

CHC NEWS

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

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NEWS

Hospital closures

Figures uncovered at the request of the Labour Party show that 304 NHS hospitals closed between 1990/91 and 1993/94 in the UK. Of these, 245 closed in England (21 new hospitals opened in England over the same period). There have been 34 closures in Scotland, 17 in Wales and eight in Northern Ireland since 1991. It took a researcher at the House of Commons Library five months to obtain the figures from English regions after health ministers responding to parliamentary questions said that the figures were not available centrally. The largest number of closures were in South & West Region which lost 56 hospitals followed by West Midlands (43) and Northern & Yorkshire (40).

Responding to the publication of the figures, health minister Gerald Malone argued that the reduction in beds is not the issue since modern medical practice allows more people to be treated with fewer beds. The Government says that in 1993/94 there were an average of 42 episodes of care per acute hospital bed compared to 35 episodes in 1990/91. However, it is long-stay rather than acute beds which have been particularly hard hit. Of the 245 English hospitals closed, 85 were psychiatric, 60 geriatric, 60 acute, 14 maternity, 14 special and 12 not known. Across all specialties, the 35,992 beds lost in England represent 14% of the April 1990 figure. Psychiatric beds fell by 24%, long-stay beds for elderly people by 18%, maternity beds by 12% and acute beds by 6%.

Guardian/Independent/Telegraph 1 May

Government seeks privately owned NHS hospitals

The Government intends that in the future new NHS hospitals should be built and owned by the private sector. It is to give approval to four schemes, which it sees as forerunners of a more general system, in which private companies will build and run hospitals, providing all services except medical care. The schemes are in Carlisle, Swindon, Norwich and Durham. The Government has already approved over 40 privately financed NHS projects worth more than £100 million, though up till now these have been for schemes such as specialist equipment, nurses'

accommodation and hospital car parks. In each of the four new schemes the hospitals will be built privately with an agreement to lease the buildings to the NHS. Health minister Tom Sackville has said that in this way, the hospitals can be built more quickly and that the risks of delay or non-performance will be transferred to the private sector. Swindon & Marlborough NHS trust has estimated that private contractors will build a new £50 million hospital on the site of Princess Margaret Hospital in five years, whereas it would take eight to nine years to build the hospital using public money. In addition, there would be no public money available for extra facilities such as car parks and crèches.

If this initiative were to take off, it could clearly have major implications. Questions arise about the nature of the contracts involved. For example: How long will they will run for? What guarantees will trusts have about the future cost of the lease? What guarantees will new hospital owners have about future health authority purchasing plans? ACHCEW would like to hear from CHCs about the wide variety of projects which are going ahead under the Private Finance Initiative.

Telegraph 17 April

Rationing home care

There are fears that a new system restricting the home care provided to elderly people in Norfolk heralds a trend for local authorities to move dependent elderly people into residential care for financial reasons rather than on the grounds of the individual's preferences and needs. Norfolk County Council has introduced a recommendation that people should not usually be given more than 14 hours home care a week - "If a client needs more than that, residential care should be considered". Norfolk's director of social services has said that the system allows flexibility and that people needing short-term intensive help will continue to get it. However, he acknowledged that other councils could use a system of quotas in a more restrictive way. With many local authorities facing a funding crisis, some social services departments (SSDs) may limit home care since in many cases it will cost the SSD less if an elderly person goes into a residential or nursing home.

Observer 30 April

Negative attitudes

Seventy per cent of the public believe that "the closure of long-stay psychiatric hospitals has put the public at risk of violence from mentally ill people" according to a survey conducted by MORI. Older people were more likely to think this than younger age groups. A quarter thought that people with mental illness were loud and shouted or stared, while 30% thought that mentally ill people were aggressive. The poll was published as the Royal College of Psychiatrists launched a petition calling for an end to "stigmatising images of psychiatric illness" which the college says deter people from seeking help. Michael Palin presented the results of the MORI poll in the programme to launch the BBC's mental health season which is to run till the end of the year. He said that there is no evidence that mentally ill people are more violent than the rest of the population.

There is an increasing feeling that employers have a responsibility for the mental health of their staff. While 70% of the public said that employers had such a responsibility in 1979, this had risen to 76% in 1990 and 78% in 1995.

Times 18 April

GPs condemn Acting on Complaints

The Government's document "Acting on Complaints" (see *CHC News* 102) has been condemned by GPs responding to a survey conducted by *Pulse*. Whereas 11% thought that the proposals would result in a significant improvement for patients and doctors, 66%

thought they would make the situation worse. There was overwhelming opposition to the proposed one-year limit for making a complaint: 86% felt that it would increase stress on GPs as complaints hung over them for longer. Only 41% of GPs favoured in-house complaints procedures, with 48% saying that they would lead to a rash of trivial complaints with no reduction in formal proceedings. GPs were also opposed to lay majorities on formal complaints panels, with 72% saying that hearings would be biased against GPs.

Pulse 29 April

Bar coded prescriptions

The NHS Executive and the Treasury are considering a system of bar coding on prescriptions to overcome the problem of prescription fraud. The move would also make savings by cutting jobs at the Prescription Pricing Authority. It is estimated that £60m is lost to fraud each year out of the £3bn NHS drugs budget. The PPA employs about 1500 staff to input details from prescription forms. The bar codes would store patient details and the cost of prescribed drugs. In two recent trials of such a system, patients were told that only the information written on the prescription was stored in the bar code and they were allowed to see the stored information displayed on a screen if they wished. The BMA's information technology working party has said that if a system ever goes ahead, these safeguards must be strictly adhered to.

Independent 9 May

PARLIAMENTARY NEWS

The employment status of CHC chief officers was raised during the passage of the Health Authorities Bill through the House of Lords. Labour spokeswoman Baroness Jay of Paddington moved an amendment aimed at preventing chief officers from becoming civil servants along with other regional employees. Baroness Cumberlege, the Health Under Secretary, replied that CHCs must be able to speak with an independent voice: "clearly it would not be appropriate for officers of CHCs to be employed by the regional offices ... so the employment contracts of staff will be held in the NHS." She added that details of how CHC members will be appointed and by whom are

under discussion, but their independence will be protected.

A Labour amendment to entrench the NHS code of practice was defeated. Opposition peers had raised concerns that regional office staff will not be able to speak out. Baroness Miller of Hendon reiterated the Government's position that the "responsibilities [of regional office staff] will ... be appropriate to those of the Civil Service, so it is right that the regional office staff should be civil servants". The "rights of regional office staff to speak out would change", but they would have more influence over central policies.

Healthcare Parliamentary Monitor 8 May

FROM THE JOURNALS

Informed consent

Two articles in *Nursing Times* consider informed consent. The first sets out legal requirements and the moral obligations on health staff. The second is a personal account of how inconsistent messages and inappropriate staff reactions to a patient's concerns can leave the patient feeling frightened and confused.

Maura Buchanan argues that when doctors obtain informed consent from patients, they are often doing little more than fulfilling legal requirements to release themselves from legal liability under the laws of battery. The law requires doctors to give patients sufficient information to understand the nature and consequences of a proposed treatment. The doctor must warn of any risks that are special in kind or magnitude or special to that particular patient. The test of whether a doctor has acted reasonably is whether s/he had acted in accordance with normal clinical practice, i.e. given the patient the amount of information that another doctor would have done in that particular situation.

The law leaves much to the discretion of individual doctors regarding what risks should be considered significant when they decide what information to disclose. The Patient's Charter, though not law, goes rather further: as a patient you have "the right to be given a clear explanation of any treatment proposed, including any risks and alternatives, before you decide whether you will agree to the treatment". This may raise patients' expectations and encourage them to seek redress through the ombudsman or the civil courts where those expectations are not met.

This article considers three aspects which health staff should consider when they make decisions about giving information to patients:

- ♦ Who should give the information?
- ♦ What information should be disclosed?
- ♦ Where should the information be given?

Involving nurses in consultations may help many patients. A nurse may be able to clarify what a doctor has said and patients may prefer to go to a nurse with questions after thinking about the discussion. In general, however, doctors will retain the main responsibility for informing patients and obtaining consent since the doctor will be responsible for treatment. Evidence indicates that training in communications skills is

effective in improving communication, clinical practice and patient satisfaction. However the greatest obstacle to ensuring that such training is an essential part of all healthcare training may be in persuading some doctors that they need to improve their communication skills at all.

Nursing Times 3 May, pages 27-29

Frances Jarman is concerned not mainly with how much information is given to patients and relatives, but with its consistency and the reactions of health staff to questions and doubts raised by patients. Ms Jarman's husband was acutely ill and faced with decisions about treatment. Staff sometimes thought that he had refused treatment when in fact both he and his wife were looking for information so that they could consider the available options. This problem was exacerbated by discrepancies in communications with different members of the healthcare team. The registrar and the consultant, for example, gave different information and opinions about the advisability of a transfer to another hospital. Faced with conflicting advice, the patient had reservations about transfer. When he expressed his worries to the consultant, the consultant did not probe into those worries, but instead reassured the patient that his reaction was right. Ms Jarman comments that in the USA, the refusal to transfer would not have been accepted at face value without further explanation. Similarly, when the patient refused a particular procedure, it emerged when he discussed it with his wife that he did not think his condition merited it and that he was frightened of the procedure. After exploring the issues with his wife, he changed his mind.

Ms Jarman stresses the need to share information with members of the family so that they can discuss it together. She also stresses that communication is more than just talking to patients: staff must also listen and try to understand why a particular patient reacts in a particular way.

Nursing Times 3 May, pages 30-31

"Indicators of success"?

The Radical Statistics Health Group (RSHG) examines the statistics commonly deployed by Government ministers who claim that they prove the success of the NHS internal market. The Group casts doubt on adequacy of the measures as "indicators of success" and on the conclusions that are repeatedly drawn from them.

It looks at the measures of finished consultant episodes (frequently, though misleadingly, used as shorthand for numbers of patients treated), waiting times for hospital treatment and numbers of children immunised against the main childhood diseases. This is too closely argued an article to describe in detail, but is well worth a read if you are interested in the significance of NHS statistics quoted in the press and the media.

Among the concerns raised are:

- ♦ whether all the measures used are in fact good proxies for "success" – for example one cannot assume that an increase in day surgery is necessarily beneficial without information about people's preferences and the availability of care at home;
- ♦ the decreased availability of statistical information about the NHS, in particular financial information but also other types of information (there are fears that the loss of information-gathering functions of NHS regions may lead to a deterioration in the quality of data);
- ♦ the lack of national data about primary care;
- ♦ that long-term trends, for example in immunisation rates and hospital activities, are being presented as effects of recent changes in the NHS;
- ♦ the lack of measures of outcome and effectiveness;
- ♦ the use of "league tables" unsupported by background information on case-mix and socio-economic data.

Reductions in long-stay episodes

One aspect of the changes in the NHS on which the RSHG does not comment in detail is the reduction of long-stay in-patients. However, a table in the article on in-patient episodes in England shows, for example, that the numbers of in-patient episodes lasting 183–365 days fell by 2986 (24.2%) between 1990/91 and 1992/93. Taking an average of 274 days for stays in this

category, this represents a reduction of 818,164 bed-days. Numbers of episodes lasting over a year fell by 5897 (32.4%). Numbers have fallen in all stays lasting 22 days and over. Calculating on the basis of the RSHG's table, the number of in-patient bed-days provided fell between 1990/91 and 1992/93: (If one takes the mid-point of each category of length of stay as the average for that category and assumes that people staying over a year in fact stayed for 18 months and that those staying 0-1 days in fact stayed one day, the number of bed-days provided fell by 6.6%.) Given the release of resources involved in providing fewer bed-days, it is hardly surprising that there has been a rise in the numbers of short episodes, resulting in 4.8% more episodes overall. Yet presumably many of the people in the long-stay categories still have care needs. Some may have been satisfactorily discharged home more quickly than before, but others will have gone into means-tested local authority care. Thus what is being heralded as increased NHS efficiency could be seen as a shift of the client group the NHS is serving and reduction in the extent to which it is providing for those with long-term care needs.

Recommendations

Among the RSHG's recommendations are that there should be a move to person-based as well as activity-based data. Links could then be made between separate "consultant episodes" for individual patients. Systems which enable this are already available at a local level. The new NHS number for patients should enable the data to be linked at a national level. There should also be improved measures of case-mix and outcome measures. In the meantime, confidential enquiries linked to routine data may be more useful than league tables. National data are needed about primary care backed up by demographic data, with comparative studies between fundholding and non-fundholding practices. Lastly, the Group recommends that Government ministers' press releases should be accompanied by Government statisticians' press releases. If there is no separate release, the sources and definitions of data which ministers use to support their statements should be added.

BMJ 22 April, pages 1945–50

CHC PUBLICATIONS

Getting the message: users' and carers' experiences of community care in Leeds

Liz Johnson, for Leeds CHC, 67 pages

In a one-year project 50 users and carers involved in community care assessments were interviewed once within a month of their assessment and once between three and six months later. Because of the low representation of members of minority ethnic communities in the sample, the author also visited day centres which cater primarily for members of the Punjabi and Caribbean communities. The report looks at the extent of need uncovered, the need for information, relations with staff, assessment and the provision of various types of services.

Almost all assessments were carried out promptly once one was requested. However, many people had only reached the point of having an assessment because of a crisis in their own or their carer's health. Of the group identified as having the greatest long-term needs, four had not previously received any services. Awareness of services and how to access them was low, with support groups and specialist voluntary agencies proving an important source of information. Only two referrals for assessment were the direct result of an intervention by a GP, in spite of the fact that most users regularly saw their GPs. Thus assessments tended to be a reaction to crisis rather than a preventive measure.

Of the 38 users involved, 24 had "core" and 14 "comprehensive" assessments. Even among those having core assessments, the level of need was high. Over 60% of users needed help with almost all tasks necessary for daily living. Among those having core assessments certain important needs were overlooked. Some people tended to have a succession of core assessments, each covering a different service. Comprehensive assessments seem to have been triggered by a perception that the service user needed residential care. The vast majority of these users did in fact move into residential care, despite the fact that none of the users or carers were enthusiastic about residential care in advance (a few were very happy with the arrangements after the event). The only users who succeeded in getting their care provided in the community after a comprehensive assessment were supported by carers who fought with them for this outcome.

Despite these difficulties with the assessment process, some assessments had succeeded in addressing people's individual needs and offering choices to users and carers. These assessments tended to be where there was an established relationship between workers and users/carers (either at home or in hospital). This finding is probably related to the finding that many respondents who expressed unhappiness about the assessment process felt that they had received very little information about that process. Few know why they were asked particular questions and some were not even aware that they were being assessed.

The author concludes that there is an urgent need for people to be better informed at all stages of their involvement with community care services. Without this they will be at a disadvantage in negotiating for services which meet their needs. When they are assessed they should know the purpose of the assessment and something of the range of services available. There are a number of recommendations about more flexible services (including ones which respond to changing needs), more support for carers and more alternatives so that people have a real choice about going into residential care and moving to a home that will meet their changing needs.

The FHSA informal complaints procedure in Newcastle upon Tyne:

a survey of complainants' experiences

Jacqueline Calder, Newcastle CHC, 29 pages

Jacqueline Calder interviewed 22 people who had approached the FHSA about making a complaint. She has analysed the findings of her interviews within the framework of five of the principles set out in the Wilson report *Being Heard*: accessibility, responsiveness, impartiality, simplicity and speed. These principles are applied to each of the stages in the informal complaints procedure: (1) accessing the FHSA, (2) a meeting with the lay conciliator, (3) resolution or other action after this meeting, (4) an informal meeting with the respondent practitioner, an impartial professional advisor and the lay

conciliator, (5) reaction to the informal procedures and in some cases a formal hearing.

Speed (except in two cases of reimbursement of dentistry costs) and simplicity were generally satisfactory. Accessibility, responsiveness and impartiality were more problematic. There were some problems with all these aspects in the early stages, but these became much more marked in the later stages and particularly with the informal meeting. Some people did not attend an informal meeting because they felt that they did not have enough support to cope with it and some felt discouraged by the lay conciliator. Nearly all felt that the lay conciliator was unbiased, or at worst

not really interested in their complaint, in the early stages, but this changed at later stages. Some complainants felt that the lay conciliator was impartial in the informal meeting, but more said that he seemed to be on the side of the professionals. Most felt that the "impartial" professional advisor was biased toward the professionals. In the end, many complainants felt dissatisfied with the outcome of their complaint, both among those who had not had an informal meeting and among those who had. Some felt more aggrieved when, having gone through the unpleasant experience of following through the complaints procedure to the end, nothing seemed to have happened.

Involving local people in health care purchasing: conference report

Bristol & District CHC, 19 pages

This conference report outlines the background to locality purchasing and progress to date in Avon. The CHC has sought to influence the development of locality purchasing in the district, insisting that it should involve local people and not just local GPs. Bristol District Health Authority accepted a CHC proposal that a community development worker be employed full-time for two years, managed by the CHC, but funded by the health authority. Six months into the project, some lessons are already emerging. Among these are that going to people in existing groups and locations is more effective than setting up new consultation mechanisms and that involvement needs to happen at a very

local level. Also, while people are keen to give their time to involvement, they are wary of yet more consultation without the prospect of positive action and change in response to their views. The CHC calls on Avon Health (the partnership between the DHA and FHSA) to take a strong lead in responding to local voices, while ensuring that no patients are neglected because their condition is simply unpopular. This is a difficult balance to achieve. For public involvement to succeed, Avon Health must keep a strong overview, ensure that equal weight is given to different participants and be explicit about how much change can be achieved within a given time.

CHC Publications: Listings

Complaints service: report for 1994 (comprising report, client satisfaction survey, internal review, recommendations, complaints policy and protocol).

Salford CHC, 36 pages

Bowburn Medical Practice Patient Survey, March 1995

North Durham CHC, 6 pages

Epilepsy Leaflet: sources of information for people diagnosed with epilepsy

Winchester & Central Hampshire CHC and Help for Health Trust

Survey of Maternity Services in the Huntingdon District 1993- 1994

Huntingdon CHC, 55 pages

Access survey for the disabled: Townlands Hospital Henley

West Berkshire CHC, 12 pages

The provision of health services for ethnic minority communities in North Tyneside

North Tyneside CHC, 11 pages

GENERAL PUBLICATIONS

An evaluation of the role and impact of Community Health Councils

Sarah Buckland, Carol Lupton and Graham Moon, Social Services Research and Information Unit, Kings Rooms, Bellevue Terrace, Southsea, Hants PO5 3AT; phone: 01705 811504; fax: 01705 832730; 34 pages, £6.50 + P&P of £1.25 for one copy or £1.50 for more than one.

This report describes a two-year study of the operation and effectiveness of CHCs. It builds on previous work (carried out in 1989) in which each CHC was classified as falling into one of five categories:

- ♦ consumer advocate
- ♦ DHA partner
- ♦ independent arbiter
- ♦ independent challenger
- ♦ patient's friend

One CHC was selected from each of these five clusters for case study. Interviews were held with the chief officer and chairperson of each CHC and recent CHC reports were collected. Interviews were also held in each area with managers from the DHA, NHS trust, the RHA, the FHSA and the Council for Voluntary Services. Questionnaires were sent to all members and co-opted members of the CHC. A street survey of 400 members of the public was carried out in two of the areas.

Findings of the study cover:

- ♦ public awareness of CHCs;
- ♦ the structure of CHCs – the role of the chief office and of members, staffing and training;
- ♦ the characteristics and involvement of members;
- ♦ the activities of CHCs in complaints, involving consumers and contact with purchasers;
- ♦ attitudes of CHCs and others on the role of the CHC in the reformed NHS.

Variations between CHCs

Differences are drawn between the responses of the individual CHCs. Unlike the others, the *independent challenger* CHC did not have internal working groups. The *patient's friend* CHC had no members who had served for six years or more, whereas 63% of the *DHA partner* CHC members had served for this long. All the members of the *consumer advocate* CHC were white. Members of the *consumer advocate* CHC reported putting in many more hours than members of other CHCs.

Despite the individual pattern of responses, the five CHCs could be divided into

those considered "collaborative" (*consumer advocate, DHA partner and patient's friend*) and those considered "independent" (*independent challenger and independent arbiter*). The chief officers in the independent CHCs were more likely to see their role as confined to facilitating and acting as a source of information for members. Collaborative CHC chief officers, while accepting this as part of their role, were more likely to express their own views. The collaborative CHCs had higher staffing levels, had more members who were in paid work and had more members aged under 60.

The division into collaborative and independent CHCs was clear in the perceptions of purchasers and providers. DHAs and trusts in the collaborative areas were more likely to see CHCs as knowledgeable, pro-active and influential. It would be useful to explore these attitudes further. It is not clear to what extent the isolation of independent CHCs stems from the philosophy of the CHCs and to what extent from a lack of commitment by and respect from their health authorities and trusts. It is also interesting that areas in which relations between CHCs and purchasers/providers are most difficult are those areas with fewest CHC staff and with a higher proportion of female, older and out-of-work members.

Public awareness

Public awareness of CHCs was low (9% has some idea of the work of CHCs, but only 2% would go to a CHC for information about local health services and 3% to complain about local health services). The authors comment that CHCs may be in a difficult position if they respond to this lack of awareness: they may not be able to cope with an increased demand for their services. If their increased responsibilities were acknowledged, they would need more resources for publicity and to deal with the resultant increased contact with the public. However, the authors note that there is little evidence of any political commitment to do this despite the rhetoric of consumerism.

Handling complaints

British Dental Association Advisory Service, Advice Sheet B10, 11 pages

BDA, 64 Wimpole Street, London W1M 8AL, phone: 0171 935 0875; fax: 0171 487 5232

This advice sheet for dentists starts by recognising that most patients who are unhappy with the treatment or service they have received do not complain. It urges dentists to develop an efficient in-house system for handling complaints so that those who do complain can be taken seriously: they may be bringing to light what many patients are feeling but are reluctant to express. After discussing general approaches to handling complaints, the sheet sets out suggestions for simple practice procedures covering various stages of a complaint and includes sample letters of acknowledgement and response. It briefly covers the process of introducing a complaints procedure. A Code of Practice is included (local details to be filled in) which can be used to publicise the procedure and inform patients.

Poverty and health: tools for change

Edited by Sue Laughlin and David Black

Available from The Public Health Alliance, BVSC, 138 Digbeth, Birmingham B5 6DR, phone: 0121 643 4343/7628; fax: 0121 643 4541

192 pages, £15 PHA members and some others (details from PHA); £30 statutory organisations

"This pack is about poverty, its effects on health and the attempts that are being made to reduce the burden of ill health that poverty brings". The editors are firm in their focus on "poverty" rather than on "disadvantage", "health inequalities" or the even more euphemistic "social variations in health". They believe that, while a concentration on "health inequalities" can provide a useful perspective, it tends to lead to a neglect of poverty as one of their main causes. Commenting to the *Guardian* on lessons from many projects which promote health in the face of poverty, David Black said that as a society we have a range of options, from eradicating poverty to tinkering with the effects of poverty. He believes that at the moment the pendulum is at the tinkering end. He has found that the most successful schemes operate on both the day-to-day and the strategic levels – they cannot get away with just "campaigning or complaining", but need a fairly strong political and policy

agenda. This perspective underpins one of the themes in the pack: the need for collaborative working both at local and national levels. Projects need to overcome their isolation both from others in the same field and from statutory agencies. The pack provides examples in which statutory agencies have begun to work more closely with communities and suggests ways for a more strategic approach.

The tools referred to in the title – ideas, information, analysis and action – are found throughout the pack. Information is provided on poverty and the link between poverty and health. A second chapter describes projects which are taking action on poverty and its effects on health. This information is analysed to examine how local activities fit into an overview of possible action. A third chapter provides more detailed case studies of selected projects. Chapter four provides supporting information on topics such as funding, evaluation and networking. The final chapter presents a database of projects and includes a disk of the database which can be run under Windows. The pack is attractive and easy to read: a good deal of effort must have gone into its design so that it is easy to find your way around and use it.

Tackling inequalities in health: an agenda for action

*Michaela Benzzeval, Ken Judge & Margaret Whitehead
The King's Fund, 2 Palace Court, London W2 4HS.
Available from BEBC PO Box 1496, Poole, Dorset, BH12 3YD, phone: 0800 262260; fax: 0800 266266, 192 pages, £14.95*

Unlike Sue Laughlin and David Black above, this report *does* start from the perspective of health inequalities. However, judging from the 8 page summary, it would not be fair to say that it neglects the issue of poverty. It takes four examples of determinants of health – housing, family poverty, smoking and access to health care – to illustrate new policy initiatives that should form part of a strategy of tackling health inequalities. It also looks more briefly at unemployment, education and childcare, all policy areas mentioned at a King's Fund seminar on the topic as essential elements of any concerted attempt to tackle inequalities in health.

General Publications: Listings

The provision of wheelchairs and special seating: guidance for purchasers and providers

Royal College of Physicians of London, 19 pages, £5

A flyer/order form for this report is being sent to CHCs

Health Policy Network. In practice: the NHS market

NHS Consultants' Association and NHS Support Federation, 29 pages £3.50

Available from the NHSCA, Hill House, Great Bourton, Banbury OX17 1QH

The development and implementation of clinical guidelines

Royal College of General Practitioners, 31 pages, £10 members, £11 non-members from RCGP Sales, 14

Princes Gate, Hyde Park, London SW7 1PU; phone: 0171 823 9698.

Consumer involvement initiatives in clinical audit and outcomes: a review of developments and issues in the identification of good practice

Marcia Kelson

Commissioned from the College of Health by the Clinical Outcomes Group, Department of Health. 62 pages.

Available on paper or on disk in WordPerfect format from Publications Unit, College of Health, 21 Old Ford Road, London E2 9PL.

OFFICIAL PUBLICATIONS

A policy framework for commissioning cancer services

Report by the Expert Advisory Group on Cancer, Department of Health and the Welsh Office

40 pages, no availability details given, DoH ref: 2603 1P 2.25k April 95

The Government has accepted the recommendations set out in this report, which are broadly the same as those outlined by the Advisory Group last May (see *CHC News* 94, p1). The need for change in the way cancer services are organised stems from the fact that there are wide variations in the outcomes of treatment at different hospitals. In the case of breast cancer, for example, recent evidence suggests that patients of surgeons "identified as having specialist skills" were 8.9% more likely to be alive five years after treatment than patients of other surgeons. An important aim of the recommendations is to ensure that those treating cancer patients treat a sufficient number of patients with the conditions concerned to ensure that they adhere to current best practice.

Seven principles stress the need for all patients to have access to a uniformly high quality of care as close to their homes as possible. Public and professional education and screening are needed to help the early recognition of symptoms. Good communication within the health system and between patients/carers/families and professionals is essential at all stages up to and including follow-up care and in some cases bereavement.

The framework envisages three layers of care:

- ♦ Primary care: guidelines should be drawn up to ensure appropriate referral and follow-up and the role of Primary Health Care Teams in the management of cancer should be developed.
- ♦ Cancer units: these should be created in many district general hospitals. They should be of a size which allows sub-specialisation in common cancers (breast, lung and gastro-intestinal). They should provide palliative care, access to counselling and other forms of support and integrate these with the primary sector.
- ♦ Cancer centres: these should normally serve a population of more than a million, though geographical constraints should be considered. A population of two-thirds of a million should be considered an absolute minimum. A cancer centre should treat common cancers for local residents and less common and rare cancers and cancers requiring specialised treatment for its whole catchment area. Radiotherapy should normally be provided in cancer centres.

National Health Service Outpatient Services in England and Wales

National Audit Office, 42 pages, £8.15. Available from HMSO.

The NAO investigated waiting times for first out-patient appointments, responses to non-attendance by patients, cancelled clinics, communications between hospital doctors and GPs, waiting times in clinics, dealing with complaints and seeking patients' and GPs' views of the service.

Waiting times

The English and Welsh Patient's Charter standards both require that all patients be seen within six months of a GP referral. Waiting times at six hospitals for dermatology; ear, nose and throat; and general medicine were investigated for this report. In March 1994 three of the hospitals were achieving a maximum six-month wait in all these specialties. At the Prince Philip Hospital in Llanelli the *minimum* wait was 19 weeks and the maximum 46 (figures had been steadily worsening over the previous year). At Mount Vernon Hospital in Northwood, by contrast, patients were waiting between one and eight weeks in March 1994, and most figures had improved over the year. It is interesting that most of the figures from the two Welsh hospitals visited were relatively poor despite the fact that targets for waiting times have been set for some years in Wales, but not in England. Examples are given of measures to reduce waiting times including: specialist clinics, evening clinics and additional consultant-led out-patient clinics.

DNAs

In 1993/94, 12% of out-patients in England did not attend their appointment (DNAs). In each of the hospital specialties examined for this report there were DNA rates of over 10%. The NAO has found examples of practical responses to this wasteful problem. After action to reduce DNAs at selected out-patient clinics, Leicester General Hospital succeeded in reducing the DNA rate at those clinics from 11% to 2%. It was found that the most effective measure was to ask patients to confirm their appointment ten days in advance of the clinic. The hospital then telephones those patients who have not confirmed by one week before the appointment.

GP and patient involvement

One page of the report is devoted to how hospitals seek patients' and GPs' views of the service. It mentions that the health authorities visited had used CHC surveys and "incorporated discussions with patients in their programme of visits to hospitals". All the hospitals had undertaken surveys of patients' opinions and four

had undertaken focus group discussions. However, the report does not go into the question of involvement in any detail. Apart from mentioning that one hospital has increased parking spaces and another improved wheelchair access to waiting areas, it does not examine the quality or coverage of the research or the extent to which health authorities or hospitals have allowed their research to influence services.

SHSA Review 1995

*Special Hospitals Service Authority, Charles House,
375 Kensington High Street, London W14 8QH;
phone: 0171 605 9700; fax: 0171 605 9728,
36 pages*

The Special Hospitals Service Authority (SHSA) was set up in 1989 to take over responsibility for Ashworth, Broadmoor and Rampton hospitals. About 70% of their 1500 patients are admitted from prison or on a court order; the remainder are not detained as a result of a criminal offence but are considered sufficiently dangerous to need special security. This review outlines recent changes that have been made to the regime at the hospitals. Patients' groups have been introduced and have achieved some changes to the day-to-day lives of patients. An SHSA variant of the Patient's Charter has been developed and complaints officers have been employed - each hospital now appoints independent investigators to look into serious complaints. Staff have been expected to adopt new working practices and, though it is clear that there have been some successes, it is difficult to judge from the review (which stresses the positive) how far the transformation has gone.

Confidential Enquiry into Stillbirths and Deaths in Infancy. Annual Report 1993.

Methods and main results, 95 pages

Additional results and tables, 123 pages

*No availability details given, DoH ref: F51/036
2382 20k, March 1995*

FROM THE VOLUNTARY SECTOR

A National Research Ethics Committee?

The Summer 1995 newsletter of Consumers for Ethics in Research (issue 17) devotes four pages to a consideration of the role that might be played by a National Research Ethics Committee (NREC). It concludes that an NREC would divert attention and resources from Local Research Ethics Committees (LRECs) and might cut short the growth of public information and debate. An NREC could result in contentious issues being settled in private committee rooms among eminent members who may be selected to agree which each other.

The authors accept that there are concerns about the *working of LRECs*. Moves are already under way to improve training of members, to increase efficiency and to standardise application forms. Better funding and administrative support and fuller use of local expert advisers are needed. However, some argue that this will not be enough. The procedures for obtaining approval for multi-centred research are long and complex, and problems arise where individual LRECs ask for changes in a research design which has to be identical in all the centres involved. Critics of LRECs argue that an NREC is needed to overcome these problems. It would approve research designs where, say, five or more centres are to be involved. LRECs would have the right to reject research projects which have been approved by the NREC, but not to comment on the research design.

It is argued here that an NREC might raise more problems than it solves. The article outlines a series of objections: How would an extra tier of approval reduce delays? Who would take responsibility for any adverse effects from approved research? Might the system introduce bias in research? (If LRECs have options only of vetoing or approving research there may be a tendency for LRECs with large minority ethnic communities, for example, to veto research because the design is unsuited to their local populations, thus concentrating research in areas with small ethnic minorities populations.) How could an NREC have adequate local knowledge or the ability to become practically involved and monitor research?

A theme running through many of the

objections is the question of who would be approving research designs. There would be a tendency for any national committee to have a membership drawn from eminent people from prestigious institutions, with "lay members" who do not represent anyone. Under these circumstances an NREC, reaching consensus in private committee rooms, could become a soft option for researchers. CERES and other small lay organisations have found examples of major flaws in research designs which expert committees appear to have missed. The authors believe that, although researchers and researched have the same overall aim of happy healthy people, their views on the means to that end often differ. There are competing concerns in research and since there is not necessarily a "correct balance" of conflicting values, review is *confusing and contentious*. An NREC might seek to avoid this confusion by selecting members who will agree with each other. However, that would merely avoid the tension of values which it is the purpose of RECs to address.

From the British Diabetic Association

The British Diabetic Association (BDA) has been helping people with diabetes for over 60 years, providing advice and support and funding research projects throughout the UK.

In 1992 the BDA and the Department of Health formed the St Vincent Joint Task force for Diabetes, which is looking at improving the standard of diabetes care offered to people with diabetes. The BDA will be involved in lobbying health care commissioners at a local level – work which may need liaison with CHCs.

The BDA will be exhibiting at the ACHCEW Annual General Meeting from 4–6 July. Representatives from the BDA are very keen to meet and build relations with CHCs, so please come along to the exhibition stand. A wide selection of information on the BDA and its work will be available over the three days of the conference.

National Drugs Helpline

The National Drugs Helpline gives free confidential advice and information over the phone. Numbers and times for the various language services are as follows:

Language	Phone	Times
English	0800 77 66 00	24 hours a day, 365 days a year
Welsh	0800 37 11 41	daily, 10 a.m. to 2 a.m.
Bengali (Silheti)	0800 37 11 42	Tuesday, 6 p.m. to 10 p.m.
Cantonese	0800 37 11 37	Tuesday, 6 p.m. to 10 p.m.
Gujarati	0800 37 11 44	Wednesday, 6 p.m. to 10 p.m.
Hindi	0800 37 11 46	Wednesday, 6 p.m. to 10 p.m.
Italian	0800 37 11 38	Monday, 6 p.m. to 10 p.m.
Portuguese	0800 37 11 39	Thursday, 6 p.m. to 10 p.m.
Punjabi	0800 37 11 43	Wednesday, 6 p.m. to 10 p.m.
Spanish	0800 37 11 40	Monday, 6 p.m. to 10 p.m.
Urdu	0800 37 11 45	Wednesday, 6 p.m. to 10 p.m.

When lines are closed, there is a taped message instead.

Waiting times for cardiac patients

One of the new Patient's Charter standards states that "you can expect treatment within one year for coronary artery bypass grafts and some associated procedures. (If your consultant considers your need for treatment is urgent, you can expect to be seen much more quickly than this.)" Rather than a "blanket" waiting time of one year from the first out-patient appointment, the British Cardiac Society (BCS) believes that there should be interim targets for waiting times. These are:

- ♦ A maximum time for a GP request for a specialist consultation with a cardiologist – 1 month
- ♦ The maximum waiting times for investigation – 3 months
- ♦ The maximum time for intervention by coronary artery surgery or angioplasty (balloon treatment) – 6 months.

The BCS considers it necessary for health authorities to decide how they are going to address each of these waiting periods. Shortening maximum waiting times should not be done at the expense of patients with other cardiac conditions or patients with urgent cardiac conditions.

DIRECTORY AMENDMENTS

A new directory is to be distributed very shortly, if it has not already arrived, so we are not listing amendments in this month's newsletter.

INFORMATION WANTED

For our files

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

Milton Keynes CHC would like to hear from any CHC which knows of a GP fundholder practice which has **removed from its list patients who are resident in a nursing home for elderly people.**

Are any CHCs aware of hospitals providing out-patient **chemotherapy for which the patient pays prescription charges** for the drugs used? If so, please contact Wigan & Leigh CHC.

Could any CHCs with experience of using questionnaires (or other methods) to help members **monitor patient satisfaction with CHC services**, please contact Berenice Grogut at South West surrey CHC.

ACHCEW would like to hear from any CHCs:

- ✦ which write to patients prior to hospital visits and/or give them forms or letters encouraging them to contact the CHC with any comments or afterthoughts;
- ✦ which have had any contact with or information about "Westminster Healthcare" which runs nursing homes.

North Tyneside CHC would like to hear from CHCs which have done work on patients' **requests for home visits and the key influencing factors.**

Preston CHC would be interested to hear from any CHC which has developed proposals and or a business case for the development of a **shopfront health information service.** The CHC would like information on your success, or failures, as it does not wish to reinvent the wheel. Please send information to the CHC or ring Anglene True on 01772 259089.

Deadline

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

Croydon CHC has been concerned about GPs and hospital consultants removing patients from their care. It is also concerned with the **accountability of consultants and the monitoring of their non-NHS activity.** It is considering trying to develop local codes of good practice with local GPs and consultants which cover areas not prescribed by legislation. The CHC hopes that GPs will subscribe to the codes voluntarily and incorporate them into practice charters. In the case of consultants, the CHC would also be asking for a voluntary, publicly available register of private interests. It would like to hear from any other CHCs which have adopted an approach of this kind and about any obstacles they have experienced.

Peter Walsh, Chief Officer at Croydon CHC would also like to hear:

- ✦ from any CHCs have been involved in work with **optometrists;**
- ✦ about CHC or patient involvement on GP **locality commissioning groups;**
- ✦ from CHCs which are aware of **medical records going missing where a complaint is in process or is likely or any cases in which it has been established that medical records were deliberately destroyed to obstruct a complaint or investigation.**

AGM NEWS

We would be very grateful for help with the production of AGM NEWS at this year's conference in Cardiff. Last year the help of just a few people made an enormous difference in enabling us to get the newsletter printed and distributed in time for participants to take copies home.

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.

FORTHCOMING EVENTS

Research into surgery

- ♦ meeting organised by Consumers for Ethics in Research
- ♦ Martyn Smith, Chief Officer of West Birmingham CHC will be chairing the meeting on ACHCEW's behalf
- ♦ on 21 June 1995, 6.00-8.30 p.m.
- ♦ at Friends House, 173 Euston Road, London NW1
- ♦ the CERES AGM will be held at 4 p.m.
- ♦ admission free

Further info from:

0181 8092 8231 or 01732 458021

Diverse needs, diverse choice

- ♦ one-day national maternity services conference
- ♦ organised by the Changing Childbirth Implementation Team, the Commission for Racial Equality and Manchester Action Committee on Health Care for Ethnic Minorities
- ♦ on 27 June 1995
- ♦ at G-Mex Centre, Manchester
- ♦ £35 purchasers/providers;
£20 consumer/voluntary organisations

Further info from:

Machem
Unit 28 Greenheys Business Centre
10 Pencroft Way
Manchester M15 6JJ
Phone: 0161 232 0488
Fax: 0161 232 9217

Not just black and white?

- ♦ conference for everyone interested in the development of good mental health services for people from African, Caribbean, Asian, Chinese, Vietnamese and refugee communities
- ♦ organised by Good Practices in Mental Health
- ♦ on 12 July 1995
- ♦ in Central London
- ♦ free to unwaged user and carers, £30 for organisations with income less than £10,000; £60 for income £10,000 to £100,000; £100 others.

Further info from:

Caroline Harding
Good Practices in Mental Health
380-384 Harrow Road
London W9 2HU
Phone: 0171 289 2034

Listen with mother conference: consulting users of maternity services

- ♦ one-day national maternity services conference
- ♦ organised by the Changing Childbirth Implementation Team and the Maternity Services Group
- ♦ on 6 July 1995
- ♦ at Marriott Hotel, Bristol
- ♦ £50 purchasers/providers; £20 user representatives

Further info from:

Caroline Newman
Project and Development Manager
Changing Childbirth Implementation Team
NHS Executive
Union Lane
Cambridge CB4 1RF
Phone: 01223 375242/375568
Fax: 01223 375569

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 18 July 1995
- ♦ at OPM office (see below)
- ♦ £185 + £32.38

Further info from:

Debra Cartledge
Events Coordinator
Office for Public Management
252b Gray's Inn Road
London WC1X 8JT
Phone: 0171 833 1973
Fax: 0171 837 5800

Retiring into poverty

- ♦ conference organised by Age Concern
- ♦ considering the problems caused by low incomes among older people and solutions
- ♦ on 19 July 1995
- ♦ at Purcell Room, South Bank Centre, London SE1
- ♦ £80 + VAT (reduced rates for voluntary org'ns, unwaged & retired people, students)

Further info from:

Claire Brooke
Phone: 0181 679 8000