £1; 10 copies: £8; 50 copies: £35; 100 copies: £65.

MIND policies

MIND launched two policy papers at its Annual Conference earlier this month: *Physical Treatments* and *Talking Treatments*. They are based on consultation on two earlier discussion reports entitled *Safe and effective?* and *The power of words* to which many groups, members organisations and individuals contributed. Each policy paper has an accompanying campaign sheet. These set out how National MIND is campaigning to achieve its policy objectives and present ideas on how Local MIND Associations can campaign. The sheet on talking treatments includes a list of questions which could be included in a questionnaire for provider units.

Winter Warmth Line

Age Concern, Help the Aged and Neighbourhood Energy Action (NEA) are joining forces with the Departments of Health and Social Security to run this winter's campaign on keeping warm. A freephone telephone advice line (numbers below) will be open from 10 a.m. to 4 p.m. Monday to Friday, with longer opening hours during periods of extreme weather. There is also a Minicom number. The lines will give advice and information on welfare benefits, insulation and draught-proofing grants and sources of practical help available locally. Callers can be referred to any one of over 8000 national and local agencies for further help, including the NEA's network of installers who provide insulation and advice services under the Government's Home Energy Efficiency Scheme. Every caller will receive the *Keep warm, keep well* booklet which contains tips on keeping warm, DIY insulation ideas and advice for emergencies.

Freephone advice numbers:

England and Wales:	0800 289404
Scotland:	0800 838587
Northern Ireland:	0800 616757
Minicom:	0800 269626

FORTHCOMING EVENTS

Locality commissioning

- one-day seminar to stimulate good practice and help CHCs "inform the purchasing process"
- organised by the North Western Regional Association of CHCs
- on 14 February 1995
- in Manchester
- charge yet to be determined (will include lunch and refreshments)

Further info from:
Glenys Syddall, Chief Officer
NW Regional Association of CHCs
Lancaster Buildings, 77 Deansgate
Manchester M3 2BW
Phone 061 833 4689

Developing HIV services with gay men

- conference on access to services, home care services, community care, services for Black and Asian gay men and housing issues
- on 1 February 1995
- at NSPCC National Training Centre, Beaumont Leys, Leicester
- £55 for booking before 1 December; £70 after 1 December

Further info from:
Annita Eddison
Admin Officer
Leics Social Services Department
Towers Hospital, Gipsy Lane
Leicester LE5 0TD
Phone: 0533 460460 ext 2744

Privatisation: can we tell what's happening?

- Radical Statistics Group Annual Conference
- to discuss what statistics can tell us about privatisation of housing, education, health and social services
- on 25 February 1995
- at Band Room, Coram's Fields, 93 Guildford Street, London WC1
- £10 (£6 unwaged) includes lunch and crèche facilities

Further info from:
Allyson Pollock
Flat 1, Northdene
20 Streatham Common Northside
London SW16 3HJ

Health information and the consumer

- conference to consider sources of health information available to the public
- organised by the Office of Health Economics
- **on 30 November 1994**
- at Le Meridien Hotel, Piccadilly, London W1
- £125 (inc. VAT)

Further info from:
Miss Elizabeth Squibb
Office of Health Economics
12 Whitehall, London SW1 2DY
Phone 071 930 9203, Fax 071 747 1419

Partnership in Practice

- A seminar on a multidisciplinary approach to improving quality in primary health care
- **on 6 December 1994**
- at Regents College Conference Centre, London NW1
- £75

Further info from:
Sara Curran
King's Fund Organisational Audit
Phone: 071 221 7141

DIRECTORY AMENDMENTS

Page 11 ***South Bedfordshire* CHC**
Director: Peter True

Page 12 **Enfield CHC**
c/o Highlands Hospital
World's End Lane
Winchmore Hill
London N21 1PN
Phone unchanged

Croydon CHC
Chief Officer: Peter Walsh

Page 16 **Chicheter CHC**
4 The Chambers
Chapel Street
Chichester PO19 1DL
Phone unchanged

Page 23 **Hereford CHC**
41 Widemarsh Street
Hereford HR4 9EA
Phone and fax unchanged