CHC NEWS

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

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NEWS

Patient's Charter extended

An updated Patient's Charter has recently been issued, to take effect from 1 April. It adds new targets in a number of areas. Contrary to reports in much of the press (which has tended to refer to new "guarantees") much of the Charter talks about what you may **expect**, rather than what you have a **right** to.

- Nine out of ten patients can expect to be seen at an out-patient appointment within three months of a GP referral, and all can expect to be seen within six months.
- The target of a maximum 18 month wait for certain categories of surgery is to be extended to all operations.
- Patients who need admission from A&E can expect to wait no longer than four hours (two hours from April 1996).
- Patients needing coronary bypass surgery can expect treatment within a year. In this type of surgery, as in others, there are no standards laid down for the wait between a first out-patient appointment and admission to a waiting list – a period when patients may undergo investigations. The British Cardiac Society would like to see attention paid to this wait. The Society says that heart bypass patients should be seen within a month of a GP referral, that the investigation phase should take no longer than three months, and patients should be operated on within a further six months.
- Except in emergency admissions you have a right to be told in advance whether you are to be cared for on a single sex-ward. If you ask for a single sex ward or bay, your wishes should be respected where possible. However, this may entail your being prepared to wait for accommodation to become available. You can expect single-sex washing and toilet facilities.
- You can expect to have a decision made before discharge about how to meet any needs you may continue to have.
- A useful target, if it is met, concerns community services. If you need a home visit from a district nurse, health visitor or midwife, you can expect to be consulted about a convenient time and to be visited within a two hour time band.
- You can expect your hospital to make it clear how you can complain while you are in hospital.
- Whereas you have a right to be registered with a GP, the Charter mentions no such right in relation to dentists. If you ask for help in finding a dentist, you can expect the FHSA to respond to your request within five working days. Only if you are registered with a dentist do you a a right to receive advice in an emergency.

Times/Independent/Guardian/Daily Telegraph 19 January, The Patient's Charter & You, DoH

New guidelines on board appointments

The Health Secretary, Virginia Bottomley, has published new guidelines for the appointment of chairpersons and non-executive members of NHS trusts and health authorities, to come into effect from 1 April. The guidelines include:

- routine use of advertising;
- clear assessment criteria to be applied by local sifting panels, reporting to regional chairmen/women;
- NHS regional offices to maintain a database of appointees giving their name, address, date of appointment, occupation and "other relevant information";
- suitable procedures for induction and training.

Ministers will continue to be responsible for deciding who is appointed to trusts and health authorities.

ACHCEW regards the guidelines as a minor step forward. Speaking on Radio 4's *Today* programme, Toby Harris doubted whether the guidelines would ensure that a wider variety of people were appointed to boards. He stressed that knowledge and use of local health services is vital if boards are to be effective, adding that CHC membership would be a useful background for board membership. He also called for independent scrutiny of appointments.

DoH press release/Today programme 14 February

Passing round the hat

Surrey County Council has been reduced to begging private homes to provide care free of charge for elderly and disabled people, having run out of money to pay for community care. The council sent a letter to 135 private homes asking them to accept residents for no payment until April, when fresh funds will be available. The letter points out that if the homes do not provide free places, they will lose business later in the year when funding is available. The deputy social services director commented "We have run out of money for this year. Although the homes will not get paid for eight or ten weeks, they will benefit in the long run by having new residents in place for the next financial year." Both the letter and the implicit threat contained in it have been given a decidedly cool reception by the homes.

Times 15 January

Ethnic minorities getting a raw deal

Two studies of health and health service use among minority ethnic groups in Britain have revealed considerable differences between these groups and the rest of the population. A national survey of health behaviour and attitudes published by the Health Education Authority shows that the health of Afro-Caribbean, Indian, Pakistani and Bangladeshi communities in England is being damaged by cultural and language barriers and that health education messages are not getting through. This risk to health is compounded by the economic disadvantage which the groups tend to suffer. The survey found that, while 15% of women in the whole population have never had a cervical smear, this rises to 30% for Indian women, 46% for Pakistani women and 60% for Bangladeshi women.

The second study, carried out by the King's Fund, found that minority ethnic groups generally experience poorer quality contact with the health service than the white population.

Independent 23 January

Options for breast cancer screening

An unexpectedly high number of women are developing breast cancer in the three-year interval between screenings, according to research carried out by a team from the Christie Hospital, Manchester. In a *BMJ* article the team has called for screening to repeated every two years.

The researchers looked at the results for 137,421 women who had previously tested negative. They found invasive cancers in 297 cases. Of the cancers identified, 20% had developed within a year of screening, 32% between one and two years and 49% between two and three years. The team says that the numbers of cancers detected at a second screening (interval cancers) are almost the same as if the women had never been screened.

While it accepts that there are many interval cancers, an article in the *Lancet* proposes a different response. It argues that even short screening intervals would not be short enough to detect many fast-growing cancers which need to be treated when they are very small. A better solution would be to spend money on encouraging women with minor breast symptoms to seek an examination as soon as possible. Women with such symptoms should have speedy access to specialist investigations rather than the typically long waits for referral.

The Department of Health will not take a decision on reducing the screening interval until trials currently under way report in 1996. The trials, which involve about 100,000 women in five centres, are comparing annual screening against three-year screening. In the meantime, all breast screening centres have been told to take two X-rays at each screening (about half the centres were taking only one) to improve the detection rate.

Were the screening interval to be reduced, substantial extra funds would be needed. At present it costs about £37 million to screen about 1.5 million women each year.

Guardian/Times 27 January

Taking self-help too far

A 70 year old woman in Scotland was mailed a scalpel and pair of forceps to remove her own abdominal stitch following a hormone implant. Stobhill Hospital in Glasgow said that about 300 patients a year removed their own stitches, and that the practice had been going on for years. The woman complained to her GP who judged that she was unable to remove the stitch herself and in turn complained to the hospital. The BMA, reflecting the reaction of many Scottish doctors, have said that it did not approve of patients removing their own stitches.

Times 31 January

Intensive care variations

Government-commissioned research has shown that there are wide variations in the provision of intensive care beds across the country, with serious shortages in some areas. The study found almost a two-fold difference in provision between regions. In areas of low provision 9.6% of patients are turned away because there is no bed, rising to 50% in one hospital. In well-provided areas, the refusal rate is 4.5%. However, one in six referrals to intensive care were deemed inappropriate. For some of these patients, a high dependency ward would have been more appropriate; others were judged too ill to have any chance of benefiting.

In response to the report, the Department of Health has instructed health authorities to review their provision and use of intensive care. The reaction of the health minister, Tom Sackville is revealing. After the ritual preamble "It is for each health authority to determine the appropriate level and type of provision ...", his concern appeared to be not that some patients might be without beds, but that some beds might be without patients: "It is no good hospitals establishing larger intensive care facilities to satisfy peaks of demand. Highly staffed beds then lie empty the rest of the year."

Guardian/Telegraph 8 February

Consultants' views of A&E referrals

A survey of consultants in A&E units shows that some believe that GP fundholders are sending patients to A&E departments in order to avoid paying for services such as X-rays out of their own funds. In the survey, 60% of the consultants said that over the last three years they have seen a rise in the numbers of patients who were registered with a GP, but could not receive treatment from the primary care services when they needed it. Nineteen per cent believed GPs were using A&E to avoid payments, though other reasons were given – to get round waiting lists (28%); pressure on GP time (17%); as a defensive measure in case of complaints (16%) and because GPs were unwilling to see patients out of hours (10%).

Dr Rhiadan Morris, chairman of the National Association of Fundholding Practices said that there is no evidence that fundholders are referring patients to A&E to avoid payments, commenting that fundholders and non-fundholders are equally likely to refer patients there.

Pulse 4 February

Disenchanted

Dr Jeremy Lee-Potter, who as head of the BMA took a conciliatory line with the Government over its overhaul of the NHS, is taking early retirement in protest at Government "dogma". Dr Lee-Potter took over the BMA council chair, replacing Dr John Marks who had more or less broken off relations with the then Health Secretary, Kenneth Clark. Dr Lee-Potter had hoped that his low key approach would encourage politicians to see that they had "got it wrong". However, his tactics angered many doctors and he was voted out of office after three years, to be replaced by Dr Sandy Macara. Commenting on his retirement he said "I failed, just as Dr Marks had failed, and I believe ... Sandy Macara will fail... For at the root of the NHS changes lies political dogma."

Guardian/Telegraph 20 January

PARLIAMENTARY NEWS

From Healthcare Parliamentary Monitor 23 January

People with disabilities

The Government has published its White paper on ending discrimination against disabled people *(Ending Discrimination against Disabled People,* HMSO, £7.35), and introduced its Disability Discrimination Bill into parliament. At the same time Harry Barnes is continuing with his private members bill, which is on the same lines as the one defeated by Government supporters last year.

Last year, Virginia Bottomley gave her support to the idea of giving disabled people the cash payments to buy in their own home care services. She is now not prepared to let any such scheme go ahead, until she is satisfied with how local authorities would handle it. It appears that ministers are worried that local authorities pleading a lack of resources might threaten to cut the level of cash payments unless funding from central Government was increased.

Complaints

Giving evidence to the Select Committee on the Parliamentary Commissioner for Administration (the Ombudsman), Alan Langlands, the NHS Chief Executive admitted that he is "worried about" the possibility that complaints handing in the NHS is getting worse. He agreed that "no definition of the NHS complaints procedure is complete without a mention of the Commissioner", implying that details should be always included in complaints leaflets. He said that the NHS Executive is committed to implementing the Wilson proposals on complaints, but that the decision on timing rested with Mrs Bottomley.

From Hansard

Dentists

Expenditure on salaried dentists (£ thousands)

	Remuneration	Expenses	Total
England			
1992/3	1,805	594	2,399
1993/4	2,729	1907	4,636
1994/5 (to 30/11)	2,398	1,439	3,837
Wales			
1993/4	35	150	185
1994/5 (to 31/12)	55	63	118

In 1992, there were 66 salaried dentists in England (principals registered at 31 December), rising to 91 in 1993 and 115 in 1994. Lambeth, Southwark and Lewisham FHSA employed 31 of the 115 in 1994. There were three salaried dentists in Wales at 1 December 1994.

Ministers were also asked how many unfilled vacancies there were for salaried dentists in December 1994. The DoH did not have the data for England for that month and did not volunteer the information for any earlier months. There were three unfilled vacancies in Wales, all of them in Gwynedd. A Welsh Office minister acknowledged that there was a deficiency of dentists in Gwynedd, adding that "more funding has been made available, but the FHSA has not seen fit to ask for it".

Excluding salaried dentists there were 15,084 principal general dental practitioners on the lists of English FHSAs at 30 September 1994, and 801 assistants and vocational trainees working under the supervision of a principal. At the same date, there were 849 principals, assistants and vocational trainees in Wales.

16 January, col 444; 23 January, col 60-1, 25 January, col 258-9.

Continuing care

Asked about national criteria against which to judge whether definitions of access to long-term health care negotiated by DHAs are reasonable and equitable, John Bowis answered that there will soon be guidance on DHA responsibilities for continuing health care. All health authorities will be "required to review their current arrangements and to ensure they are securing an adequate level of continuing health care to meet the needs of the population". In his evidence to the Select Committee of the Parliamentary Commissioner (see above), Alan Langlands said that the guidelines would require health authorities that had withdrawn from the provision of continuing care to reinvest in it, and that arrangements would be set up to monitor this.

Hansard 24 January, col 174, Healthcare Parliamentary Monitor 23 January

"Information no longer available"

Estimates of spending per head by age group for personal social services and family health services – latest figures available 1989/90.

23 January, col 14

"Information not held centrally"

Numbers of people removed from waiting lists for reasons other than treatment.

23 January, col 15

Access to health centres

Under Part M of the Building Regulations 1991, it is local authority building control officers who hold responsibility for ensuring that health centres are adequately accessible to disabled people.

26 January, col 343

Priority Setting in the NHS: Purchasing. Volume 1.
First report of the House of Commons Health Committee Session 1994/95, 94 pages, £15.60, HMSO

This report considers factors influencing the demand for NHS services then examines how choices are made. It includes a section on the role to be played by the public in priority setting.

Selecting effective treatments

The committee visited Oregon, USA, where a systematic approach to priority setting has been instituted. While some lessons can be drawn from the experience, the committee points out that the factors behind the need for the Oregon Plan do not apply in the UK – not least that in the USA, some 14% of GDP is spent on health care compared to about 6.6% in the UK, with little difference in health outcomes.

In Oregon, specified treatments do not receive public funding. While the committee found that health authorities in the UK were not adopting the Oregon approach systematically, they too were excluding (or reining back the purchase of) certain treatments. It noted that, while these exclusions (which arguably concern services at the margin of provision) tend to dominate debate, variation in the provision of routine procedures is vastly more significant. There are wide variations in the use of procedures such as hysterectomies and tonsillectomies. This raises the questions both of equity and of appropriateness. The effectiveness of routine treatments is a contentious issue, but the committee concludes that even at a conservative estimate 5% of surgical procedures currently provided may be ineffective. If the resources used on these treatments could be freed, the savings would almost certainly be greater than any savings made by completely excluding individual treatments at the margin. It welcomes the establishment of the Cochrane Centre in Oxford and the NHS Centre for Reviews and Dissemination in York, both aiming to build up and disseminate information on effectiveness. One recommendation is that all health professionals should be required to justify decisions to deviate from informed best practice.

Scrutiny

The report consistently calls for the publication of reliable data on plans, patterns of treatment and research. Openness and clarity is needed in decisions about clinical protocols (on treatment decisions) so that they can be properly scrutinised. CHCs have an important role in ensuring that such scrutiny takes place. Since the committee believes that the mechanisms for scrutiny should not be left to the initiative of local district purchasers, it recommends that the Department of Health requires purchasers to establish clear local arrangements. It specifically recommends that purchasers seek the views of CHCs during the formulation of protocols.

Public involvement

In a submission to the committee, ACHCEW commented that purchasers are not yet effectively involving CHCs or local people in decision-making. In general, evidence submitted suggests that few health authorities are involving the public in making choices. Insofar as there has been public involvement, it has concerned the provision of specific services rather than overall priorities. The DoH is called upon to issue minimum standards on involving the public in the continuing development of services.

A distinction is drawn between obtaining feedback from the public on specific services and information on local needs on the one hand, and involving the public in setting priorities on the other. On *feedback and consultation*: "The role of CHCs may need to be further developed to enable them to support these initiatives, for example to help them take on an enhanced consumer research role, with the resources to buy in relevant expertise as and when needed and to promote their involvement in the use and development of research techniques to gain public views and feedback on local services."

Priority setting is and should remain the responsibility of health authorities, but they should allow themselves to be influenced by local discussion. The committee is not convinced that this is happening in all cases.

Finally, the committee calls for a rethink at a national level on public involvement: the aims of the process, what the public should be doing, what changes they should hope to see and what methods are effective. Only when all parties are committed to being open in their decision making and to creating a well-informed local community will we have a firm basis for setting priorities.

FROM THE JOURNALS

A vision of the future

Members and Officers who attended ACHCEW's 1993 conference may remember John Spiers, who enthusiastically supported the NHS reforms in the Guest Debate. Mr Spiers is an adviser to John Major on the Patient's Charter.

In an article in the *Guardian,* Mr Spiers gives his wholehearted backing to the idea of giving CHCs a more powerful role. He is concerned with how public services can be made accountable to users, when most users are unable to transfer their custom elsewhere. The alternative approach is to gives consumers a voice through an institution which could apply sanctions. CHCs are the natural candidates, though they would need a stronger role as Community Outcome Councils (COCs).

So far CHCs have remained "frugally funded, hardworking and committed voluntary organisations of little account", viewed with suspicion by the Government. With their meagre resources, they have no hope of counterbalancing the phalanx of the BMA, the Royal Colleges and managerial networks.

Strengthened COCs could be given the leading role in patient advocacy, patient audit and tracking of long-term care. They could also have an educative role with the public. They would need to be independent of the health authority, but be given access to all the information it holds. They would also need direct access to GPs and could help to ensure GP accountability. COCs would be given the power to require purchasers to publish targets in every clinical directorate. They would push for the development of outcome measures to be incorporated into routine service delivery.

Mr Spiers suggests that COCs, alongside GPs, might eventually make health authorities obsolete, as part of a framework which starts by giving patient values priority. In this way he believes, CHCs could be transformed from bodies with allegiances to local politics, the NHS structure and focused on grievances, to well-funded bodies loyal to outcomes and a broader definition of "consumer interest".

CHCs might welcome this vision, but Mr Spiers gives no hint as to how that "phalanx" of powerful interests or the Government might be persuaded to allow it to come about.

Guardian 8 February

Dental proposals

Which? Way to health conducted a survey of dentistry to see what effect Government proposals are having, and may be expected to have. Researchers posing as patients found that 60% of practices would take on adult fee-paying NHS patients (up from 53% in 1992). However, over a third of these said that patients would need a check-up first. The proportion of patients whose most recent visit to a dentist had involved private treatment had doubled to 34%. Of those who had not visited a dentist for 18 months (26% of respondents), 41% gave cost as the reason.

The Government proposals include few details of costs. It is clear though that patients would pay the full costs of "complex" treatments unless they are exempt from fees. Some currently-available complex treatments would not be available on the NHS at all. There would still be a ceiling on what you pay for a course of treatment, but is not clear what it might be. The charge for a check-up may be reduced, though it is not clear what will happen to charges for everyday treatments (it is worth bearing in mind that private charges for procedures range from about two times to four times the current NHS charges).

The authors conclude that reduced check-up charges might encourage more people to attend, but worries about final charges may deter them anyway. People on low income who are not exempt from charges will be hard hit by increases in costs. Poorer people may not be able to get many complex treatments which are excluded from NHS provision. On the positive side, tighter rules on provision may make ineffective treatments less likely.

A long-term proposal is that dentists should be employed by FHSAs on a sessional basis. This, says *Which?*, would discourage unnecessary work and reduce the scope of dentists to pick and choose patients. The British Dental Association argues that it might lead to waiting lists for dental treatment.

Which? Way to Health February 1995

A brief mention:

For those interested in patient advocacy, there is an article in *Nursing Times* (25 January) on the moral, ethical and legal implications of nurses developing an advocacy role.

NEWS FROM ACHCEW

Community Health Services

Last month ACHCEW published *Community Health Services,* a report which pulls together research, including CHC surveys, carried out over the last ten years. It concludes that although the services are highly valued by patients and provide care tailored to individual needs, they are poorly resourced and considered a low priority by NHS managers. According to the report, the services are being run down to a level where they are unable to help those in most need. Staff of the Community Dental Services, for example, have been cut by 25% over 12 years and the number of patients treated by the service has fallen by over 400,000 in the same period.

The report also identifies an impact of the NHS reforms – community services that were previously coordinated on a district-wide basis are now becoming fragmented as services are both purchased and provided by different health bodies.

All this is happening when the NHS and Community Care Act is placing additional burdens on community health services. ACHCEW concludes that there is an urgent need for more resources if the services are to cope with the increased demand.

Training workshops

Liz Rikarby, ACHCEW's Training Officer, has now arranged a set of workshops for CHC Members, Chairs and staff:

- Understanding the role of CHCs
- Tackling research
- Setting performance standards for CHCs in the context of a changing health service
- Complaints – monitoring, setting standards, measuring the quality
- Local voices – giving users an effective voice in the shaping of health services
- Working with the media/Using the media effectively
- Understanding and working in the community
- A guide to contracting in the NHS

CHC offices should by now have received full details.

AROUND THE CHCs

Chester & Ellesmere Port CHC has produced a range of leaflets:

- About Chester & Ellesmere Port CHC
- Getting access to medical records
- Guide to Independent Professional Review
- Guide to making a complaint or enquiry through the CHC

The CHC is shortly to produce:

- Guide to mental health review tribunals and detention under the Mental Health Act
- Guide to FHSA service committees and tribunals – complaints about family practitioners
- Guide to the hospital complaints procedures
- Guide to taking legal action
- Questions you should ask before your operation

The CHC can provide all the documents on disk in all common wordprocessor formats. They could then be customised to suit individual CHCs. Alternatively, CHCs without the facilities to produce their own leaflets may be able to arrange for Chester & Ellesmere Port to provide them with originals ready for printing.

South Manchester CHC has discovered that GPs are refusing to prescribe Nicorette Nasal Spray to people who are trying to give up smoking. Three local women have been refsed the spray by their GPs, despite Virginia Bottomley's call on health professionals to take every opportunity in helping people to quit.

Alison Ryan, Chair of the CHC, commented:

> "There seems to be confusion amongst GPs as to whether the Government has banned the prescription of this spray. Although nicotine gum and patches are banned, sprays are not.
>
> "It is bizarre that NHS prescriptions for methadone to heroin addicts and valium to alcoholics are given, but yet again those trying to quit smoking are singled out for cuts in NHS provision."

The CHC believes that the Manchester Health Commission should use its authority to make sure the spray is prescribed.

CHC PUBLICATIONS

Health services in Oldham for people with multiple sclerosis
Oldham CHC, 13 pages

In interviews with 30 Oldham people who have MS the CHC was forcefully struck by the fact that they had to make all the running to get the services they needed. Although GPs, nurses and social workers were seen as helpful, they were not proactive, but tended to respond to demands for help. Those who are reluctant to make demands therefore come off badly.

Shortfalls in service concerned physiotherapy (much appreciated insofar as it was available), patchy coverage of district nursing services and inadequate bathing services. Responsibility for bathing is a matter of contention between health and social services and in any case is not frequent enough. On occasions, people go a whole month with one "all over wash". Continence services were criticised for inflexibility and insufficiency. Some people did not meet the criteria for receiving continence pads, although they sometimes need them. In addition, carers, already with enough on their plates, have to go to centres at prescribed times for supplies – the CHC suggests that there could be a delivery service as there is already for children. People were satisfied with the service for providing aids, though not with their ugly design. They were far from satisfied with the system for arranging major adaptations, and their cost.

Inevitably, being told that one has MS is a distressing experience. Some people's distress can only have been heightened by the way the information was given – or not given. In some cases, family members were told of the diagnosis, but told to keep it from the patients; another woman found out that she had MS only when she was admitted to a ward with many other MS patients in it. GPs were seen as better in giving information honestly and with understanding than were consultants.

IN BRIEF

Report of Respite Care Conference
Bristol & District CHC, 16 pages

A major theme emerging from this conference was the need for information to assess needs and to enable people to know what facilities are available and how to access them. Another theme was the need to coordinate services better. To this end, common funding, guidelines and standards need to be shared between agencies. The CHC also recommends that respite beds in private homes should be block-purchased to enable a planned approach and domiciliary provision should be extended.

A very present help ...? A survey of patients aged 65 and over, discharged from Pilgrim Hospital, Boston
South Lincolnshire CHC, 32 pages

This report evaluates discharge protocols and to present patients' views of Care Management. In general the survey respondents gave positive answers to questions about discharge, though there were some problems: having to wait around on the day of discharge (for medicines/transport etc.); 19% were not told what to avoid doing when they got home and 10% felt they were not well enough to go back home. On the whole Care Management worked well, with a couple of worrying lapses: one woman, for example, did not receive the expected meals on wheels for five days. The CHC concludes that, overall, services do indeed provide "A very present help".

IN BRIEF

In for a day: Patients' perceptions of day surgery in North Tyneside General Hospital
North Tyneside CHC, 107 pages

This report is based on 18 interviews with people who had experienced day surgery and a questionnaire filled in by 110 patients (73% response) at least four days after day surgery. (Percentages below refer to the questionnaire survey.)

For some people day surgery clearly works very well. Most were very satisfied with the decision to have day surgery. Two people (2%) were not satisfied and 20% only "reasonably satisfied" – some were apprehensive about the short stay. The CHC comments that fuller discussion with the patients about their worries might have helped. Many people were very glad to get home quickly and experienced no more pain than they expected. Though most were "just a little worried" before the operation, this is hardly surprising for people about to undergo surgery. However, a number of people experienced problems of one kind or another, some of which could be solved for future patients. Problems revolved around: information, the opportunity to ask questions, not feeling fit enough to be discharged and unexpected levels of pain.

Thirty seven per cent of respondents had had a preoperative assessment before the day of surgery. The great majority found it reassuring. However, the amount of worry reported by patients was not statistically linked to whether they had had such an assessment. By contrast, receiving written information before the operation was significantly linked with feeling "not at all worried". Similarly, patients who had previous experience of day surgery were significantly more likely to be "not at all worried".

Six per cent of respondents (so probably around 14 patients a month) did not feel well enough to be discharged. Some felt rushed, but didn't want to make a fuss. One respondent commented that "disorientation after anaesthetic is not the best situation in which to argue" and another two commented that they could have done with another hour in bed or sitting somewhere.

Once people had returned home, 35% experienced more pain than they had expected, though most did nothing about it. The CHC comments that this may be because staff use phrases such as "slight discomfort", which can be misleading. It suggests that counselling *after* the operation might help in giving people more accurate information about how much pain they are likely to experience and how incapacitated they are likely to be for the next few days.

Lastly, there were some problems with timing of operations (and hence waiting on the day of admission) and with staff seeming rushed. Improved scheduling of operations and scheduled contact after the operation might relieve both these problems.

For the record

Patient Information Survey
East Yorkshire CHC, 18 pages + hospital information booklet

Back home: discharge survey from Bassetlaw District General Hospital
Bassetlaw CHC, 64 pages

A survey to study the practical accessibility for people with a visual impairment in existing buildings at Wordsley Hospital
David J.S. Harley, Dudley CHC, 11 pages

Accessibility survey 1994 – covering NHS establishments and the CHC office
Central Nottinghamshire CHC with help from DIAL, 61 pages

Survey of South Manchester clinics and health centres
South Manchester CHC, 31 pages

Leighton Hospital Crewe: outpatient department survey
Crewe CHC, 20 pages

Aggression in GP surgeries
Barking, Havering and Brentwood CHC, 15 pages

How do we get to our out-patient appointment? (And why do we sometimes miss it?). A survey of travel by patients to out-patients clinics at Frimley Park Hospital
West Surrey and North East Hampshire CHC, 23 pages

OFFICIAL PUBLICATIONS

Urgent and emergency admissions to hospital

Clinical Standards Advisory Group, 90 pages, £10, HMSO. Government response available free of charge from BAPS, Health Publications Unit, Heywood Stores, Manchester Road, Heywood, Lancs, OL10 2PZ.

This study's main aims were to examine the timing of various stages in the route taken by patients attending for emergency attention (doctor first attending patient, initial clinical action, admission to a bed and definitive clinical management) and to follow up patients' medical records in order to investigate associations between early actions and outcome at 28 days.

There were extreme variations in the time between arrival at hospital and admission to a bed. An average of 39% of referrals were admitted to a hospital bed within an hour, but this ranged between hospitals from 2% to 84%. Hospitals in the South East performed significantly worse on this count than hospitals elsewhere. The most common explanation for delays in admission were no bed (43%) and no doctor (16%). The most common reasons for delay in starting definitive clinical management were no doctor (50%) and no theatre (27%).

Twenty-eight days after admission, 83% of patients had been discharged home, 11% were in convalescent homes or hospitals and 6% (range 2%-10%) had died. Hospitals which had admitted a high proportion of patients within two hours of arrival, were significantly more likely to have lower death rates. (One should not, however jump to conclusions about the reason for this – it could be that a policy of admitting terminally ill patients leads both to more pressure on beds and to higher death rates, for example.) The reasons for this association are being investigated further.

Among the Group's recommendations are:

- urgent moves to provide 24 hour availability of emergency theatres;
- the appointment of bed managers (of adequate seniority) to operate a 24 hours service;
- moves away from "consultant owned" beds to bed pooling schemes;
- review of staffing levels and distribution.

The Government response to the recommendations listed here (and many of the others) is that "this is a useful, though not necessarily exhaustive, checklist of issues which hospitals will wish to consider in the light of local priority and available resources." See *News* section for new waiting time targets for A&E.

Report of the brain injury rehabilitation conference, Peterborough, March 1994

Department of Health, 23 pages, copies available from BAPS, Health Publications Unit, No 2 Site, Heywood Stores, Manchester Road, Heywood, Lancs, OL10 2PZ.

Report of the Advisory Group on Osteoporosis

Department of Health, 86 pages, copies available from Central Print Unit, Department of Health, Room 285D, Skipton House, London Road, London SE1 6LW; phone: 0171 972 1670

Transitional costs: the case for better management

(Concerning the costs of reducing the size of existing mental health facilities , double running during transfer to services in the community and one off costs incurred during closure programmes)

NHS Executive, Mental Health Task Force, 19 pages, copies available from BAPS, Health Publications Unit, DSS Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs, OL10 2PZ.

Clinical audit in primary health care

Report to the Clinical Outcomes Group by the Primary Health Care Clinical Audit Working Group, Department of Health, 62 pages

CHCs should have received copies of Patient Perception Booklets on:

- Accident & Emergency Departments
- Incontinence
- Epilepsy
- Multiple Sclerosis
- Stroke
- Children with hearing impairment

All are produced by the NHS Executive
Further copies are available from BAPS, Health Publications Unit, DSS Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs, OL10 2PZ.

Voicing needs: advocacy and empowerment
Video produced by the Mental Health Task force of the NHS Executive to show how advocacy projects can benefit not only the users of services, but also managers and professionals.
Copies have gone to local authority directors of social services, health authority purchasing directors and service user groups.

Have you a complaint about a family doctor, dentist, chemist or optician?
CHCs should have received copies of this leaflet produced by the NHS Executive. Further copies are available from BAPS, Health Publications Unit, Heywood Stores, Manchester Road, Heywood, Lancs, OL10 2PZ.

IN BRIEF

Improving your image: how to manage radiology services more effectively
Audit Commission, 76 pages, £11, HMSO. Copies should have been sent to CHCs

Evidence to the Audit Commission suggests that around 20% of X-rays carried out in the UK are inappropriate (some are never even reviewed by the clinicians who asked for them). This may be due to worries about legal liability, uncertainty on the part of doctors or a wish to reassure patients. Not only do unnecessary X-rays cost about £20 million a year – more importantly over-exposure to X-rays can carry a health risk. The report recommends that doctors follow the guidelines produced by the Royal College of Radiologists on using radiology services.

Review of contracting: The third national review of contracting 1994
NHS Executive Purchasing Unit, 43 pages, copies available from 0113 254 5313

This report is based on a postal/phone survey of English DHAs, which achieved a 100% response rate. It looks at developments in main contracts, extra contractual referrals and contracts for specialised services. Respondents were asked about changes over the last year, and changes expected in the coming year. There appears to be a trend towards more "sophisticated" contracts, entailing more disaggregated information, and more detailed specifications. A section on other issues found that 36% of DHAs had gone to arbitration in setting 1994/95 contracts. Another finding is that 86% of DHAs had contracts with non-NHS sectors of which 33% were with the voluntary sector and 30% with the private sector.

IN BRIEF

GENERAL PUBLICATIONS

Serving two masters: consultants, the National Health Service and private medicine
Dr John Yates for Dispatches, Channel Four Television.
For copies please send an A4 envelope with two 25p stamps to Dispatches: Serving two masters, PO Box 4000, London W3 6XJ

Perhaps the new targets for out-patient appointments will play a part in rectifying the situation described in this report, namely the great disparity between waiting times for private and NHS treatment and the variation of waiting times within the NHS. The average waiting time for NHS orthopaedic out-patient appointments is 25 weeks, compared to two weeks for the private sector. Some NHS hospitals underline the *year* of the appointment on appointment cards to stop patients coming 12 months early. Many patients in long queues for NHS treatment would see the same surgeons months earlier if they had insurance or could afford to pay privately. Dr Yates (who headed the Government's task force on waiting lists in the 1980s) highlights a number of "coincidences", for example that specialties with the longest NHS waiting lists are also the specialties with the highest private sector earnings.

Part of the deal when the NHS was set up was that consultants could hold "maximum part-time" contracts with the NHS. This allows them to take on private work with no constraints on earnings in exchange for forgoing a proportion of their NHS salary (currently one-eleventh). The theory is that the health authority can expect "as much" from the consultant on a maximum part-time contract as on a whole-time contract. The consultants can, however, take on private work during normal NHS work hours. For years there was no clarity about how much they could take on. In 1990, for the first time, Duncan Nichol, then Chief Executive of the NHS, set a guideline that they should not undertake more than one *planned* private session a week, though cases would need to be considered individually. The BMA subsequently rejected Duncan Nichol's guideline. The Government said that it was his personal view, and not Government policy.

The House of Commons Public Accounts Committee noted that, even with the guideline, health authorities need a more accurate picture of the level of consultants' NHS and private commitments, partly to ensure that consultants are not putting patients at risk by working excessive hours. The House of Commons Health Committee and Welsh Affairs Committee both called for the Health Department to carry out a study to determine the influence of private practice on waiting lists and waiting times. None of the committees met with a positive Government response.

Dr Yates attempted to find out how much time consultants spend in private work (private consultations and operating time). He estimates that the average surgeon is spending about 2.3 hours per week on operations in normal working hours, with a wide variation between surgeons. Travelling time and immediate pre- and post-operative care must be added to this estimate. A survey of orthopaedic surgeons and ophthalmologists indicated that 58% of the surgeons devoted two or more sessions a week to private consultations. Overall, surgeons in these specialties are likely to be spending an average of three half-days a week on private work.

The report closes with a call for a rigorous enquiry and urgent clarification, involving three steps:

- gathering detailed evidence about private and NHS work done by surgeons;
- producing clear guidance on the contractual obligations of NHS consultants;
- an explanation of why ministers, departmental officials, NHS managers and auditors have been so reluctant to address this issue.

In partnership with patients:
Involving the community in general practice
A handbook for GPs and practice staff
National Consumer Council, 24 pages

This handbook should have gone out to all CHCs, so here is merely a note on the contents:

- Reviewing communications with patients
- Increasing patient involvement in the practice
- Looking at the quality of services
- Making use of patients' suggestions and complaints
- Working with the local community

Mixed sex wards: views of patients, the public, purchasers and providers
Patricia Wilkie and Eileen Tyrrell for the Patients Association, 38 pages, £5

The study on which this report is based included a survey of patients in East London and North West Surrey and a survey of purchasers and providers of acute NHS care across the country. It was widely publicised and members of the public were invited to send their comments.

The findings of the patient survey will be familiar to many CHCs. Ninety-two males and 117 females responded to the survey. A large majority (77%) would prefer to be on a single-sex ward, with women more likely to express this preference than men (83% and 66% respectively). In fact, 54% were on mixed sex wards, of whom 41 said that they were in a bed close to someone of the opposite sex. Very few indeed were asked about their preferences. The general strength of feeling on the subject can be gauged by the fact that 600 members of the public wrote in with their comments, all but four of whom objected to mixed sex wards. The letters also reveal just how insensitively individuals can be dealt with. One visitor wrote, for example, that a teenager was the only female patient among five male geriatric patients. "Her self consciousness was obvious as she lay with the sheet pulled up to her chin .... She admitted she had trouble sleeping." Another woman was asked about her periods in the hearing of men in the same bay, although she had earlier informed staff that she was unhappy with the bed arrangements.

Given the strength of feeling among a substantial proportion of patients, it is amazing how little has been done by providers and purchasers to address the issue of mixed wards. Only 16 acute sector purchasers responded to the survey. Of these only two specified in their contracts whether patients will be nursed in mixed sex wards. Only three have a policy about purchasing care which includes nursing patients in mixed sex wards. The others had no such specifications or policy. Of 71 providers, 16 have a policy about mixed sex wards and 29 were considering introducing a policy. Both purchasers and providers mentioned that if patients didn't like the arrangements, they could complain. The Patients Association finds this quite unacceptable, since the simple truth is that most people won't complain.

As a result of the new Patient's Charter targets, the situation may improve somewhat, especially in relation to washing and toilet facilities and being informed in advance. However, the Patients Association is clear that the requirement on hospitals to give people an option where possible is not adequate. Non-emergency patients will have been waiting some time. Do these patients not state a preference and "hope for the best", or do they state a preference and hope that this will not delay their admission for an indefinite time?

Half a century of promises
Alan Walker's Graham Lecture to honour Counsel and Care's founders, Bob and Joceline Graham
Counsel and Care, Twyman House, 16 Bonny Street, London NW1 9PG; Phone: 0171 485 1550

For 50 years, politicians have been eloquent in their support of community care. In all that time, no Government has lived up to its rhetoric on the subject. Professor Walker describes how, as early as the 1940s, when proposals for community care were developed, there was never any legislative commitment to ensure its delivery for older people, as there had been in the case of non-institutional care of children.

The unfulfilled consensus started to break down at the end of the 1970s. Policies of promoting the private sector, closing long-stay hospitals and marginalising social services as care providers in practice pushed older people, not into care in the community, but into residential homes. While there are still few private domiciliary services, beds in private residential homes trebled during the 1980s. Many residents occupy them only because there is no reliable community-based alternative. What is more, new private homes are skewed towards younger age groups of elderly people with fewer needs.

Professor Walker explains why large numbers of providers do not guarantee individual choice for elderly people. Most people have no choice either in choosing their home or in controlling its arrangements once they are residents. What is more important than theoretical notions of choice is good quality provision. He sets out a vision of how this could be achieved on the basis of rights to expanded home care provision financed through general taxation.

INFORMATION WANTED

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.

Northumberland CHC is embarking on the production of an information pack on **palliative care for patients and relatives**, to include:

- general guidance on care;
- detailed information on local services;
- pointers to sources of further information and support.

The CHC would like to hear from any other CHCs which have carried out similar work.

Llanelli-Dinefwr CHC is considering a proposal to **manage a health information line**. The service will be jointly funded by the health authority, the social services department and the CHC. The CHC would like to hear from other CHCs involved in similar projects.

South West Surrey CHC would like to hear from CHCs which have a system of monitoring the views of people **complaining about the CHC's service/help** with their case. ACHCEW would also be grateful to be sent any information on this topic.

Could CHCs please send copies of their **Annual Plans** to ACHCEW so that we can develop a collection – and many thanks to the CHCs which have already done so.

Last August SE Staffs CHC sent a request, on behalf of the **Restricted Growth Association,** asking for information on orthopaedic and paediatric facilities in their areas, with special reference to restricted growth. The Association does not have the means to reply personally to every CHC which sent information, and so has asked us to pass on its thanks. The information, which proved very useful, has been collated for use in a mailshot on the issue.

FROM THE VOLUNTARY SECTOR

Are your health messages understood?

Access to health information and screening services: breaking the barriers of literacy

Community Health UK is running a three-year project:

- to promote awareness of literacy barriers in the presentation of health information by poster, leaflet and public announcement;
- to initiate and support changes on behalf of people with low levels of literacy whose first language is English;
- to develop work in conjunction with service users.

The group intends to develop a resource pack showing best practice in communicating local news on services.

Community Health UK would like to hear from anyone with an interest relating to "easy reading" health information material and would be grateful for examples of good and bad practice in written information.

As part of the initiative, the group will be holding a free seminar in Bath on 3 April 1995. Participation will be by invitation to a selection of those who contact the group expressing an interest. The seminar will focus on barriers in the way of those with poor reading skills.

If you are interested, please contact: Melanie Doherty, Project Development Officer, Community Health UK, 6 Terrace Walk, Bath BA1 1LN. Phone: 01224 462680; Fax: 01225 484238.

Deadline

If you have items for inclusion in the next issue of *CHC News*, could you please get them to ACHCEW by 7 March.

FORTHCOMING EVENTS

Back to the future: the development of disability information services

- the National Disability Information Conference and Exhibition
- includes a choice of sessions on many topics
- on 23–24 March 1995
- at the East Midlands Conference Centre, University of Nottingham
- £75 (inc VAT). This includes accommodation on the night of Thursday 23 March. If you want to come on the Wednesday (£22.20 extra) contact the address below.

There are a limited number of bursaries available for some disabled people (bringing fees down to £16.25 or £38.45 if you come on the evening of Wednesday March 22). If you would like to take advantage of this contact the address below **IMMEDIATELY**. Special forms must be returned by **25 February.**

Further info from:
Helen Kinnings
Policy Studies Institute
100 Park Village East
London NW1 3SR
Phone: 0171 387 2171

Locality purchasing: models, progress and issues

- two day seminar
- on 27– 29 March 1995
- at School for Advanced Urban Studies
- £279 including all meals and accommodation
- a limited number of bursaries available.

Further info from:
Deborah Marriott
Phone: 0117 946 6984

Primary care led purchasing

- to consider the impact of GP fundholding on patients, providers, health authorities & FHSAs
- organised by Gate House
- on Wednesday **1 March 1995**
- at Queen Elizabeth II Conference Centre, Westminster, London SW1
- £195 + 34.13 VAT

Further info from:
Jacky Barry
Gate House
St Barts Hospital, London EC1A 7BE
Phone: 0171 726 4311

DIRECTORY AMENDMENTS

Page 3 North West
Add: **North West Regional Association of CHC Chief Officers**
This Association was established on 11 January.
Chris Dabbs, Salford CHC, has been elected chairperson.
The details of the secretary and address will follow.

Page 13 Islington CHC
Change of address
164 Holloway Road
London N7 8DD
Phone: 0171 609 6096
Fax: 0171 609 4015

Page 26 Chester & Ellesmere Port CHC
New mobile phone no: 01831 308043

Page 28 Preston CHC
Chief Officer: Mrs Angelene True

Page 30 Clwyd South CHC
Fax: 01978 366866