CHC NEWS

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

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Number 102
April 1995

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NEWS

Acting on Complaints

The Government has issued its response to the review of NHS complaints procedures (CHCs have been sent a copy). The target date for implementation is 1 April 1996.

There will be a two-stage complaints procedure throughout the NHS. If a complaint is not resolved at stage 1, a convener – a non-executive director of the relevant NHS trust (hospital complaints) or health authority (primary care services) – can decide whether to set up a panel to reconsider the complaint. If s/he decides not to convene a panel, the complainant can put his/her case to the Health Service Commissioner (the Ombudsman).

Patients can complain up to a year after the event being complained of (this time limit can be waived at the discretion of the complaints officer or convener). At stage 1, an initial response should be sent within two working days and a full response within four weeks. No time limits have yet been set for stage 2.

The Ombudsman's jurisdiction is to be extended to cover clinical complaints against all NHS staff and all complaints against family health service practitioners and their staff. He will retain jurisdiction over complaints about purchasing.

While ACHCEW welcomes some aspects of the proposals – faster responses, better staff training and the recognition of the CHC role – it has reservations. It believes that complainants should have the right of access to an investigation which is independent of the NHS. Under the Government proposals, the investigating panel will normally comprise:

- an independent lay chairperson from a regional list;
- the convener (see above); and
- a non-executive from the health authority or a GP fundholder (hospital complaints) or another independent lay person drawn from the regional list (for primary care complaints).

ACHCEW has reservations about the proposed separation of complaints and disciplinary issues. It has also called for funding for CHCs to assist complainants. The Wilson Committee report called for specific funding for this purpose (see *CHC News* No 93), but the Government response merely says that it expects the CHC role in complaints to continue.

Acting on Complaints, Department of Health

Openness in the NHS

The Government has issued its Code of Practice on Openness in the NHS, to be implemented from 1 June 1995. It applies to RHAs, DHAs, SHAs, FHSAs, trusts, family health services, the Mental Health Act Commission and CHCs. The general principles are that the NHS must respond positively to requests for information and answer requests quickly and helpfully. It should also make the public aware of what information is available and ensure that there are clear arrangements to deal with complaints. The Code sets out what information must be provided and what can be withheld. Charges can be made for some information, but CHCs (among others) cannot be charged.

Health authorities and trusts must provide information requested unless it falls within one of nine exemption clauses such as "management information, where disclosure would harm the proper and effective operation of the NHS organisation". The requirements are organised differently for other NHS organisations. GPs, for example must publish practice leaflets, and fundholders must publish or make available five additional items. Since there is no general requirement on them to provide information in the way there is for DHAs, there is no list of exemptions. As a result, they can withhold a wider range of information. While DHAs must make available "contracts with providers, both NHS and non-NHS", for example, the Code lays down no such requirement for fundholders, who are to make available "plans for major shifts in purchasing" and "an annual practice plan describing how the practice intends to use its fund ...". They may *optionally* include plans for general medical services activity.

ACHCEW has welcomed the Code as a "substantial step in the right direction". However, it is concerned about some of the let-out clauses. Some exemption categories are vague: for example. requests for information which are "manifestly unreasonable, far too general or would require unreasonable resources to answer" are exempt. The Association is concerned that these clauses could be misused as a means of refusing to disclose negative or embarrassing information.

Code of Practice on Openness in the NHS, NHS Executive

Court arguments

In the case of B, the ten-year-old girl who was refused further funding for curative treatment by Cambridge Health Authority (CHA), the Appeal Court rejected each of four arguments put by the judge in the High Court. In the High Court, Mr Justice Laws ruled against CHA, saying that the decision to withhold funding had "assaulted" B's fundamental right to life. In the Appeal Court, Sir Thomas Bingham said that the Authority had acted rationally and fairly in denying B treatment. It was not for the courts to interfere in such circumstances with the way health authorities make medical judgements on funding.

The four arguments advanced in the High Court and rejected in the Appeal Court were:

1. Mr Justice Laws considered who should make the decision about what was in B's best interests, assuming that she could not make the decision herself. He concluded that it should be the parents, not the doctors. Therefore the DHA should not have based its decision on what was clinically appropriate without regard for her father's views. Sir Thomas rejected this argument, saying that to complain of that was "to shut one's eyes to the reality of the situation".
2. Mr Justice Laws did not accept CHA's argument that it had rejected the request for treatment on the grounds that it would be considered experimental. The Appeal Court accepted CHA's argument on this point: the treatment had to be regarded as experimental since a third phase of chemotherapy followed by a possible second bone marrow transplant did not have a tried record of success.
3. Mr Justice Laws said "merely to point to the fact that resources are finite tells one nothing about ... the legality of a decision to withhold funding in a particular case". He said that CHA had not adequately explained the priorities which led it to decline to fund the treatment. Sir Thomas said that to believe that treatment could be provided no matter how much it costs would be "shutting our eyes to the real world". "Difficult and agonising judgements have to be made" on how to allocate a limited budget.
4. Mr Justice Laws said that CHA had wrongly failed to consider providing the £15,000 needed for the chemotherapy. If that phase was successful, another £60,000 would be needed for a bone marrow transplant. CHA, he said, should have considered the case on the basis that the first call was for £15,000 only. The Appeal Court rejected this argument on the grounds that "it is not reasonable to embark on this expenditure, when quite patently they have to continue if it proves successful".

Independent/Times 11 March

Dental proposals

The Government has published its response to consultation on the dental Green Paper (see *CHC News* No 98). It proposes:

- to extend and tighten up the **prior approval scheme** under which dentists must seek permission for certain expensive or complex treatments;
- to reform the **continuing care payments system** in order to target patients most in need of treatment –
  in regard to children there may be a scheme to pay dentists according to the state of a child's teeth on registration or by paying more in areas where children have high levels of decay, if no agreement can be reached on these payment systems, "the Government will consider the future of these payments";
- not to introduce **sessional payments** – it had been thought that such payments might replace fee per item of service payments, a suggestion which had been opposed by the dental profession;
- to extend the **community dental service** to help patients in parts of the country where NHS provision is minimal;
- in the long-term to introduce a **purchaser/provider split** in dentistry – pilots will be held in some areas.

Telegraph/Independent 6 April

Advance directive guidelines

New BMA guidelines warn doctors that they must abide by advance directives made by patients or risk being charged with common assault. In an advance directive, a patient may specify circumstances under which he or she would not wish to receive certain types of treatment.

The guidelines state that if a patient has expressed a wish not to receive treatment, but the patient's family wants the patient to be kept alive at all costs, the doctor's duty is to the patient.

They also state that doctors and nurses who conscientiously object to withholding treatment as requested by an advance directive, must hand over the care of the patient to another professional.

The BMA has stressed that the guidelines have nothing to do with euthanasia – patients will not be able to ask doctors to give treatment intended to shorten their lives.

Guardian/Independent 6 April

New powers to discipline doctors

A Bill allowing the General Medical Council to deal with incompetent doctors has been published. It has been strongly criticised by Jean Robinson who was a lay member of the GMC for 14 years.

The Medical (Professional Performance) Bill will allow the GMC to investigate cases where a doctor's performance is alleged to be "seriously deficient". At present, the GMC can discipline doctors only for "serious professional misconduct". If the allegations are held to be true, the GMC will be able to require a doctor to undergo training or work under supervision. Where doctors refuse to comply or fail to improve, the GMC will have the power to suspend them. If the Bill becomes law, the measures will be implemented in 1997. The chief executive of the GMC estimates that about 100–150 doctors might be investigated under the new powers each year, of whom around 50 might face sanctions.

Jean Robinson's criticisms are that the system will operate in private, that the criterion of "seriously deficient" is poorly defined and that complainants will not have a right to be represented or to seek judicial review of decisions.

Independent 17 March

Mental illness among children rises

The numbers of children receiving hospital treatment for mental illness has risen sharply. There are now about a 1000 children under ten years old being treated in hospital for psychoses, severe depression and eating disorders – up by 50% in three years. Since the mid-1980s, the numbers of 10–14 year olds in hospital for mental illness have risen by a third to about 1200. An expert in the Cambridge University Child and Adolescent Psychiatry Department estimates that 20,000 children of school age are suffering from a serious depressive disorder. The increases are being blamed on family break-ups, lack of communication at home and pressure at school. Some schools are beginning to respond by recognising that young children can suffer depression. A number have visiting therapists to listen to children.

Sunday Times 19 March

Bereaved relatives poorly supported

A Government-commissioned survey has shown the relatives of hospital patients who die suddenly are receiving inadequate support from casualty departments. Fewer than half of the 248 departments surveyed have special rooms for relatives to visit the dead patients – some refused relatives such a visit. Only half the departments provide formal training for staff. Most hospitals have a sitting room for relatives, though not all provide facilities such as a phone or toilet. The report recommends that relatives must have access to patients who have died – in a special room set aside for the purpose. They should be supported by a trained member of staff.

Independent on Sunday 19 March

Job insecurity

Virginia Bottomley's post as Secretary of State for Health is looking increasingly insecure as pressure is put on John Major to replace her. Rumours are rife of a summer reshuffle. Mrs Bottomley had to face the wrath of Conservative London MPs in the House of Commons after she issued a written answer confirming her plans to close St Bartholomew's Hospital and run down Guy's. The MPs were angered both by the decision itself and by the fact that Mrs Bottomley chose not to announce the decision in the House. Several MPs, spurred on by former cabinet minister Peter Brooke, have warned that they will vote against any plans which include the Health Secretary's proposals. Labour hopes to stage a debate on the issue within the next few weeks.

Times 6 April

Village communities

Pressure from families of "severely mentally handicapped" adults has persuaded the Government to review its community care policy for this group. The families have argued that transferring residents from hospitals to small houses in the community is both cruel and unnecessarily expensive. They advocate "village communities", some built on existing hospital sites, which they say are less isolating and less expensive than both hospitals and community care. As well as rejecting the "dogma of integration", the village community campaign rejects the use of the phrase "learning difficulties" on the grounds that it minimises the problems their relatives face.

Independent 4 April

PARLIAMENTARY NEWS

Accountability of public bodies

There is no statutory requirement for any of the advisory non-departmental public bodies sponsored by the DoH to:

- hold public meetings
- conduct public consultation exercises
- conduct consultation exercises with outside commercial interests
- publish a register of members' interests
- publish agendas for meetings
- publish minutes of meetings.

Some of the bodies do some of these things voluntarily, though none hold open meetings or publish agendas for meetings. Only two are listed as conducting public consultation exercises: the British Pharmacopoeia Commission and the Nutrition Task Force.

Hansard, 6 March, col 51

Clinical Negligence Scheme

The Government is to go ahead in setting up a voluntary scheme in which NHS trusts will be able to pool the risk of meeting large clinical negligence costs (see *CHC News* 91). Members of the scheme will pay an annual contribution determined by the trust's size, type of clinical work and history of claims. Members which adopt good policies on risk management will get a discount. The scheme will pay part of the costs of claims over a certain threshold. The scheme is to help ensure that claims are handled "sensitively and fairly, with early settlement where a clear case of negligence can be shown". Hospitals are to be encouraged to give:

- prompt and sensitive explanations to patients or relatives,
- the offer of remedial treatment and
- early settlement in cases involving financial redress.

Costs of clinical negligence claims were estimated at £100m in 1993-94 and provisionally at £125m in 1994-95, of which £26m were settled by North Thames region

Healthcare Parliamentary Monitor Issue 151, Hansard, 6 March, col 41

Dentistry

From July 1992 to July 1994 a weekly return form showed how many FHSAs were not providing emergency dental services. The data are not available from 1994 since "more detailed data have been collected weekly on the number of patients referred to the emergency dental service, the community dental service, hospital dental service and salaried dentists instead." Since January 1994 the DOH has received 212 letters in which the main point has been the availability of general dental services.

Hansard, 28 March, cols 564-5

Management information from Welsh FHSAs shows enormous variations between areas and a general rise in the numbers of patients de-registered by NHS dentists. These figures do not show how many of the patients may have been able to re-register with another dentist.

	Deregistrations		
	1992	1993	1994
Clwyd	2335	568	6859
Dyfed	225	1015	2635
Gwent	490	1073	2977
Gwynedd	4960	3031	5213
Mid Glamorgan	31	86	581
Powys	0	0	0
S. Glamorgan	151	3914	1432
W. Glamorgan	0	0	44
Total	**8192**	**9687**	**19741**

In 1993 Welsh FHSAs were asked for help by 16,049 people wanting to register for a dentist. The figure in 1994 was 15,009.

The Times reports on deregistrations in England. There have been 829,000 since 1992, the worst hit areas being Kent and Gloucestershire in each of which dentists have dropped 58,000 patients.

Hansard, 21 March, col 192; 31 March, col 868, Times 16 March

Information not available centrally

Numbers of people removed from GP lists in Wales in each of the last three years. This information is available centrally in England.

Hansard, 24 March, col 385

Durations of GP consultations

Survey results: average times (minutes) per consultation			
Activity	1985-86	1989-90	1992-93
Surgery and phone consultations	8.2	8.8	8.8
Home visits (inc travel time)	24.4	25.5	25.2
Homes visits (time in home)	13.1	13.5	13.2
Clinics	11.0	12.0	12.6

Hansard, 29 March, col 675

Fundholding

GP fundholders held nearly 9% of the total NHS budget per patient in 1994-95.

From April 1995, 52 sites will pilot total purchasing schemes in which the practices will manage all hospital and community health services resources on behalf of their patients.

Hansard, 28 March, col 569

FROM THE JOURNALS

Elective ventilation of potential organ donors

Elective ventilation is the procedure by which selected patients who are dying from a rapidly progressive brain haemorrhage are transferred to an intensive care unit where they are ventilated for a brief period before death is confirmed by diagnosing brainstem death. The organs of these patients can then be removed for transplant. A protocol on the use of the procedure, drawn up in Exeter, was suspended after doubts were raised about its legality. Recent Department of Health guidelines make it clear that ventilation should be limited to those who may possibly benefit. Where the doctor's intention in referring the patient for ventilation is not for the patient's *own* benefit, the practice is unlawful.

This set of articles looks at the social, ethical and legal aspects of the issue from differing perspectives.

- Doctors who have been using the protocol at Exeter argue that the practice is ethical and beneficial to society. They also argue that under the protocol they ventilated patients at the moment they died although the death was not diagnosed formally till later. They believed that the protocol followed 1983 DoH guidelines and are clearly dismayed that they have had to suspend it.
- Julia Neuberger, looking at the matter from a lay perspective, argues that even if relatives and society believe that benefit can come out of the practice of elective ventilation, that does not necessarily make it ethical. It merely provides one argument in its favour.
- An intensive therapy unit consultant believes that the current law protects the most vulnerable. She also looks at practical implications for intensive therapy units, for example that the practice might lead to an increase in the numbers of patients in persistent vegetative state who do not suffer brainstem death.
- The director of a transplant unit argues that the Exeter protocol would never have been necessary if there were sufficient intensive care staff and beds to offer routine resuscitation to most stroke patients, as happens in many other Western health services.
- Two lawyers explain why elective ventilation is illegal. The patients involved are not in a position to give or withhold consent, and relatives cannot give consent on their behalf since such consent can be given only where it is in the patient's best interest. Though elective ventilation may benefit society at large, it cannot, the lawyers argue, be in the interests of the patient in question. In the case of Tony Bland, one of the Law Lords argued that unless it is in the patient's interest to continue invasive care, the continuance of an intrusive life support system would constitute a crime.

While some would want the legal position to remain as it is, most of the contributors to this set of articles call for change. At present organ donor cards authorise the removal of organs for donation only after death. The wording on the card could be amended to enable consent to elective ventilation. This might justify the argument that, where such consent was given, elective ventilation would be in the best interest of the patient. If this argument was not accepted, the law could be changed specifically to allow elective ventilation.

BMJ 18 March

Older people attending A&E

A study at Whipps Cross Hospital in London examined whether the A&E department was able to help older people who attended, whether the patients' problems had been dealt with adequately and whether they were coping at home after discharge.

The authors estimated that 60.7% of the visits were "justified". Most of the "unjustified" visits fell into the categories of "generally unwell" or "chest problems". The authors suggest that social isolation may play a large part in these attendances, as may a reluctance to visit GPs for various reasons. However, they also note that it can be rational for patients to consider the worst possible explanation of their symptoms until this is excluded.

Overall, the authors conclude that older people need more intensive health care attention than they are getting. While there is a need for education on appropriate responses to symptoms, the best policy may be to provide appropriate care, rather than to try and deflect the care into the community. Many of the patients were pleased to receive the follow-up check undertaken in the study and several were given advice on social support and how to take appropriate action in case of problems. The authors suggest that health visitors, or failing that hospital liaison sisters, could play a useful role in following up this vulnerable group with a view to identifying underlying problems.

Nursing Times 29 March

Pointer: Nurse Practitioners

There is room for only a brief mention of two items on Nurse Practitioners in Vol. 68 of *Health Visitor*. The first, *Testing the boundaries,* looks at the experiences in two major pilot projects. The second is a professional briefing which examines how the role and status of NPs might be defined. It suggests that defining a specific NP discipline and role limits its potential and the potential for development of current community NPs.

AROUND THE CHCs

Both **Lancaster** and **Chester & Ellesmere Port CHCs** have been in contact with chemists over ways of responding to high prescription charges.

It is possible to buy some prescribed medicines **over the counter** for less than the prescription charge of £5.25. Chester & Ellesmere Port CHC has discussed its concerns about high charges with the Cheshire Local Pharmaceutical Committee. Cheshire LPC is now advising its members to tell patients which drugs can be bought more cheaply over the counter. In some cases this may give savings of up to £4.00 per item.

Lancaster CHC found out that some chemists in an adjoining district had drawn up a list of medicines which are cheaper over the counter, **including prescription-only medicines**. The chemists have found that local doctors are usually willing to issue a private prescription free of charge since the prescription then does not register against their NHS drugs budget. Patients can then buy some prescribed medicines for less than £5.25. The CHC has circulated a newspaper item on the subject to all GPs and chemists in its district. The CHC has also written to the Secretary of State for Health outlining its concerns about the prescription charge.

The Health Commission for Wiltshire & Bath has instructed local GPs to consider costs before accepting responsibility for expensive treatments. This should not be seen as whole-scale rationing if the practice is relatively "cheap", but "practices at the other end of the scale will be well advised to look elsewhere in their drug budgets to find saving". Practices prescribing within the target range will be eligible for bonus payments. The Commission is holding no contingency funds back to cover overspends and warns practices that they should not simply assume that they can overspend on the target budget. **Swindon & District CHC** is very concerned at the pressure this puts on GPs, especially on those operating in high cost areas. Hugh Barnett, the Chief Officer, commented "It's now official: GPs must put cost before care when deciding whether to prescribe expensive treatments for their patients." The CHC has sent a letter to the Health Commission expressing its concern.

Thank you to the CHCs which responded to the **ACHCEW communication survey** – 130 in total. The responses will be used to inform the production of a communications "toolkit" which will be circulated to all CHCs.

CHC PUBLICATIONS

North Staffordshire Patient's Charter Survey

Ursula Dobraszczyc, Christine Sime and Catrina Alferoff
For North Staffordshire HA and CHC, 51 pages

This study examines experience of, and satisfaction with, services (in hospital, outpatient clinics and community-based clinics) in relation to the Patient's Charter standards on information, privacy and being treated with respect. It not easy to come up with measures for such "soft" standards. Among other difficulties, an individual patient's experience is unlikely to be uniform – within a generally satisfactory hospital experience, for example, a patient may have experienced difficulties with one member of staff. How, then would this patient answer a question on satisfaction with staff attitudes? In any case, even valid and reliable measures of satisfaction on these standards may not provide managers with useful information on which they can act. This survey tried to get beyond an over-simplistic enumeration of satisfied and dissatisfied patients by going into a fair amount of detail on patients' experiences as well as their satisfaction with them. The questionnaire (3,240 were returned) included 50 questions, 40 of them on the Charter standards. In-depth interviews with 300 of the survey respondents give a further insight into what specific aspects of care were appreciated or caused problems.

Among the findings are that 23% of respondents replied "no" to: *Do you now feel you were given enough information about your condition?* In interviews, information about recovery and aftercare emerged as an area of dissatisfaction. Overall, satisfaction with privacy of physical facilities and special clothing was high, but 23% of respondents had been *Concerned that [their] discussions with healthcare staff could be overheard.* People who said that they did not now have enough information were more likely than others to say that they had been concerned about being overheard (38% compared to 18%). By asking detailed questions of this type, and analysing associations between the answers, this survey should provide managers with useful indications of what is actually causing problems for the minority of patients who express dissatisfaction.

The public voice in the health services

Tom Richardson for Anglia and Oxford RHA, 45 pages

This review of work in the Anglia and Oxford Region presents brief details of the methods used in an impressive array of 88 recent CHC projects to involve the public. The projects used many different methods and covered a wide variety of topics. A discussion of the projects and of public involvement in the NHS makes it clear what a valuable resource the work put in by CHCs is, and could be, for NHS purchasers and providers.

The CHCs were found to be reluctant to shift the emphasis of their work too far from providers, since Trusts are undertaking most of the planning in the NHS and there is little evidence of most purchasers taking a firm strategic lead. A general theme to emerge from the review was that DHAs were not starting from the point of empowering people. In some ways this makes CHC work all the more important, but a number of CHCs doubted whether the DHA wanted the quality user input that is available. Another danger of purchasers' relative weakness is that CHCs may end up doing what DHAs should be doing themselves, particularly in service monitoring. For example, Tom Richardson argues that the routine feedback to hospital and social services staff from community workers about discharged patients should be a standard part of contracts, with details available for CHCs. CHCs should not necessarily have a responsibility to be involved unless there are difficulties in their area.

Relations with GP fundholders are also discussed. Some fundholders are developing ways of involving their patients, but this is at their own discretion. Similarly some are working on consultation with CHCs, but this is usually because of pre-existing good personal relationships. Tom Richardson calls for a statutory obligation for GPs to consult their patients and CHCs about their purchasing intentions before fundholding is further extended. There are promising signs of GPs, both fundholders and non-fundholders, being open to CHC participation in new systems of locality planning. It is suggested that it may be in such locality planning, alongside practice-sensitive commissioning, that the future lies.

CHC Publications: Listings

Report on study of catering services at Good Hope Hospital Trust
North Birmingham CHC, 32 pages

"This is what the public thinks of me": a survey of the public's awareness of mental health *15 pages*
Satisfaction survey: mental health day service provision, *21 pages*
North Tees CHC

Maternity Services in South Cheshire: local voices research in the light of "Changing Childbirth"
Crewe CHC, 20 pages

Health needs of the elderly in the Dukeries area
Central Nottinghamshire CHC, 114 pages

Views on maternity services: the experiences of women living in East Cheshire
Macclesfield CHC, Local Voices Project 2, 27 pages

Users' perceptions of the district nursing service in Blyth
Northumberland CHC, 33 pages, £3

An accessibility survey for people who use wheelchairs
Dudley CHC, 10 pages

Report on Exmouth and Budleigh Salterton locality healthcare facilities
Exeter & District CHC, 29 pages

Consumer survey report at Bognor Regis War Memorial Hospital
Chichester CHC, 19 pages

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.

OFFICIAL PUBLICATIONS

Contracting for acute health care in England
National Audit Office, 38 pages, £8.15. Available from HMSO

This report focuses on: the information needed and the information that is actually available for contracting; the types of contracts being used; and the contracting process. The research took place in North East Thames, Yorkshire and Oxford regions in the summer of 1993.

Information

The purchaser/provider split in the NHS has created a need for more sophisticated information systems which can be used to analyse information in new ways and to pass it between purchasers and providers. Without reliable data categorised in ways that can be used by managers as well as health professionals, health purchasers cannot compare the services of different providers in order to use their powers to buy the best health care for their populations, or even be certain what health care they are buying. The National Audit Office found that the present state of information systems limits health authorities' ability to monitor contracts. One purchasing consortium found that when it questioned hospitals' claims of numbers of patients treated, the hospitals typically reduced their claims by 20%. Hospitals are investing in

systems which will provide the required information. A National Steering Group on Costing and a National Casemix Office have been established to help improve the quality and comparability of data on treatments and costing. It is unlikely that health authorities will continue to accept Finished Consultant Episodes as the basis for contract management, but any move away from this will presumably require a massive overhaul of information systems. The NAO comments that the additional costs of investment in information need to be assessed against likely benefits, though the costs incurred to date and likely to be incurred in the future fall outside the scope of this report.

Contract types

Though limited by the information available, contracts have been becoming more sophisticated as experience is gained in the new system. While some health authorities have included sanctions in their contracts to enable them to withhold payment, on the whole they felt that sanctions were not particularly effective. Most health authorities preferred to use persuasion and close contact in order to improve performance. Most contracts are still negotiated on an annual basis. While longer-term contracts were seen to give the benefits of stability and an avoidance of repetitive negotiations, few health authorities have been willing to use them because of the uncertainty of the environment in which they work.

The process

The report looks at the relationships between the various actors in the contracting process. Twelve CHCs in the areas visited were generally satisfied with the level of consultation with the health authority. This contrasts with the perception of GPs, who gave varied responses. In Buckinghamshire, for example 15% of GPs visited said that they had not been consulted by the health authority, while in Leeds almost 80% gave this response. While all 12 CHCs said the health authority took some of their comments on board, 28% of GPs said none of their comments were taken on board, and a further 30% did not know or gave no response to the question. Although CHCs were content with their role in monitoring, they would have liked to receive more information from the health authorities' own monitoring activities. There was much less involvement of GPs in monitoring.

The doctors' tale: the work of hospital doctors in England and Wales

Audit Commission, 92 pages, £12. Available from HMSO. Copies have been sent to CHCs.

This study is concerned with the organisation and working practices of doctors in acute hospitals. It identifies a huge agenda for change in the way doctors work, train and interact with the rest of the hospital. The overall messages are that managers need to see that clinical professionals are well supported and that doctors need to take more responsibility for the service as a whole, their use of resources and their own day-to-day work. Having set out some current facts about medical staffing, the report looks at:

- the deployment of doctors in relation to demand;
- consultants' contributions to the work of the hospital;
- the local organisation of medical training;
- obstacles likely to impede change.

Many of the changes needed relate to skill mix and deployment of doctors. Current practices are often outmoded, with the result that grades and skills of doctors do not reflect patients' needs or medical training requirements. There is a lack of clarity about responsibilities for tasks, both between professional groups and among doctors. Over 40% of the junior doctors surveyed said they had not been give a job description, and among the rest many job descriptions did not cover important aspects of the work. As a result, they are carrying out inappropriate tasks: some tasks which do not need medical training and some which may be beyond their competence. The Audit Commission found a wide variation in the extent to which Senior House Officers (SHOs) worked unsupervised. In some hospitals SHOs were undertaking most of their operations without a more senior doctor being present. This implies either that they are being asked to operate alone when they need a more senior doctor present, or they are not having their competence extended. The Commission calls for more consistency and clarity in the allocation of tasks and makes recommendations for medical staffing plans. To develop and implement such plans will be far from easy given the complexity of the issues and professional sensitivities. The report concludes that trust boards must take the task on, and makes several recommendations on what responsibilities clinical directors should be given and accept if they are to address the problems.

Official Publications: Listings

A strategy for people with learning disabilities
Health of the Nation Initiative. Department of Health. 40 pages.
Copies from HMSO, Oldham Broadway Business Park, Broadgate, Chadderton, Oldham OL9 0JA.

Centrally commissioned research programme (a programme to support the formation of health services policy, social services policy and central policies directed at public health)
Department of Health. £5, 68 pages. Copies available from: BAPS, Health Publications Unit, DSS Distribution Centre, Heywood Stores, Manchester Road, Heywood, Lancs, OL10 2PZ.

The NHS Executive has launched a ***Quarterly Review*** which is to provide information about NHS performance on a regular basis. Copies should have been sent to CHCs. Further copies can be obtained by calling the Health Literature Line on 0800 555777.

GENERAL PUBLICATIONS

Health promotion with older people: a fresh approach

Ageing well (UK) Age Concern England, Astral House, 1268 London Road, London SW16 4ER; phone: 0181 679 8000; fax: 0181 679 6069. Single copies free with A4 SAE (43p stamp), 36 pages

The booklet aims to identify principles of good practice and to encourage primary health care teams (PHCTs) to initiate projects. The first half of the booklet covers definitions and issues such as statutory commitments, funding and evaluation. The bulk of the booklet gives examples of projects run in a variety of settings by members of PHCTs.

Asthma in the classroom: What can be done? What should be done?

National Asthma Campaign, National Asthma Training Centre & Applied Psychology Research Group, 72 pp
The National Asthma Campaign has sent this conference report to all CHCs believing them to be well placed to monitor local implementation of a national strategy such as the one outlined here.

Over a million school children in the UK have asthma: an average of four in a class of 30. Much of the conference discussion concerned the management of asthma at school, with an emphasis on the administration of inhalers both in routine use and in emergencies. Legal obstacles to the general provision of inhalers and the administration of medication need to be addressed as well as the support and training of staff. The conference called for action on various fronts including changes in legislation, the distribution of school sets of inhalers and the inclusion of asthma as a target area in the *Health of the Nation* strategy. This last point might be important in bringing about recommendations added as a postscript to the conference on environmental issues, since these would require the involvement of a wide range of agencies.

From margin to mainstream: developing user- and carer-centred community care

Joseph Rowntree Foundation. Available from BEBC Distribution, PO Box 1496, Parkstone, Poole, Dorset BH12 3LL; phone: 01202 715555; Fax 01202 715556. £9.

Four local authority case study sites found that user and carer involvement could result in significant changes in the way care is planned, managed and delivered. The project reported here lasted two years and worked through building up communication and using it to change services – all the users and carers were clear that involvement was not an end in itself. Without change, involvement was simply a drain on time and energy. The report describes practical techniques to help organisers change in ways which make it possible to respond rapidly to user and carer perceptions and judgements.

General Publications: Listings

Expanding care: a practical guide to diversification for care homes
Jenyth Worsley for Age Concern England, 1268 London Road, London SW16 4ER, 144 pages, £14.95

Emergency contraception information pack
Family Planning Association and Health Education Authority
Public information leaflets, a poster, information sheets and guidelines for professionals
Packs have gone to all GPs and Practice Nurses and to all Family Planning Clinics, among others. Leaflets and posters available from the Family Planning Association, 27-35 Mortimer Street, London W1N 7RJ

INFORMATION WANTED

From time to time Aylesbury Vale CHC is approached by people who have been sent **invoices for treatment at A&E** following a road traffic accident. The CHC would be interested to hear from:

- other CHCs which have received such complaints and about the results of subsequent actions;
- CHCs in areas where such charges are not levied.

Have any CHCs experienced problems locally with **opposition from GPs to the implementation of *Changing Childbirth***? If so, could you please get in touch with Rotherham CHC.

Jane Dunkley, Chief Officer of North Staffordshire CHC, has recently been approached by individuals who can fairly accurately date a **deterioration in the health of an elderly relative to the time of an influenza vaccination**. If any other CHCs have come across this, or know of research in this area, please contact her.

Nottingham CHC wants to hear from any CHC with examples of good practice in the field of **pharmacy applications in rural (controlled) localities** – for example public meetings with the local medical committee/local pharmaceutical committee etc.

North Manchester CHC would like to hear from CHCs aware of **dental treatment delayed by long waits for prior approval from the Dental Practice Board**.

Do any CHCs know of **training or support initiatives for lay members of Maternity Services Liaison Committees** (apart from the training provided by GLACHC)? If so, please contact ACHCEW.

AGM NEWS

We would be very grateful for help with the production of AGM NEWS at this year's conference in Cardiff.

If anyone is willing to offer help with:

- reporting on events
- writing
- proofreading
- taking and/or processing photos
- organising photocopying
- distributing copies

could you please get in touch with ACHCEW.

For our files

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

FROM THE VOLUNTARY SECTOR

Everybody's Business

A survey published by Action on Elder Abuse found that fewer than a quarter of health authorities and trusts have a policy on dealing with abuse of older people – some did not recognise the need for a policy. It found little joint working between health, social services and other agencies and low rates of monitoring policy. The organisation is calling for:

- national guidance on policies;
- a commitment to multi-agency collaboration;
- clear procedures in each agency for acting on reported incidents;
- a lead officer in each agency to coordinate work on the issue;
- systematic training and education.

Everybody's Business: taking action on elder abuse is available for £5 from Action on Elder Abuse, Astral House, 1268 London Road, London SW16 4ER.

Child Safety Week

Child Safety Week will run from 3 to 9 July. The Child Accident Prevention Trust (CAPT) has produced a Starter Pack to help anyone who is thinking of running an activity during the week. It includes a handbook, colour safety leaflets, quiz sheets, posters and stickers to attract publicity and get the safety message across.

Packs are available for £5 from CAPT, 18–20 Farringdon Lane, London EC1R 3AU. Cheques payable to Child Safety Services Ltd. For further information contact Lesley Corner at the CAPT on 0171 608 3828.

DIRECTORY AMENDMENTS

Since a new directory is to be issued within the next few weeks to include the many changes that have been sent to us we are not listing amendments in this month's newsletter.

Deadline

If you have items for inclusion in the next issue of *CHC News*, could you please get them to ACHCEW by 10 May.

FORTHCOMING EVENTS

Working with the Chinese Community

- conference sponsored by the Northern Race Relations Advisers' Group and Tameside MBC
- at Tameside Conference Centre, Denton, Greater Manchester
- on 18 May 1995 (**closing date for applications 3 May**)
- £25

Further info from:

Angela Thompson
NORRAG Co-ordinator
c/o Equal Opportunities and Policy Unit
Central House
Forster Square
Bradford BD1 1DJ
Phone: 01274 752776
Fax: 01274 390076

Delivering Cancer Care: the black perspective

- conference on the purchase and provision of cancer care for black and minority ethnic communities in the UK
- organised by CancerLink
- on 5-6 September 1995
- at Church House Conference Centre, Westminster, London
- £175 day one; £210 both days

Further info from:

CancerLink
17 Britannia Street
London WC1X 9JN
Phone: 0171 833 2818
Fax: 0171 833 4963

Healthcare Risk Management

- building an integrated approach to the development and implementation of multi-disciplinary pathways of care
- at the King's Fund Centre, 126 Albert Street, London NW1 7NF
- on 17 May 1995
- £100 + £17.50 VAT

Further info from:

Healthcare Risks Solutions Ltd
Kennedy House
115 Hammersmith Road
London W14 0QH
Phone: 0171 602 7700
Fax: 0171 602 8833

Invest in Breast Together

- conference to launch the joint initiative of the Royal College of Midwives and the Health Visitors Association
- 25 May 1995
- Church House Conference Centre, Westminster, London
- £35 inc VAT

Further info from:

Conference Co-ordinator
Profile Productions Ltd
Northumberland House
The Pavement
Popes Lane
London W5 4NG
Phone: 0181 566 1902
Fax: 0181 579 9258

What's in a Name? Psychiatric diagnosis, needs assessment and decision-making

- one-day conference organised by MIND
- on 17 May 1995
- at Connaught Hall, London WC1
- £60 MIND members, £75 non-members

Further info from:

The Conference Administrator
MIND
Granta House
15-19 Broadway
London E15 4BQ
Phone: 0181 519 2122
Fax: 0181 522 1725

MIND Training Courses

- Legal Rights and Mental Health: a foundation course
- on 17-18 May 1995
- at Regent's College, London
- £300; £250 legal aid practices, £175 voluntary sector

- Mental Health Law Update
- on 14 September 1995
- at Regent's College London
- £175; £110 voluntary sector

Further info on either course from:

Mary Burguieres
Course Organiser
Phone 0181 519 2122 ext 214
Address as above