CHC NEWS

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

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NEWS

Prescription charge rises by 10.5%

April's rise to prescription charges has been announced. They are to go up by 50p to £5.25. At 10.5%, this is three times the current rate of inflation. Prescription charges were 20p in 1979.

- Season tickets are to go up to £27.40 (four months) and £74.80 (a year).
- The maximum fee for a single course of dental treatment will rise from £275 to £300.
- Charges for items such as elastic stockings and tights will also rise at 10.5%.
- The increase in the value of optical vouchers, however, is to rise more or less in line with inflation – up by 3.25% on average.

Responding to widespread criticism of the increase in charges (from the BMA, the Royal Pharmaceutical Society and Opposition MPs) , health minister Gerald Malone pointed out that 81% of prescriptions are now dispensed free of charge (mainly to people on very low incomes) compared to 60% of prescriptions in 1979. The average cost of an NHS prescription is £8.80, although now over half of prescriptions cost the NHS less than £5.25.

The DoH estimates that evasion of prescription charges costs the NHS £30 million a year. To clamp down on fraud it is introducing a new prescription form to be introduced from 1 April. Patients exempt from charges will be required to tick one of 13 boxes on the form, give their name and sign a declaration. Those holding a current NHS charges certificate for full help (AG2) will be required to fill in their certificate reference number (at present this requirement applies only to War/Service Pensioners). Patients who are not exempt will be required to fill in how much they have paid.

The Royal Pharmaceutical Society is seeking confirmation that pharmacists will not be responsible for checking patients' eligibility for exemption, but merely that they have ticked a box and signed it. Pharmacists believe that even this will increase the time they have to spend explaining to patients how to fill in the form. However, without checks on individuals, it is not clear how simply giving patients a wider choice of boxes to tick and asking for a signature will reduce deliberate fraud.

Hansard 22 February col 219, Independent/Guardian 23 February, Telegraph 24 February, Pharmaceutical Journal 25 February

Guidelines on board appointments cut little ice with Nolan committee

The Nolan committee, which is looking into standards in public life, has reacted coolly to the new guidelines on the appointment of chairmen/women and non-executive members of trust and health authority boards (see *CHC News* No 100). Surveys have found that about 40% of NHS trust board members have Conservative links. About 6500 appointments (900 a year) are ultimately the responsibility of the Health Secretary. Giving evidence to the Nolan committee, Alan Langlands, chief executive of the NHS, said that *Mrs Bottomley rejects about 10% of proposed* NHS trust board members. The Nolan committee has revealed that it has received more complaints about Tory placements on NHS trusts than about any other subject – it is of the opinion that the new guidelines are inadequate to restore public confidence. It was disappointed that sifting panels would not be required to include an independent element, despite a call from NAHAT for external scrutiny. Mr Langlands said that proposals for a compulsory external element had been rejected, though sifting panels were free to appoint an independent member if they chose.

Telegraph/Guardian 15 February

Charges for compulsory care?

Taken together with the Mental Health (Patients in the Community) Bill published in February (*CHC News* No 99), changes to legislation being considered within the Department of Health might mean that some mentally ill patients discharged from hospital could be required to pay for a compulsory programme of care.

The Mental Health Bill proposes that patients detained under the Mental Health Acts should be required to agree to a care plan before hospital discharge. This could include a requirement to live in specified accommodation or to attend for medical treatment, an occupation, education or training. In addition, the Health Department is reviewing the provision in the Mental Health Act (1983) which states that social service departments cannot charge formerly detained patients for after-care services. This raises the prospect of these patients being required to use particular services and being required to pay for them.

The Mental Health Bill has been criticised by Liberty, MIND and the Community Psychiatric Nurses' Association (CPNA). Under the Bill, an estimated 3000 people would be placed on supervised discharge orders. The orders would authorise their being "taken and conveyed" to a hospital, clinic or place of work, education or training in accordance with their care plan. Community Psychiatric Nurses would probably undertake most of the supervision duties. The CPNA says that CPNs would thus have more powers than any nurse has ever held, with no additional training or backup. The Bill provides for extra costs of £1.9 million a year, but this is to meet only an expected increase in appeals to mental health review tribunals. Liberty has warned that the Bill could contravene the European Convention of Human Rights, a suggestion which has been denied by Department of Health lawyers.

Guardian/Independent 17 February

Welsh CHC boundary changes

The Welsh Office has announced boundary changes to 12 of the 22 CHCs in Wales. After consultation on the issue, the Secretary of State for Wales has decided not to go ahead with the major changes originally suggested. Instead, adjustments are being made "where CHC and local authorities boundaries can be matched up easily". The following changes will be effective from 1 April 1996:

- **Rhymney Valley CHC** will take over responsibility for the present Borough of Islwyn area from **South Gwent CHC**. Rhymney Valley CHC boundaries will be coterminous with the new Caerphilly Unitary Authority (UA).
- Responsibility for most of the present Borough of Colwyn will be transferred from **North Clwyd CHC** to **Aberconwy CHC**, creating a new CHC covering the whole of the new Aberconwy and Colwyn UA area.
- **South Clwyd** and **Montgomery CHCs.** Boundary aligns with Powys and Wrexham UAs.
- **Vale of Glamorgan** and **Bridgend CHCs.** Boundary aligns with Bridgend and Vale of Glamorgan UAs.
- **Swansea-Lliw Valley** and **Neath-Port Talbot CHCs.** The boundary will align with Swansea and Neath & Port Talbot UAs.
- **Cardiff** and **East Glamorgan CHCs.** Boundary aligns with Cardiff and Rhondda Cynon Taff UAs.

Welsh Office press release 22 February

GP retirement scheme scrapped

Health minister, Gerald Malone, has decided to scrap a planned scheme to reward London GPs who "do not feel they are coping" and who take early retirement (see *CHC News* No 95). Under the scheme, under-performing GPs could have been paid up to £143,000 to leave the NHS. When the scheme was first proposed, GP leaders pointed out that it would reward poor performers and not good performers who might want to leave the service. Mr Malone has now accepted this view. Instead more money is to be provided to retrain doctors. The Government is urging the medical profession to make use of new disciplinary procedures to encourage doctors to take up retraining.

Telegraph 17 February

Breast cancer service directory

The Cancer Relief Macmillan Fund has produced a directory of breast cancer services (based on a King's Fund survey) which it is distributing to all the GPs in the country. The directory is not available to the public, though information from it can be obtained through GPs or the National Health Information Service (0800 665544).

The directory lists the services offered by 216 hospitals, including information on staffing, numbers of cases treated annually, facilities on-site and the speed of diagnostic results. Information on success rates is not available. The directory shows that services vary widely: one in twelve hospitals surveyed has no specialist breast surgeon; one in eight has no radiologist with a specific interest in the disease; and one in seven has no oncologist or radiotherapist specialising in breast cancer. According to the King's Fund even these figures, provided through a self-completion questionnaire, may be over-optimistic.

The survey does not appear to support the claim that many women are seen in hospitals which see too few cases. The British Breast Group recommends that a minimum of 50 cases per year should be treated in any one unit. Since only 10% of women referred to specialists are found to have cancer, this implies that a unit should receive a minimum of 500 referrals a year. At this rate, about 250 units would be needed nationwide, each serving a population of between 200,000 and 300,000.

Times 21 February

FOCUS ON ... NHS CONTINUING CARE

The Government has issued guidelines on *NHS responsibilities for meeting continuing health care needs* (HSG (95) 8 – copies have been sent to CHCs). According to the *Independent*, "health authorities, social services directors, the Carers National Association and Age Concern have welcomed its greater clarity." Attempting to summarise what the guidelines say, "clarity" is not the word that springs to mind. The opening paragraph affirms that the NHS has responsibilities "around" rehabilitation, palliative health care, respite health care, community health services support and specialist health care support in different settings, but it is not always clear what those responsibilities are. Eligibility for NHS care will vary between settings ("specialist palliative health care" in nursing homes, but "palliative health care support" in residential homes for example). There is also explicit recognition that the "balance, type and level" of services will vary across the country.

That said, the guidelines do lay down some markers. They will check the rush to close long-stay beds, and possibly lead to some being reprovided, at least in the short term. They make it clear that NHS purchasers have responsibilities for arranging and funding a wide range of services. Where they are not now purchasing a full range of services, they must address this in their 1996/97 contracts. In addition, they should not proceed with plans to reduce continuing care services or alter hospital discharge criteria before finalising policies and eligibility criteria (see below), unless the plans have been agreed with local authorities.

The process

The guidance is clearest on the process to be followed by health authorities, some GP fundholders and local authorities. A timetable is set out for them to agree on local policies. Draft policies and eligibility criteria must be drawn up by 29 September 1995. They should be made publicly available for consultation and be finalised for implementation by 1 April 1996. From that date, health authorities must report annually to the NHS Executive on their planned and achieved level of spending and activity on continuing health care. The new guidelines expire on 1 March 2000 – it would be interesting to know what continuing responsibilities the Government hopes the NHS will have after that date.

Eligibility for in-patient care

Another reasonably clear element is the minimum criteria for eligibility for continued in-patient care. The NHS should arrange and fund care for people:

- who need complex or intense medical, nursing or other clinical care requiring regular supervision of a consultant, specialist nurse or other NHS member of the multidisciplinary team;
- whose need for frequent, not easily predictable, intervention requires the regular supervision of these staff;
- who require routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff;
- have a rapidly degenerating or unstable condition requiring specialist medical or nursing supervision;
- who are already in-patients and are likely to die in the very near future.

If a patient meets the eligibility criteria for continuing NHS in-patient care but a bed is not available, the agreement of the health authority should be sought for an extra contractual referral to another hospital or nursing home in the NHS or independent sector.

Curtailments in eligibility for NHS care

The National Health Service Act 1977 section 3(1) states that:

"It is the Secretary of State's duty to provide ... to such an extent as he considers necessary to meet all reasonable requirements -

(a) hospital accommodation;

(b) other accommodation for the purpose of any service provided under this Act

(c) medical, dental, nursing and ambulance services;

...

(e) such facilities for ... the after care of persons who have suffered from illness as he considers are appropriate as part of the health service; ..."

Before the explosion in numbers of private nursing homes, patients' nursing needs (not necessarily specialist – see (c) above) would have been seen as the responsibility of the NHS. Under the new guidelines specialist medical and nursing care and community health services should be provided to residents of nursing homes, residential care homes and their own homes by the NHS. However people now

ineligible for in-patient NHS care may still have nursing needs which fall in the gap between "specialist nursing care" and community health services support. Presumably these people, who might once have been long-stay NHS patients and at least covered by (e) above, are now expected to move into nursing homes and receive means-tested care.

In this context, discharge procedures are important. The new guidance replaces the Health Circular HC (89) 5. It retains the right in the earlier guidance of patients (except for those being placed under Part II of the Mental Health Act 1983) to refuse to be discharged into a nursing home or residential care home. However, the new guidance adds that, where no agreement is reached, it may be necessary "to implement discharge to the patient's home or alternative accommodation with a package of health and social care within the options and resources available. A charge may be payable by the person to the social services department for the social care element of the package". It does not say what should happen to a person who refuses to be admitted to a nursing home, but whose nursing needs cannot be met by such a package.

Review panels

Patients, their families and carers are to be given the right to ask the health authority to review a decision about eligibility for NHS continuing in-patient care. The health authority should respond within two weeks. Normally, the health authority should seek advice from an independent panel, though it is not compelled to do so, nor to abide by its decision. Detailed guidance on these panels will be issued by the end of June.

Reactions

The British Medical Association has responded to the guidance, saying that it "clearly signals the end of the welfare state providing free care from the cradle to the grave". By shifting the emphasis from the NHS to social services "that simply means that many long-term patients will face means-tested care".

The president of the Association of Directors of Social Services, Robin SeQueira, commented that the guidance "clearly circumscribes the right of elderly people to continuing health care free at the point of use". Although he hoped that variations across the country will not be too wide, "they could be very wide". It is important to patients how much of the care provided in their own homes falls within "social care for which social services departments can charge". The *Independent* comments that "none have yet sought a legal charge on an individual 's house to be recovered when they die, but several are contemplating that. "

Mr SeQueira, Dr Sally Greengross, director general of Age Concern, and Christine Hancock, general secretary of the Royal College of Nursing have all called for a full inquiry into the funding of longer-term care. Christine Hancock raises two particular concerns: firstly, the position of patients due for discharge in areas where social services are being curtailed as community care budgets are exceeded and, secondly, the local determination of eligibility criteria for NHS care. Review panels may be of some help in this area, but she questions whether panels can be sure they are making the right decision without some indication of nationally acceptable criteria.

Guidelines, Independent 24 February, Guardian 8 March

PARLIAMENTARY NEWS

Single sex wards

A Bill to give hospital patients a statutory right to be treated in single sex wards has been introduced in the House of Lords by Lord Stoddart of Swindon. In the second reading, the Bill received cross-party support.

It was opposed by Lady Cumberlege, who spoke for the Government. She argued that the Bill would "impede the provision of quality clinical care, shackle management and introduce rigidity" and that there was "a problem in defining 'a ward'". Lady Cumberlege added that the proposals would be impractical in emergency situations such as a natural disaster.

The Bill passed its second reading (as is conventional in the Lords) and its committee stage. Without Government support, it has no chance of becoming law.

Healthcare Parliamentary Monitor, Issue148

ACCOUNTABILITY

Virginia Bottomley gave the following list when asked in what ways openness and accountability are promoted in the Department of Health and the NHS. We have grouped the items under our own headings and reworded some for the sake of brevity.

National Health Service

- accountability through ministers to Parliament

Publication of information

- annual reports and audited accounts of health authorities and trusts
- local purchasing strategies and plans
- consultation documents on major proposals with background and options
- summary business plans by trusts
- annual plans and reports by GP fundholders
- reports by directors of public health on local needs and services
- league tables
- registers of members' interests
- contracts for health services including quality and quantity
- information on complaints
- reports on Patient's Charter standards

Meetings

- health authority meetings open to the public
- NHS trusts' annual public meetings

Rights/standards/codes

- patients' rights and national and local standards under Patient's Charter
- codes of accountability and conduct for members of NHS bodies
- statutory rights of access to personal health information

Consultation

- statutory obligation to consult on substantial changes of service
- statutory rights for CHCs to be consulted on substantial changes to services and to obtain information

Scrutiny

- audit and remuneration committees
- by Audit Commission

Other

- power to patients through GP fundholders to ensure more accountability of providers

Further plans

- code of practice on openness in the NHS
- accountability framework for GP fundholders
- new procedures for appointments to NHS bodies [now published]
- a response to the Wilson review of NHS complaints

Department of Health

- accountability of ministers to Parliament

Publication of information

- annual departmental report
- NHS annual report
- Chief Medical Officer's annual report
- Social Services Inspectorate annual report
- detailed information bulletins and reports
- framework documents and published reports of the Medicines Control Agency, Medical Devices Agency, NHS Estates Agency and NHS Pensions Agency
- reports and accounts of the Youth Treatment Service
- statements from all agencies adopting Citizen's Charter principles

Scrutiny

- estimates and appropriation accounts scrutinised by the National Audit Office and the Public Accounts Committee
- accountability to select committees

Codes/standards

- code of practice on access to Government information
- a charter for members of the NHS pension scheme [being produced]
- NHS Estates Agency accreditation for British Standard 5750

Responses

- responses to letters
- responses to Parliamentary Questions

Hansard, 17 January, cols 441-2

Other written answers

Aggregate savings made by GP fundholders in Wales:

1991/92	£40,000
1992/93	£454,000
1993/94	£4,120,000
1994/95 (estimate)	£6,000,000

This excludes £137,000 of savings on pilot projects which were surrendered and reallocated by the Department of Health.

In 1993/94, the biggest savings were made in Gwent (£1.08m), Powys (£876,000) and Clwyd (£832,000).

Hansard, 24 February, col 373; 28 February, col 504

The following business plans have been approved under the private finance initiative since 3 November 1994 (when health ministers last gave estimates in a Written Answer).

Royal Victoria Infirmary & Associated Hospitals NHS Trust
Multi-storey care park £3.2m

Eastbourne Hospitals NHS Trust
clinical waste incinerator £3.0m

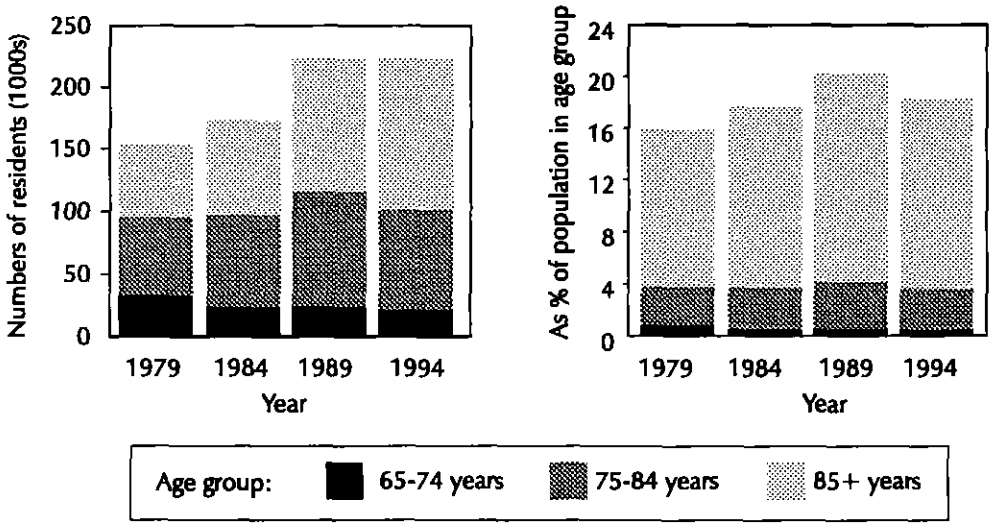
Merton, Sutton & Wandsworth HA
residential accommodation £1.0m

Mid-Downs HA (Princess Royal Hospital)
magnetic resonance imaging £1.0m

Hansard, 27 February, col 420

Residential care

Long-term residents in residential care homes for elderly and physically and/or sensorily disabled people, England



Information not available centrally

Costs per person to public funds of those receiving continual residential care
Estimates for the total number of people who require residential care

Hansard, 28 February, cols 495-6

Carers (Recognition and Service) Bill

A Bill that would give carers a right to be assessed for social services to meet their own needs has received unexpected backing from the Government. The private member's Bill has been proposed by Malcolm Wicks, Labour MP for Croydon North West. The Association of Directors of Social Services estimates that the Bill would cost local authorities at least £280 million. The association has called on the Government to provide additional resources to meet the need. *Independent 8 March*

NEWS FROM ACHCEW

CHC Black Members' Group

Khurshid Alam, who is Chief Executive of the National Association of Racial Equality Councils and is himself a CHC member, has approached ACHCEW with a view to establishing a CHC Black Members' Group. Such a Group would be independent of ACHCEW, and would provide a forum in which black CHC members could pursue common interests and initiatives.

Any black members who are interested in the initiative should contact:

Mr Khurshid Alam
Chief Executive
National Assoc of Racial Equality Councils
8/16 Coronet Street, London N1 6HD
Phone: 0171 739 6658
Fax: 0171 739 1528

AROUND THE CHCs

The Coordination and Development Unit of **North Thames CHCs** has surveyed the complaints catchment policies of CHCs in the region. There was considerable divergence in how CHCs handle complaints from non-residents about local providers and from residents about non-local providers, though a number of CHCs indicated that they would deal with complainants flexibly. Neighbouring CHCs, particularly those within the same health authority district, have begun to develop reciprocal arrangements. North Thames CHCs are to hold a workshop on this topic at ACHCEW's AGM.

On 15 February, Tessa Jowell, MP for Dulwich, launched **Southwark CHC** and Southwark Carers' *Listen to Carers* campaign which is calling for real services to the borough's 30,000 carers. The campaign is calling for the immediate provision of a new range of services and a ten-year plan to provide services to carers based on need. It is calling on Lambeth, Lewisham & Southwark Health Commission to commit 0.5% of its revenue budget to developing direct services for carers, increasing by 0.5% every year until 2005. It suggests that the health commission should employ a full-time worker to implement its Strategy for Carers and that the Government should create a junior ministerial post to take on specific responsibility for carer issues.

North Tees CHC has drawn up a *Research Protocol and Guidelines* which it will apply in every research project which the CHC undertakes either in its own right on in partnership with other agencies. The guidelines draw on the general principles in recognised codes of conduct. Where the CHC cooperates with another agency in research, it will ask the agency to sign an agreement which recognises the guidelines. The CHC is very optimistic that they will receive wide acceptance: they have already been adopted by the local purchaser and are being considered by the local community and acute trust and by social services.

North Tees CHC has also been involved in drawing up a *Consultation Protocol and Guidelines* developed by the three Cleveland CHCs (**Hartlepool, North Tees and South Tees**) and the local purchaser (Tees Health). The document presents a clear (not necessarily exhaustive) list of subjects on which CHCs will be consulted and recognises that CHCs should be involved an early stage whenever Tees Health is contemplating strategic or operational change and development. The guidelines have been developed to encourage open discussion, though they confirm that CHCs have a right to object to a final decision even if they have been involved in discussions. An appendix lists subjects for consultation alongside possible consultation methods in each case. Some subjects will require routine consultation, though timetables will vary according to the content of individual items. The appendix sets out specific timetables for this and the coming year.

North Tees CHC would like to hear from any CHCs that have entered into similar written undertakings with their health authorities, and particularly if the agreement involves more than one CHC.

Copies of both protocols are available to other CHCs free of charge from North Tees CHC.

CHC PUBLICATIONS

Sacrificing dignity for efficiency:
a report of a survey of policies, practices and preferences on mixed sex hospital wards
Nikki Joule for GLACHC, 40 pages, £10

This study forcibly reiterates what surely by now must be common knowledge: that many patients strongly object to being placed on a mixed sex ward. The Royal College of Nursing estimates that, despite the widespread objections, over half of all acute hospital wards are now mixed.

Last month *CHC News* reported on a survey in which providers and purchaser commented that if patients didn't like the arrangements, they could complain. An interesting point raised by one CHC is that people often do not complain directly about mixed sex wards, but that the issue is frequently raised as part of a complaint which is ostensibly about something else. Surveys on the issue generally find many people who object to mixed sex wards, but a fair proportion who say they "don't mind". One respondent to this survey suggests that some of these people "are not expressing *preference,* but *acceptance* of NHS treatment whatever the regime" – a suggestion backed up by a *Nursing Times* study.

GLACHC reviewed existing evidence from London, carried out a postal questionnaire survey of CHCs and DHAs in the Thames Regions and invited comments from members of the London Health Alliance. It was also inundated with letters and phone calls from individuals wanting to state their views. Much of this report details patient concerns.

What is being done?

Of 22 DHAs which responded to the survey, only seven had a specific policy or specifications related to mixed sex wards. A few were currently reviewing standards for next year's contracts, but many DHAs rely on providers to interpret the Patient's Charter Standard as they see fit. Asked about difficulties in operating policies with regard to mixed sex wards, DHAs were most likely to refer to pressure on beds, exacerbated by high levels of emergency admissions. One outcome of this pressure is that men and women may be mixed in small bays. In some ways this is worse than being on a larger mixed sex ward. In many cases, the capital costs of changing structures in order to achieve adequate privacy were seen as a major constraint.

It is surprising that in a number of cases staff do not appear to be sensitive to the issue of mixed sex wards. A number of CHCs reported instances of men and women not being placed in single sex bays or at opposite ends of a Nightingale ward, when this could have been done. On one CHC visit most patients speaking to the CHC said that they objected to being in mixed sex bays, and staff told the CHCs that if patients objected, they would try to move them. As the CHC notes, this is not good enough as many patients may be reluctant to speak out.

Some hospitals and health authorities are making efforts to address the problems. In some, procedures state that people should be put on a same sex ward even if it is in the wrong specialty (unless the facilities are not appropriate) or that extra beds should be put on wards or in bays until a space on a same gender ward in the correct specialty becomes available. In other cases, clinical specialty overrides any consideration of gender. Purchasers can flex their muscle over these issues, though many shrink from doing so. East Sussex Health Authority expects a 90% compliance rate with its specification that sexes in bays or rooms should not be mixed (other than in high dependency areas) and may impose penalties if this is not met. One local commissioner has floated the idea of moving a contract to a hospital which did provide single sex bays.

In her conclusions, Nikki Joule points out that the practice of mixing the sexes inappropriately is a casualty of the competing demands of patient need and the demand to improve throughput and efficiency. She argues that hospitals need flexibility to leave beds empty from time to time without being penalised as being inefficient. Bed occupancy rates in London commonly run at 90–95% and often at 100% or over. Lowering this rate would not necessarily be less efficient since it would enable better planned provision. She also calls for capital funding to enable the provision of single sex facilities and for a revised Charter Standard which would establish single sex provision as the norm and not the exception.

Information and communication survey
Health Watch Project, Warrington CHC, 51 pages

This survey aimed to obtain views on the accessibility and quality of written information and on the quality of communication between patients and staff in GP practices and hospitals. The report presents both quantitative and qualitative results. GP practices had a good supply of information leaflets, but not of the Patient's Charter. It would be helpful if both they and hospitals could display a list of leaflets available on request or from other sources. Over 40% of respondents did not want a say in how their GP surgery is run. Despite high overall levels of satisfaction, comments show that individuals experienced problems in communicating with staff in both GP surgeries and hospitals.

Continence service satisfaction survey
Rochdale CHC, 18 pages

The issues which concerned continence service users most were choice of products, quantity provided and information. Having the right product is very important for users' quality of life, but many people do not know who to contact about this, and many would not find it easy to come forward with their problems. Under half the respondents were aware that an emergency service existed: the CHC comments that this information needs to be available to *all* users. A third of respondents said they would be willing to pay for extra supplies, and some are already doing so; 17% said that they received too few products from the service.

Experiences of older people (over 75) on discharge from acute hospitals
Barking Havering & Brentwood CHC in conjunction with Age Concern, 20 pages

Nine key themes arise from this survey, which was based on a questionnaire and interviews. Two of the themes are that the "need for relatively small amounts of service may create significant difficulties" and that "people with complex needs tend to get all the services they need". The authors comment that there is a need to understand what factors (for example length of stay or availability of an advocate) influence subsequent provision of services. With such an understanding it should be possible to make services responsive to individual need and to fast track help to people who may be at risk for want of a relatively small amount of service.

Obtaining CHC publications

If you want copies of any CHC publications, could you please contact the relevant CHC direct (details in directory) and not ACHCEW.

Who benefits?
a survey of health benefits for people in Salford
Salford CHC, 23 pages

Salford CHC sent questionnaires on help with travel costs and prescription charges to the three hospital provider units in Salford. All units have done some work on producing leaflets etc. to alert patients to the Hospital Travel Costs Scheme (HTCS), but efforts at publicity were variable. Training has tended to go to staff who are not involved in direct patient care. Factors affecting accessibility to the scheme (e.g. office opening hours and location) were very variable, as were procedures for checking eligibility and reimbursing people who arrive by taxi. The payment per mile for car travel varied between hospitals. On a positive note, all units provided overnight stay facilities for parents/escorts. Some of the variability must be due to the fact that the scheme has not been discussed in contract negotiations for any of the units. This last point also applies to the two adult provider units in the case of prescription charges reimbursement schemes. One of the 17 recommendations is that access to services for people on low incomes and the management of the HTCS and prescription charge reimbursement schemes should be considered during contract negotiations.

For the record

Survey of patient opinions in the Maternity Unit, Royal Berkshire Hospital, October 1994
West Berkshire CHC, 10 pages

Report of selected out-patient departments
Brighton CHC, 37 pages

Survey of Maternity Service Liaison Committees in London
Briefing Number 23, GLACHC, 356 Holloway Road, London N7 6PA, 9 pages

Children under five with a special need
Community Service Working Group, Dudley CHC, 21 pages

OFFICIAL PUBLICATIONS

Mental incapacity

Law Commission, Law Com No 231, 290 pages, HMSO, £21.85

This substantial piece of work makes proposals for an integrated new scheme for decision making on behalf of those who lack capacity to take their own decisions. Covering personal, medical and financial matters it applies both to those who have a mental disability which renders them unable to make a decision on the matter in question and those who, because of unconsciousness or for any other reason, are unable to communicate a decision.

The report considers the "general authority to act reasonably" (clarifying decisions which can be taken without having to apply for formal authorisation); advance statements about medical care; a new form of power of attorney (this "Continuing Power of Attorney" would permit the delegation of authority over personal welfare decisions, and would not be limited, as at present, to authority over "property and affairs"); independent supervision of medical and research procedures; decision making of courts and arrangements that would be needed in the judicial forum. It includes a section on a proposed emergency protection scheme intended to enable local authorities to protect vulnerable people at risk of harm. The Commission sets out a draft Bill covering all these areas.

An "advance refusal of treatment" would be refusal of any medical, surgical, dental or other procedure intended to have later effect if the person should become incapable of giving or refusing consent. They could be made by people aged 18 or over who have the necessary capacity to make a decision. It could be withdrawn at any time if the person has the capacity to do so. People would be presumed not to have made an advance refusal of treatment unless there is evidence to the contrary. It would be an offence for a third party to conceal or destroy an advance refusal with an intent to deceive. The "general authority" referred to above would not authorise any treatment or procedure if an advance refusal of treatment was known to apply. However, an advance refusal should not preclude "basic care" such as pain relief, nutrition or hydration.

Media reports have tended to concentrate on the consideration of advance directives, but the other sections of the report also contain important proposals. For example, the Bill sets out different levels of authorisation for medical and research procedures in cases where consent has not been given or delegated.

Certain procedures would require the **approval of a court**. These include procedures likely to render the person permanently infertile except where treatment is for a disease of the reproductive organs or to relieve the *existing* detrimental effects of menstruation. Thus sterilisation "intended to guard against any future distress which might arise from an unintended pregnancy" would require court approval. This is a tougher criterion than the present one which allows sterilisation for "menstrual management" without judicial authority. This level of authorisation would also be required for the donation of non-regenerative tissue or bone marrow.

Certain procedures would require a **certificate from an independent medical practitioner** (appointed by the Secretary of State). These include electro-convulsive therapy whether or not the patient is "liable to be detained" under the 1983 Mental Health Act. This would extend the protection of a formal second opinion to people unable to consent without requiring them to be compulsorily detained. This level of authorisation would also be required for abortion and for the administration of medicines for a mental disorder for longer than three months.

Health Survey for England 1993

Health of the Nation Initiative. Produced by the Social Survey Division, Office of Population Censuses and Surveys, 518 pages, £38, available from HMSO

Interacting: multimedia and health

Janet Leonard, Health Education Authority, Hamilton House, Mabledon Place, London WC1H 9TX, £7.99, 121 pages

Multimedia is a potentially powerful tool for health education. With their ability to deliver sound and pictures simultaneously, and in many cases to demand interaction from the user, multimedia systems can present information in understandable ways, reinforce messages and test understanding. This book has been written primarily for those who deliver or make decisions on health education and the dissemination of public health information.

An opening section on equipment gives brief explanations of most of the computer terms used, including the various types of compact disk, which most multimedia systems use. The next section deals with developing multimedia packages: planning, designing and "authoring". The sub-section on planning provides a checklist of issues to resolve before embarking on a project. This includes getting together a working party with experts in the subject, in education and in technical aspects. Design expertise will be needed from someone on the working party – the author suggests that this can be offered by the educational expert. The next two sub-sections are for use by the working party when a decision has been made to go ahead.

The section of initial interest to people who are coming to the topic for the first time will be the case studies which show a range of ways in which multimedia can be used: from an in-house production, *Cancer patients and their families at home,* produced by Marie Curie Cancer Care to a sophisticated interactive training package for midwifery developed by a software house. Another example is the Attica British Sign Language Tutor. This system provides lessons which lead to a variety of conversation topics and a dictionary (which provides pictures of the signs being used by different people in different contexts). A great advantage of multimedia for this purpose is that the system uses a camera. This enables users to practise and record their efforts which can be played back and compared with the original. This is much less confusing than practising in front of a mirror in which case the images look the wrong way round.

The last section of the book looks at possible future uses of multimedia in the wider health care context. Finally the author urges health educators to recognise the potential of the new technology and to make decisions on production, content, marketing and ethics before the market is flooded with poorly produced and possibly ill informed titles.

GENERAL PUBLICATIONS

Taking care of the carers: the need to recognise and support the role of unpaid carers in the UK

British Medical Association, BMA House, Tavistock Square, London WC1H 9JP, 9 pages

This paper was launched in time for the second reading of the Carers (Recognition and Services) Bill (see Parliamentary News). The BMA supports the Bill. The paper looks briefly at the evidence of inadequate current support for carers in both financial and practical terms and at the cost to carers of caring. The future demand for long-term care is certain to grow, while the rapid growth in state funding of long-term care in home settings is likely to end. Unpaid care is likely to remain central to provision, yet a number of trends indicate that unpaid carers may not be able to support their current level of provision, let alone cope with future demand.

The BMA concludes that it is very important that people are encouraged to continue caring, though they should always be free to choose not to. It stresses that carers deserve to be treated reasonably and makes recommendations for support both to encourage them and to recognise their contribution. In terms of practical support carers should have a right to at least two weeks respite care a year and regular time off from caring. In financial terms, there should be a carers' allowance which acts as an adequate earnings replacement benefit and compensates for the time spent caring.

Public Concern at Work: First Annual Report 1994
Public Concern at Work, Lincoln's Inn House, 42 Kingsway, London WC2B 6EN; phone: 0171 404 6609; 28 pages

The objective of the charity, Public Concern at Work, is to promote good practice and compliance with the law in the public, private and voluntary sectors. It starts from the viewpoint that healthy organisations pay proper attention to concerns raised by their employees. By dealing with the message rather than victimising the messenger, they will foster a sense of responsibility among the workforce and help to avert future problems.

The charity encourages employers to set up procedures for employees to raise concerns. As part of this work it has provided training for NHS trust managers. It also gives advice to those who bring their concerns to the charity. In its first year it received 620 requests for legal advice just over 60 of which related to the NHS or other health organisations

With an income of some £154,000 in its first year, Public Concern at Work does not have the resources to investigate the substance of each concern – although it does so in some cases. Its main approach is to ensure that concerns are brought to the attention of those in charge of the organisation or the regulatory authorities, who are then faced with taking appropriate action in the knowledge that they could otherwise be held to account.

The charity welcomes subscribers, who receive copies of its series *Speaking up by Sector* and other publications. Subscriptions are £15 from the above address. The same phone number can be used to raise a serious concern about danger or malpractice.

For the record

Alzheimer's. A practical guide for carers to help you through the day.
Frena Gray Davidson, Piatkus Books, 5 Windmill Street, London W1P 1HF; phone: 0171 631 0710. £8.99, 281 pages.

In partnership with patients: involving the community in general practice
A handbook for GPs and practice staff
National Consumer Council, 20 Grosvenor Gardens, London SW1W 0DH, 25 pages, £5
Copies have been sent to CHCs.

FROM THE VOLUNTARY SECTOR

Pregnant at Work

The Maternity Alliance has produced a leaflet for employed women who are pregnant. It sets out their legal rights:

- to maternity leave and extended maternity absence
- to maternity pay and maternity benefits
- in cases of dismissal
- to health and safety protection
- to time off for antenatal care

For a free copy, send a self-addressed envelope to: The Maternity Alliance, 15 Britannia Street, London WC1X 9JN.

Innovations in Information

Innovations magazine aims to stimulate inventive ways of getting information to disabled people and to those who are professionally and personally involved with them.

The magazine welcomes ideas on how to make information available so that other readers can benefit from your experience

Free sample copies available from: National Information Forum, Post Point 202C, BT Camelford House, 87 Albert Embankment, London SE1 7TS; phone 0171 582 7603; fax: 0171 735 8229.

Medicines in the Single Market

The Consumers in Europe group has produced an information leaflet for UK consumers. It sets out some minimum standards for information about medicines as required by the European Union and UK law. It also gives advice on asking for safety information and making complaints. Limited numbers of the leaflet are available free of charge from CEG, 24 Tufton Street, London SW1P 3RB; phone: 0171 222 2662; fax: 0171 222 8586.

Infertility Awareness

The National Infertility Awareness Campaign, which is supported by ACHCEW, believes that last year's activities have had some effect in encouraging purchasers to fund at least some level of infertility treatment and in putting infertility onto the political agenda. The campaign has redefined its objectives for 1994/95:

- to convince health ministers and officials that more modern and cost-effective investigation and treatment should be offered routinely in preference to older treatments which have lower success rates;
- to achieve a full range of infertility investigations and treatments throughout the country with uniform provision, given that fertile couples have access to most types of treatment from contraception to birth and beyond;
- to communicate key messages to the public, health authorities and health boards, MPs and the Department of Health.

As part of the 1995 campaign, there will be a Focus week from 17 to 24 June, including three events in the South, Birmingham and Scotland and local days of action. The campaign is already looking at the feasibility of setting up an All-Party Group on infertility to add weight to its activities.

For further information contact the NIAC office on 0800 716345.

INFORMATION WANTED

Correction

The request for information in the last edition of *CHC News* from South West Surrey CHC should have read: "The CHC would like to hear about different systems of monitoring satisfaction with the complaints service offered by CHCs. Of particular interest is how to **obtain feedback from complainants**, bearing in mind the sensitivity of many of the issues involved."

Liz Kelly at Nottingham CHC is working towards a **code of practice for consultation** with the general public. She would be grateful if any CHCs with experience which could be of use please contact her.

St Helens & Knowsley CHC would like to hear from any CHC which has conducted a quality assessment survey on **hearing impairment**.

Bristol & District CHC would like to hear from any CHCs whose health authorities have developed procedures to **monitor re-admissions following complications after day surgery.**

Are CHCs aware of any policies or **good practice in relation to prisoners** being treated in NHS hospitals? If so, please contact Cath Arnold, Manchester North CHC.

Liverpool Central and Southern CHC is involved in purchaser/provider discussions about **sub-fertility service provision**, including providing guidance leaflets to inform the general public about alternative investigations and treatments, with likely timescales. Could any CHCs which have produced such leaflets or know of any other models please contact Liz Powell.

South Manchester CHC would like to hear from any CHCs which know of FHSAs which have **paid loss of earnings to complainants** who attend Service Committee hearings.

Does your FHSA monitor trends and/or publish figures on the numbers of **patients who have been removed from GP lists**? If so, could you please contact North Tyneside CHC with the name of the relevant FHSA.

ACHCEW would like to hear from CHCs which:

- have been in contact with people who may have been **infected with hepatitis C from blood** supplied by donors through the Blood Transfusion Service.
- been involved in issues related to **Depo Provera.**
- been concerned about how **dentists record and protect sensitive information** in patients' notes.
- are, or intend to be, involved in the development of **Community Fundholding.** This is a new option for GP practices with 3000 or more patients to be introduced in April 1996.

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

FORTHCOMING EVENTS

Men's health matters

- conference for all those involved in men's health, including patient support groups
- will address the gender gap between the health of men and women
- organised by The Medicine Group
- on 11-12 July 1995
- at Queen Elizabeth Conference Centre, London
- £295 if register before 30 April and £375 after, but there are criteria for reduced cost places. Phone TMG for details.

Further info from:
Carole Jordan
TMG Conference
62 Stert Street, Abingdon
Oxfordshire OX14 3UQ
Phone: 01235 555770
Fax: 01235 554691

Moving on

- a national community health conference
- organised by Labyrinth Training and consultancy
- 6-7 June 1995
- Bradford City Hall
- £135 + £23.63 VAT statutory (inc CHCs)
- £80 + £14 VAT voluntary/community

Further info from:
Abi Pirani
Labyrinth Training and Consultancy
7-9 Prince Street
Haworth
West Yorks BD22 8LL
Phone: 01535 647443
Fax: 01535 647482

Between apathy and outrage: involving the public in healthcare choices

- workshop for purchasers and CHC members and officers
- organised by the Office for Public Management
- on 23 May 1995
- at OPM office in London
- £185 + £32.38 VAT

Further info from:
Debra Cartledge
Events Coordinator
Office for Public Management
252b Grays in Road
London WC1X 8JT
Phone: 0171 837 1973
Fax: 0171 837 6581

Public health and public services

- third annual forum of the Association of Public Health
- 24-25 May 1995
- London
- 2 days £170 + £29.75 VAT APH members £220 + £38.50 VAT non-members
- one day £90 + £15.75 VAT members £125 + £21.88 VAT non-member

Further info from:
Programme Unit
Office for Public Management, as above

Deadline

If you have items for inclusion in the next issue of *CHC News*, could you please get them to ACHCEW by 5 April.

DIRECTORY AMENDMENTS

Page 3 **North West Association of CHCs and Association of CHCs in the Mersey Region**
Secretary: Ms Glenys Syddall
c/o Manchester CHC
Lancaster Buildings
77 Deansgate
Manchester M3 2BW
Phone: 0161 833 4689/832 8183
Fax: 0161 833 3839

Page 7 **South West Durham CHC**
Change of address:
14 Tenters Street
Bishop Auckland
Co Durham DL14 7AD
Phone: 01388 605013
Fax: 01388 608903

Page 12 **Add: Brent CHC (w.e.f. 1 April)**
Chief Officer: to be advised
45-47 Praed Street
London W2 1NR
Phone: 0171 402 0380
Fax: 0171 402 1271

Enfield CHC
Fax: 0181 364 2731

Page 13 **Haringey CHC**
Fax: 0181 801 9590

Add: Kensington, Chelsea & Westminster CHC (w.e.f. 1 April)
Chief Officer: to be advised
45-47 Praed Street
London W2 1NR
Phone: 0171 402 0380
Fax: 0171 402 1271

Page 14 **Parkside CHC**
w.e.f. 1 April, this CHC will be split in two.
Please delete this entry and insert Brent CHC and Kensington, Chelsea & Westminster CHC as above

Page 27 **Lancaster CHC (w.e.f. 31 March)**
Chief Officer: Mrs Judith Deft

Index **Delete Parkside CHC**
Add Brent CHC and Kensington, Chelsea & Westminster CHC