CHC NEWS

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

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NEWS

Out-of-hours victory for GPs

GPs have achieved all their key objectives in a deal with the Government over out-of-hours care.

Among the items agreed are that:

- GPs will have the right to transfer out-of-hours responsibility to any named principal, but they cannot contract out of the responsibility altogether. "Adequate means of easy communication" must be provided for patients to get in touch with the night doctor. ("Out of hours" is defined as 7 p.m. to 8 a.m. on weekdays and 1 p.m. on Saturdays to 8 a.m. on Mondays.)
- All GPs will have access to a £45 million fund (for this financial year) set up to develop alternative out-of-hours services, such as primary care centres.
- The current two-level night visit fee will be replaced by a £2000 retainer for each GP plus £20 per night consultation (10 p.m. to 8 a.m.) whether this is carried out by the GP or by a deputy and whether it takes place in a centre or in the patient's home.
- The doctors' pay review body will price out-of-hours work separately from the cost of daytime cover.
- The Government will launch a publicity campaign to discourage the public from calling out doctors at night for "trivial" complaints.

As a result of the deal, it will become increasingly common practice for patients to be asked to travel to a doctor rather than being seen at home after hours. Where patients are currently visited by their own doctors out of hours, they will increasingly see a doctor other than their own GP.

The General Medical Services Committee of the BMA accepted the package unanimously. The committee is to continue exploring the possibility of separate contracts for day and night cover. This may eventually lead to some doctors contracting to work office hours only, although the Government is likely to resist such a change.

Doctor 28 September, Telegraph/Times/Independent 22 September

Dental registrations fall

NHS dental lists have fallen by almost a million over a period of nine months, according to figures from the Dental Practice Board. The figures show that, in England and Wales, 22 million adults were registered with an NHS dentist in June this year, compared to 22.9 million in September 1994, a fall of 4%. Child registrations had fallen by 80,000. The Department of Health says that the number of NHS dentists is at a record high and that NHS dental care is available throughout the country.

In some areas special measures are being taken to ensure that people can access NHS dentistry. A scheme has been set up in Wales to attract British and overseas dentists. Dentists moving to areas where there are problems are being offered start-up grants of between £25,000 and £50,000. In return they must contract to do 35 hours of NHS work a week for a minimum of five years. In other places dental practices are recruiting overseas staff. An NHS-only practice in Great Yarmouth, for example, has recruited two dentists from Denmark and three from South Africa, having failed to recruit dentists from Britain.

Times 9 September, Indep. on Sunday 24 September

Medical negligence mediation

A voluntary mediation scheme to deal with alleged cases of medical negligence is being piloted in Oxford & Anglia and Northern & Yorkshire Regions. In the first case handled by the scheme, a woman complaining of inadequate care at Hinchingbrooke Hospital, Huntingdon, was given an unreserved apology by the hospital and compensation. The hospital agreed that Ruth McCall had lost her unborn baby after a hospital consultant "failed to provide a good standard of medical care". The findings have been referred to the General Medical Council.

Both Mrs McCall and the hospital expressed satisfaction with the system. Mediation is carried out by solicitors who are trained for the scheme – in this case by a solicitor discussing the case with Mrs McCall and hospital representatives in separate rooms. The hope is that the scheme will provide a simpler, cheaper and quicker way of settling disputes than litigation. It may also enable patients to bargain for remedies which are not available in the courts, such as the retraining of doctors or changes in hospital practices.

The pilot scheme is being run by the Department of Health and is likely to be extended to other regions if it proves a success.

Telegraph 23 September

Rationing gaining currency

At home ...

Berkshire Health Authority is one of many health authorities which are restricting or withdrawing treatments available on the NHS. It has been more open than some, however, and is currently putting out proposals for public consultation as part of its purchasing plan. The Authority has already drawn back slightly from its proposal to withdraw 12 common procedures under the NHS. It does, however, plan to reduce the purchase of many of these.

Treatments to be reduced

- varicose vein treatments
- insertion of grommets for glue ear
- correction of breathing difficulties which cause snoring
- dilatation and curettage for women aged under 40

Treatments to be largely withdrawn

- sex change operations
- stomach tucks
- the removal of wisdom teeth

Treatments already not routinely funded

- tattoo removal
- IVF
- some cosmetic procedures
- reversal of sterilisation
- alternative therapies

The Authority needs to find £7 million savings out of the £220 million it spends annually. It estimates that it will save more than £3 million by reducing the number of operations. It hopes to achieve further savings by internal economies and reducing GP fundholder budgets.

Telegraph/Times 27 September

... and abroad

Many industrial countries are investigating ways of restricting state health spending. Britain spends some 6% of GDP on health care. However, even countries which spend more than this, such as **Germany** and **Sweden**, are finding it difficult to contain health costs. In the **USA**, which spends 12% of GDP, a variety of cost-cutting measures are being considered, including the Oregon plan. Under this plan, 688 possible categories of illness and treatments were listed. The state provides only the first 568 treatments on the list.

A recent report from the Royal College of Physicians (see page 4) reviews some of the methods being used in other countries.

In **Canada**, where there is comprehensive insurance-based health care, many provincial governments are "de-insuring" some services which are judged to be medically unnecessary. They are also reducing funding for long-term care, charging co-payments for services and cutting back on the list of drugs provided through the public health services.

New Zealand is attempting to define a core of essential services which will be guaranteed. The effectiveness and benefit of all services will have to be proved if they are to be included in this core.

In **The Netherlands** a package has been proposed which will confine guaranteed treatments to those which are necessary, effective and efficient and not easily regarded as the responsibility of the individual. Restrictions may include excluding dental care for adults, agreeing a limited drug list, setting a time limit on physiotherapy and setting charges.

RCP report, Guardian 19 September

Fertility treatment tables

The Human Fertilisation and Embryology Authority has published performance data for in vitro fertilisation and donor insemination services. ACHCEW welcomes the fact that the public are to be provided with information, but it has reservations about the methodology used for comparing performance between centres.

The HFEA also published a list of questions people should ask when they are considering using a clinic's services (see overleaf).

For copies of the performance tables, send a self-addressed envelope with a 52p stamp on it to: HFEA, Paxton House, 30 Artillery Lane, London E17.

Fertility treatment centres: questions to ask

What tests would be carried out by the clinic?
What treatments are offered by the clinic?
Is there a waiting list for treatment?
How many times will I have to visit the clinic?
What is the cost of treatment?
Who are the donors of sperm and eggs?
What information does the clinic provide to patients?
What counselling is on offer?
Does the clinic have a patient support group?
What is the clinic's live birth rate?
What is the risk of a multiple birth?
What will happen if I get pregnant?
What will happen if I don't get pregnant?
How long has the clinic been established?
How does the clinic involve the male partner?

Guardian 12 October

PARTY PIECES

Dissent in the ranks

The official Liberal Democrat statement debated at the party conference spoke of moving the focus of policy away from the structure of the NHS and avoiding large-scale reorganisation. The party would maintain the purchaser/ provider split, with a switch from purchasing to "commissioning".

The statement also proposed:

- a National Inspectorate of Health and Social Care to raise standards and promote the interests of patients
- freezing prescription charges and restoring free eye and dental check-ups (financed by a large increase in tobacco taxes);
- focusing policy on health promotion which would address the effects of poverty, pollution etc.;
- putting local people on hospital trusts;
- setting up regional health and social services boards.

In the event the conference voted for local authorities to commission NHS care, causing considerable annoyance among party leaders who warned that councils are not in a position to take on the extra workload. The motion was passed by a substantial majority.

Guardian 15 September, Independent 21 September

Action or reaction?

Margaret Beckett used much of her conference speech to criticise the Government, accusing it, on the one hand, of frightening people into taking out private health insurance, and on the other of keeping quiet about a two-tier "safety net" system before the next election. She demanded that the Government should:

- end mixed-sex wards (as she promised Labour would do).
- set minimum standards for community care
- ban tobacco advertising
- halt current efforts to market test 48 clinical services with a view to contracting them out.

Labour would:

- replace the internal market with a "cooperative commissioning framework" – the purchaser/provider split would be maintained;
- put all GPs on the same financial footing as fundholders (Labour policy towards fundholding seems to be hardening, and now amounts to the phasing out of the fundholder scheme – it has certainly been received badly by GP fundholder organisations);
- stop the trend towards private investment in the NHS.

Guardian 5 October

Courting popularity

In his speech to the Conservative Party conference, Stephen Dorrell announced that NHS trusts must publish their full administrative costs for 1995/96 and cut them by 5% in 1996/97. He has thus reversed the much-criticised decision taken by Virginia Bottomley in June that trusts need publish only senior management costs, which account for some 3.9% of trust budgets. It is estimated that full administrative costs account for about 10.5% of budgets.

Health authorities will also be required to cut administrative spending by 5%, but it is not clear how this will be assessed as DHAs and FHSAs are to merge next April.

Mr Dorrell has promised that the savings (expected to be about £140 million) will go to improved patient care and not to the Treasury.

An efficiency scrutiny group is to report within 90 days on ways of reducing paperwork in hospitals and community services.

Mr Dorrell also announced that from next April the Patient's Charter would include a standard that no-one should wait more than two hours in A&E for admission to hospital.

Independent/Guardian 12 October

"TALKING OURSELVES INTO A CRISIS"

Those who do not believe that the most enlightening debates take place on the floors of party conferences can always turn to the reports from the great and the good to see what the future holds in store. September provided the depressing spectacle of two distinguished groups and one ex-chairman of the NHS Trust Federation accepting with little resistance the limitations of a publicly funded health service, though they propose rather different solutions.

Setting priorities in the NHS

This report from the Royal College of Physicians of London cites an article in the *Journal of the Institute of Actuaries* which estimates that by the early years of the next century 11% of the nation's wealth will be consumed by long-term care. Funding for the whole of the NHS has been running at 6–7% of GNP for over a decade. The College steers clear of any arguments about how additional funding will be made available; instead, it accepts that prioritising within the NHS will be necessary. This report sets out a framework for decision-making in the NHS and sets down some concerns of hospital doctors.

The report stresses that decisions should be made openly, with health authorities continuing to be responsible for maintaining national priorities and for deciding on the balance between health promotion, illness prevention and treatment. It voices concerns about the expertise of fundholders in some decisions they are required to make; about the impact of reduced referrals to specialist units; about training and R&D; and about decisions being made by those whose first priority is to contain costs rather than to maintain quality. It sees waiting lists as a valid *rationing mechanism* for low priority treatments.

Experts or representatives?

The RCP proposes that a National Council for Health Care Priorities should be established to find ways of improving priority setting in the NHS which would involve, educate and inform the public, the professions and Government. Although the press release accompanying the report and the report summary say that the Council should include representatives of the public, the detailed proposals on membership in the report do not specify this. "The Council must be expert rather than representative in nature." It must be "sensitive to the concerns of users". In order to secure the commitment of the Government, "the Secretary of State for Health [would nominate] members in consultation with the Royal Colleges, the Standing Conference on Public Health, representatives of the nursing and other health care professionals, and other appropriate organisations".

The report is available for £7.50 from The Royal College of Physicians, 11 St Andrews Place, Regent's Park, London NW1 4LE

Not insidious

Those who can afford to take out health insurance should do so in order to ensure that the NHS can continue to care for vulnerable and elderly people, according to the retiring chairman of the NHS Trust Federation. Rodney Walker said that if the NHS was to maintain existing levels of service, it would need a 20% real funding increase by early next decade. He said that the NHS must be protected for "the elderly, the seriously ill, the most vulnerable and those who need emergency services". The Government should provide tax relief in order to encourage private health insurance.

Mr Walker's comments came the day after Margaret Beckett had been heckled at the NHS Trust Federation conference for saying that Government policy was leading to privatisation of the NHS. Responding to her Mr Walker had said that no-one in the hall believed that they were part of "some insidious process towards privatisation".

Independent 14 September, Guardian 15 September

Healthcare 2000

Headlined as a "thorough examination" by *The Times*, this report contains a couple of graphs, a handful of figures and the conclusion that "it is not possible to expect the continuing gap between resources and demand to be closed through increased tax funding alone". Two members of the Health 2000 group refused to sign the report, one because it travelled too far in the direction of privatisation, the other because it did not go far enough. One gets the impression that the authors and those who refused to sign have been driven by feelings of what is inevitable or desirable rather than by persuasive and detailed evidence.

The report sets out clearly theoretical options for healthcare funding and provision and, in qualitative terms, the pressures on the NHS. However, though it raises a host of questions, it does not provide the materials with which to answer them.

The population aged over 65 is forecast to rise from 10 million today to 18 million "before the middle of the next century". No figures are put on what this may mean for the need for expenditure on care of elderly people. Nor is there an analysis of the implications of demographic changes for tax revenues.

The possibility of funding through health insurance is floated, but dismissed because "a system funded predominantly through individual contributions has found little favour in the UK." The arguments for insurance are given in five and a half lines. The arguments against take up barely more space. A good deal of detailed research and argument on this important topic is available: it is neither presented nor cited here.

On such flimsy bases as these, it is concluded that a proportion of healthcare funding must be provided by individuals through options such as user charges. It leaves open for debate the issue of whether such payments should be permitted within the NHS or confined to the private sector. If payments are allowed within the NHS, they might include charges "for private rooms with a choice of food ... for certain treatments that are not universally provided ... [and] for appointments within a specified time limit in primary care and in non-urgent secondary care."

The public's view

Healthcare 2000 considered patient representation. It says that attempts to increase the powers of CHCs have been marginal compared with the power of managers and professionals and doubts whether piecemeal reform of current systems would be adequate. Instead it proposes a statutory Patients Standards Board which would monitor the implementation and development of national and local patient's charters and other measures of patient-based standards from the consumer's point of view. It should consult with patients, their representatives and carers and be resourced to act on behalf of patients at national and local levels. The Board would report on local performance in conjunction with users, self-help groups and CHCs.

A Consumer Resource Centre should provide patients, carers and self-help groups with information from the NHS R&D initiative and about providers and clinicians.

REACTIONS

- Philip Hunt, NAHAT's Director, rejected the view that the NHS cannot be funded wholly from taxes. "We are in danger of talking ourselves into a crisis which is not there."
- Stephen Dorrell said that he saw the NHS "not as a safety net, but as a universal provider of high quality health care"
- Margaret Beckett said that the report confuses the question of whether everything medically possible is worth doing with the question of how it should be funded. There is no doubt, she said, that that is through the NHS.
- Bob Abberly, Unison's head of health, accused the report of making "a self-fulfilling prophecy". Whether money will be available in the future "is a matter of choice and political will".

A quite different dissenting note came from Roy Lilley, who will be familiar to those who attended ACHCEW's AGM in Cardiff. In typical style he announced that the report had not addressed the real problem: "The NHS should be privatised. It is a living example of a nationalised industry that is dying on its feet."

Times 19&20 September, Daily Telegraph 20 September

UK health and healthcare services is available for £10 from Healthcare 2000, PO Box 2996, London W11 4WL.

FROM THE JOURNALS

No safeguards

If a doctor judges that a patient is unable to care adequately for him/herself at home and that the patient is unable to make a decision due to mental incapacity, that doctor has the power to admit the patient to a nursing home against his/her will, with no right of appeal or review.

This happened in a case of an elderly woman who lives alone and has dementia. The woman has been assessed as self-caring, continent and mobile. On occasion she becomes confused (she has sometimes taken her pills in the wrong order, for example, but never forgets to take her medication and she once put her hand into a pan of hot fat). She was clear, lucid and insistent when she refused to go into a nursing home, saying that she wanted to go to her own home. Her consultant psychiatrist disagreed. He insisted that she would be at risk if she went home and that he had the legal power forcibly to send her to a nursing home. In a letter to Sandwell Social Services (which had been shocked by the decision) he wrote: "one is able to make a decision regarding the treatment and overall management of a particular patient, who is deemed to be unable to make a decision or give informed consent due to his or her mental incapacity". Another similar case, recently described on Radio 4, involved an elderly woman who was transferred to a nursing home and not allowed to return home to live with her daughter despite the fact that both the woman and the daughter wanted her to do so.

The legal precedent which may allow doctors to make such decisions was set in a House of Lords ruling in 1989. That case ("Re F") concerned a woman with learning difficulties whom a doctor wished to sterilise without her consent. The Law Lords ruled that if the doctor was of the opinion that the best interest of a patient would be served by being treated, then the doctor had the right to treat the patient even without consent. According to Ian Bynoe of the Institute of Public Policy Research no clear precedent has been set which refers specifically to a decision about where a person will live, rather than about the medical treatment they will be given.

The powers of doctors in these cases do not rely on the Mental Health Act. Under that Act, a patient detained in hospital would have the chance to apply to a mental health tribunal and to receive legal representation to review his/her detention in hospital. Under the Mental Health Act there are also safeguards if patients are to be given treatment, such as consent of the patient or a second medical opinion. None of these safeguards apply in decisions which rely on the House of Lords ruling as a precedent. According to the Alzheimer's Disease Society, where people with dementia can no longer be supported at home, then the usual procedure is to use the Mental Health Act.

A senior social worker has commented that, in the end, money will become the deciding factor. If this is the case, then there might be pressures on doctors not to send people to nursing homes against their will. Recent Department of Health guidance (HSG(95)8) says that people who have been assessed as not requiring NHS continuing in-patient care do not have the right to occupy indefinitely an NHS bed. However, unless a patient is being placed under Part II of the Mental Health Act 1983, s/he has the right "to refuse to be discharged from NHS care into a nursing home or residential care home". In this case, and if the patient refuses "alternative options", "it may be necessary for the hospital ... to implement discharge to the patient's home or alternative accommodation". This seems to imply that if a patient is admitted to a nursing home against his/her will, s/he should be admitted as an NHS patient. In these cases, the NHS might have responsibility to pay for the nursing home place.

The Law Commission published a draft bill early this year (see CHC News 101) which would tighten up ambiguities in this area. Under the draft provisions, where a patient is judged incapable of making a decision, his/her objections could be overridden. However, safeguards such as second opinions and judicial supervision would make such decisions less dependent on the opinions of individual doctors.

Community Care, 21-27 September

Declaration on the rights of patients

The World Medical Association (WMA) has issued a new declaration on the rights of patients. The British delegation welcomed most of the requirements on doctors, but took issue with some of them. The declaration is not legally binding on doctors, but it carries a moral authority.

The BMA has objected to the word "always" in this extract from section 4: "... physicians should always try to save the life of a patient unconscious due to a suicide attempt." Dr Sandy Macara, chairman of the BMA council, said that this excludes taking into account a living will or other unequivocal wish of a patient not to be resuscitated if they become unconscious.

The BMA also has reservations about parts of two sections which touch on treatment against a person's wishes:

Section 5: "... If the representative, or a person authorised by the patient, forbids treatment which is, in the opinion of the physician, in the patient's best interest, the physician should challenge this decision in the relevant legal or other institution. In the case of emergency, the physician will act in the patient's best interest."

Section 6: "... diagnostic procedures or treatments against the patient's will can be carried out only in exceptional cases, if specifically permitted by law and conforming to the principles of medical ethics."

BMJ 16 September

Total purchasing

Uli Freudenstein, a GP in Sheffield, argues that GPs should welcome total purchasing in which practice budgets cover all care, including emergency and maternity care. There are now 50 total purchasing pilot sites. Since they are larger than average fundholding practices, total purchasing generally involves a group of GP practices.

Dr Freudenstein sets out his views of why total purchasing has advantages over both fundholding and locality commissioning:

- in some areas, fundholders have accounted for more emergency admissions than would have been expected; total purchasing will remove any incentive to boost emergency admissions;
- where more than one practice is involved, practices will have to cooperate and will be under pressure to conform to agreed policies;
- siphoning off savings into individual practices on a large scale will cease;
- all GP practices taking part will be motivated to take part in policy-making, whereas in locality commissioning many GPs are free to carry on much as before;
- total purchasing can break down the barrier between primary and secondary care funding, gradually shifting resources and the workload to primary care and the community;
- total purchasing groups will be in a better position to reorganise care after hospital discharge, reducing the number of hospital beds needed and making seamless community care feasible.

Health Matters, Issue 22

Cutting hospital costs

An article in the *British Journal of Health Care Management* describes Coventry's Fast Response Service which was set up to identify and deliver the most appropriate package of care for patients. The service accepts referrals from GPs, hospital liaison sisters and social services (though social services seem not to have referred people in practice). A district sister assesses patients to determine their needs or the needs of their families. S/he then contacts the FRS to arrange for the package of care to be delivered. This may be in the patient's own home, in a community unit, by social services or in a hospital.

The article tentatively evaluates the success of the service in reducing expenditure on hospital stays, although this is difficult since there is no firm basis on which to judge whether patients would have been admitted to hospital had the service not been in place. It also sets out a "sensitivity analysis" which can be used to estimate saving under different assumptions about the costs of hospital stays and the proportion of FRS clients "avoiding hospital admission". It does not, however, assess the cost of care provided by the alternative carers: at home, in community units, or by social services.

British Journal of Health Care Management, 1995, Vol 1 No 12

AROUND THE CHCs

Cluster groups

Aware that many members of the public have great difficulty in attending CHC meetings, **Mid Essex CHC** has set up seven "cluster groups" in its district. In this way the CHC hopes to find out about the concerns of a diverse group of people who have contact with, and know the views of the public on, matters relating to the NHS and community care. Their comments will be fed back to the CHC and the DHA.

The groups meet quarterly in community and day centres and pubs. Each meeting is given a subject for discussion and an opportunity is given for members to bring up their own topics for discussion. Each meeting lasts about 2 hours and has 8-12 participants. Refreshments are provided at meetings and a mileage allowance is paid, as is the cost of a sitting service for a carer.

Patients' representative

Salford CHC has met with a welcome response to concerns it had raised about the relocation of long-term mental health patients at Salford NHS Trust. The North West RHA has agreed to fund a patients' representative post. The post holder will be independent of the hospital and health authorities and will work for the CHC. S/he is to help patients to say what things they would like in the future and to make sure that their views are responded to.

Deadline

If you have items for inclusion in November's *CHC News* could you please get them to ACHCEW by 7 November.

ECT: a need for change

Patricia Dawson, Director, Scottish Association of Health Councils

In 1992 a young man who suffered from schizophrenia fell from a bridge to his death.

His name was Joseph and he is sadly missed by his family. His brother, Alex, has for the past three years mounted a growing campaign to protect vulnerable patients. The campaign highlights changes needed to the Mental Health Act to ensure that a second opinion is required where ECT is proposed for any patient, whether voluntary or compulsorily detained.

The Scottish Association of Health Councils, at its AGM in September 1995, voted to support the need for change and to lobby the Secretary of State for Scotland. Alex's campaign is aimed all local authorities, major voluntary and statutory groups, MPs etc. throughout Britain.

He already has huge Scottish support. We ask for yours.

This is not only a Scottish problem. The rights of all patients to a second opinion and to informed consent are crucial.

We would ask you to consider the issues and write to Alex with your letters of support:

Alex Doherty
86 Livingstone Street
Linnvale
Clydebank G81 2RH
Phone/fax: 0141 941 2507

Joseph's story is the subject of documentary programmes and press articles. Copies are available from Alex.

The Scottish Association of Health Councils would also be pleased to discuss the issues. Contact the SAHC at 18 Alva Street, Edinburgh, EH2 4QG; phone: 0131 220 4101; fax: 0131 220 4108.

CHC PUBLICATIONS

Discharge process and after care following a stay in the Gwynedd acute hospitals
Aberconwy, Arfon Dwyfor, Meirionnydd and Ynys Môn CHCs, 25 pages

This survey involved interviews with 77 people who had been discharged from two Gwynedd hospitals. Patients were asked about: discussions prior to discharge; travel home; letters for GPs; information provided about after care and treatments; medication; and contact with healthcare professionals after discharge.

One question was on previous hospital stays, although **readmissions** were not the main focus of this survey. It emerged that 27% had been in hospital within the last three months suffering from the same condition. The CHCs comment that without further analysis no firm conclusions can be drawn from this: some patients may be suffering from chronic conditions and might have been expecting fairly regular readmission. However, the readmission figure is high enough to warrant further research.

The CHCs were disappointed to find that 21% of interviewees said they had not been involved in any **discussions about discharge** (51% said they *had* been involved). Even more (30%) said that their family/carer had not been involved in discussion about discharge (27% said families/carers had been involved). Comments – for example "was impressed by interest in home conditions" – showed that those who were involved in discussions appreciated the fact. Although 30% of respondents had not been told of their discharge until the day of the discharge, the majority were happy with this.

Three aspects of the discharge process produced a number of critical comments. Patients were unhappy with long **delays in getting medication** to take home. (One patient had to leave without it and a family member made a 90 mile round trip the next day to pick it up!) Although only seven patients used an **ambulance** or ambulance car to get home, there were some adverse comments about the service: rushed staff and the inability of an ambulance to take all the aids. Lastly, several patients suggested that care could be improved by **more aids once they got home**, such as hoists, and more help from social services. The CHCs comment that under half the patients were given **written information about care at home** or contact names and telephone numbers. More written information of this kind would help discharged patients to get the care they need.

CHC publications: Listings

Should NHS-funded circumcision be provided for religious and cultural reasons? Debate report
Lewisham CHC, 22 pages

Findings of a survey of patients' satisfaction with minor injury services at Victoria Hospital
A collaborative study undertaken on behalf of Communicare NHS Trust and East Lancashire Health Authority by Blackburn, Hyndburn and Ribble Valley CHC, 23 pages

Findings of a survey of patients' satisfaction with A&E services at Blackburn Royal Infirmary
A collaborative study undertaken on behalf of Blackburn, Hyndburn and Ribble Valley NHS Trust and East Lancashire Health Authority by Blackburn, Hyndburn and Ribble Valley CHC, 19 pages

Survey of mixed sex facilities at Warrington Hospital NHS Trust
Warrington CHC, 9 pages

Survey of ophthalmic services in North Tyneside
North Tyneside CHC, 10 pages

Visiting Pack
A recently updated version of this pack which is used by members to make visits to local hospitals. Available from Rachel Matthews at Nottingham CHC. £1.50 to cover copying and postage.

Survey of 12–15 year olds' views on health services provision

Basildon & Thurrock CHC, 15 pages

Young people were asked about local provision of health services, their use of current services and for their ideas on future health service provision. Asked about "what sort of health advice and care young people would like", the respondents were most likely to volunteer ideas about counselling and emotional health. Important areas of concern for young people concerned advice and confidentiality. Many expressed a wish for services separate from those of the family doctor, offering a less formal service and with no connection to their parents.

Day surgery in East Yorkshire

East Yorkshire CHC

The Royal College of Surgeons has produced guidance on the selection of patients for day surgery. This survey found that a number of points of the guidance are not being followed in East Yorkshire. The RCS guidelines state that the upper limit for day surgery is about 65–70 and set out various support requirements, for example that "housing must be adequate for a comfortable recovery". However, 8% of respondents were aged 75 and over, and these patients did not have their home circumstances investigated prior to admission, nor were they offered a choice of day or in-patient care. With 53% of patients finding that they needed "quite a lot" or "a great deal" of help on returning home, adequate assessment of circumstances is clearly important at an early stage. In the event, the majority of patients in this survey appear to have been satisfied with day treatment: 90% said they would recommend being a day patient to a friend in a similar situation.

Survey of spinal cord injured patients treated at Pinderfields hospital and discharged into their local community, *98 pages*
Summary report and recommendations of the Regional Council, *20 pages*

Study commissioned by the Northern & Yorkshire Regional Council of CHCs from the Social Policy Research Unit, University of York

The Pinderfields Spinal Injuries Unit (SIU) is the Yorkshire Regional Centre for the treatment of spinal injuries. The study covered patients' perceptions of: the SIU; the effectiveness of the rehabilitation process; and community services. It thus included issues such as employment, education and financial affairs as well as therapy, care and support, and the hospital environment. Nursing care at the unit was highly praised, but there were significant problem areas, for example on help and support with personal relationships and feelings. There is a detailed list of recommendations, most for the attention of Pinderfields Hospital, but some for others such as the local authority. These recommendations are answered point for point by the hospital.

The response says that some of the deficiencies revealed by the study are recognised and are being or have already been addressed. For example support offered to partners of people with spinal injuries is being reviewed and an effort has been made to improve help and advice on looking after children after discharge from the unit. However, many recommendations have produced the response that the constraints of existing accommodation do not allow what would seem to be fairly basic improvements, for example to toilet/washing facilities, personal space for patients, the grouping of patients into appropriate age groups, the availability of telephones and the provision of a quiet room for visiting.

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

Moving forward: a consultation document on the regulation and inspection of social services

25 pages. Available from Department of Health, PO Box 410, Wetherby, West Yorkshire, LS23 7LN.

This document was published to launch a review of arrangements for regulating and inspecting personal social services in England and Wales. It identifies issues for review and does not put forward firm proposals.

The document describes current arrangements for regulation and inspection of both social services and private and voluntary nursing homes. It then describes developments which have affected the context in which these procedures operate. The principles and practice of regulation and inspection are discussed and 19 questions are posed for those wishing to respond to the review process. The last section outlines possible models of regulation and inspection including the possibility of self-regulation backed up by an accreditation scheme.

Responses are to be sent to an independent assessor, Tom Burgner. His report to the Department of Health will be published. Comments should be submitted to him by the end of February 1996. ACHCEW is listed among the organisations invited to comment in the review process. The consultation document appears not to have been sent to individual CHCs, but the introduction says that comments from anyone would be welcome.

Could CHCs please send ACHCEW copies of responses they wish to make by mid-February.

CHANGE OF ADDRESS

From 1 November 1995, all DoH publications previously available from Heywood Stores in Lancashire will be available from:

Department of Health
PO Box 410
Wetherby LS23 7LN
Phone: 01937 840 250
Fax 01937 845 381

Provision of the national freephone Health Information Service

NHS Executive, HSG(95)44, 22 pages.
Listed as available from: Health Publications Unit, DSS Distribution Unit, Heywood Stores, Manchester Road, Heywood, Lancs, OL10 2PZ, but see the box at the bottom of this page.

From 1 April 1996 the responsibility for contracting for Health Information Services (HISs) will be passed to health authorities. Regional offices are to manage the transfer of responsibility. This guidance sets out requirements which an HIS must meet.

The service will continue to be available through the existing freephone number: 0800 665544. It must be available for a minimum of 35 hours a week, but where it is currently available for longer than this the existing level of service must be maintained. A minicom service must be available and health authorities should consider other ways of accessing the service, for example through libraries.

The minimum information to be provided is listed. This includes charter standards; waiting times; information about diseases, conditions and treatments; outcomes and effectiveness data; information on complaints procedures; health promotion information; and national information (to be provided in the form of briefings from the NHS Executive). Information about primary health care services should be in line with that required by the *Code of Practice on Openness in the NHS*: while certain information which is important to patients must be made available, GPs and other independent contractors "can not be required to publish sensitive information about their businesses".

The introductory section to the guidance states that it is "important for health authorities to ensure that HIS service providers are aware of the significance of developing and maintaining effective communications channels with their local CHCs." This is not mentioned in the "mandatory core service specification". The core specification does say that people wanting to complain about health services should be given contact details for the local CHC and an explanation of the CHC's role in supporting individual complainants.

Official publications: listings

Building partnerships for success: community care development programmes
Department of Health, 42 pages
Available from DoH, PO Box 410, Wetherby LS23 7LN; phone: 01937 840 250; fax 01937 845 381

Report of the Genetics Research Advisory Group

A first report to the NHS Central Research and Development Committee on the New Genetics
Chaired by Professor Martin Bobrow, 33 pages

A second report to the NHS Central Research and Development Committee on the New Genetics
Chaired by Professor John Bell, 47 pages
Both published by the Department of Health

GENERAL PUBLICATIONS

Charging consumers for social services: local authority policy and practice
A report on charging for adult social services in England
National Consumer Council, NCC Publications, 20 Grosvenor Gardens, London SW1W 0DH; phone/minicom: 0171 730 3469; fax: 0171 730 0191; £11.50, 164 pages

This detailed and very informative report attempts to shed light on the ill-understood duties and powers of local authorities in relation to charging and to describe the system in practice. It draws on detailed written information from 41 local authorities and on visits to five authorities. Most of the report is concerned with charging for non-residential services though, since some authorities are merging some aspects of charging for non-residential and residential services, it also looks at the impact of savings and the financial status of a spouse on charging for residential services. There is also a chapter on respite care.

The confusion among local authorities as to their responsibilities and powers is repeatedly demonstrated – hardly surprising given the skimpy nature of national guidelines. The confusion among members of the public must be even greater since many local authorities fail to inform users or potential users of procedures or to make it clear where they were enforcing legal requirements or using their own discretion. There are several examples of information from local authorities which appears not to reflect the law.

The report sets out some relevant legal requirements on local authorities and on their discretionary powers. It describes the dilemmas faced by local authorities which are trying to provide services within tightly constrained budgets. The responses to these dilemmas vary widely across England – the report outlines various broad approaches. Throughout it draws attention to the information provided to clients and potential clients, including some examples of good practice, but many where a good deal of improvement is needed.

General publications: listings

The Council's proposed standards for incorporation into contracts for hospital and community health care services
United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 4 pages. Available free of charge from UKCC Distribution Centre, 23 Portland Place, London W1N 4JT

IN BRIEF

Living with a drug user: a leaflet for the partners of drug users
66p each, reductions for 10 and more copies, 18 pages.

Aims to help partners of drug users think about themselves and their needs and to think about positive ways of helping their partners. It includes (among other things) information on: Coping if you have children, What to do if your partner doesn't want help, Should you stay or should you go? and a number of practical issues.

Family support group pack
£5.50

Both from ADEAM National, 5th Floor, Epworth House, 25 City Rd, London EC1Y 1AA; phone: 0171 638 3700; fax: 0171 256 6320.

A revised information pack on setting up and running a support group for the families and friends of drug users. New sections include "When a member leaves the group" and "What to do when a group ends". Aimed at group facilitators and volunteers involved in support or self-help groups.

ADFAM National also runs a **national telephone help line** for the families and friends of drug users:
0171 638 3700
10 a.m. – 5 p.m. Monday to Friday

Caring for all our children
Action For Sick Children, Argyle House, 29-31 Euston Road, London NW1 2SD; phone 0171 833 2041; fax: 0171 837 2110.
£85.

This training pack adopts a practical approach to raising awareness of the needs of black and ethnic minority children among health staff. It provides detailed notes for trainers, including ideas for group activities and workshops, and handouts and worksheets which can be photocopied. It has been piloted in five hospitals across the country. The training is intended for all staff working with children, from senior consultants to care assistants.

ACHCEW has heard praise of the pack from health staff who say that it includes plenty of attractive ideas for interactive training sessions. CHCs might want to consider encouraging their local trusts to buy it.

IN BRIEF

INFORMATION WANTED

Preston CHC would be interested to hear from CHCs whose local trusts have produced guidelines/protocols for staff to meet the **cultural and religious needs of patients when dealing with a death.**

Norwich CHC would like to hear from any CHC which has used an **agency for advertising the CHC**, with details of cost and outcome.

Estelle Morris, Labour MP for Birmingham Yardley, is concerned about increasing **complaints against locum doctors** and about the **employment of non-principal doctors by private locum services**. If you have any information or concerns regarding locum cover, Sue Hayes would be pleased to hear from you on 0171 219 6242, or care of Estelle Morris MP, House of Commons, London SW1A 0AA.

Nottingham CHC would like to hear from any CHC which has information about, or experience of, **problems relating to Norplant contraceptive devices**. For example, have they heard of any GPs or hospitals who are not willing to remove the rods, or cases in which doctors have not been trained in their use?

Mark Woodcock, Deputy Chief Officer at Bristol & District CHC, has been assisting a member of the public to pursue an informal complaint against her GP for not diagnosing **Obstetric Cholestasis** during her pregnancy. Cholestasis is a disorder in which bile production by the liver and its flow to the intestine is interrupted. Obstetric cholestatis can be a serious condition and is associated with an increased rate of perinatal mortality.

The Chief Medical Officer issued an update in November 1994 drawing attention to the need for early referral to an obstetrician. The British Liver Trust (Central House, Central Avenue, Ransomes Europark, Ipswich IP3 9QG; information line: 01473 276328) has also produced a leaflet on the topic.

Bristol & District CHC approached the local FHSA asking it to circulate the British Liver Trust Leaflet to GPs under a detailed covering letter. The model for the letter was one which has already been used by a West Midlands FHSA. The Bristol FHSA refused to send out this letter, saying that it would constitute an interference in GPs' clinical judgement. Instead, it is prepared to circulate the leaflet with only a bland covering letter.

If any other CHCs have approached their FHSA on this issue, Bristol & District CHC would be very interested to hear how the FHSA has reacted.

Hartlepool CHC would like to hear about work carried out that looks at the **perceptions of members of the public of their health needs.**

South Birmingham CHC is trying to find out if there are any support groups for people suffering from, or bereaved as a result of, **Bud Chiari Syndrome.** In addition, have any CHCs had any complaints about diagnosis and treatment of this syndrome? Please contact: Louise Kilbride on 0121 458 2888.

Preston CHC would be interested to receive any **health promotion literature/booklets on Chlamydia and Wart Virus.**

Harrow CHC (and ACHCEW) are interested in information on **Men's Health Programmes** and/or **Men's Screening Clinics** in other areas.

Martin Rathfelder, member of South Manchester CHC, is preparing a new edition of *The Law relating to Community Health Councils* – an annotated guide to the legislation. He would find it very helpful if anyone who has been **involved in legal action (whether successfully or not) about CHCs and their rights and responsibilities** could get in touch with him. A free copy will be given to any reader who can supply the text of a significant legal judgement.

Bradford CHC ethnic issues sub-committee is wishing to raise the issue of **how minority ethnic groups are treated in Accident and Emergency departments**. They have come across a view that it is not necessary to speak someone's language to treat them when they present at A&E. CHC members wished to spend time in Bradford A&E department to observe how people not speaking English well were treated. They ran into difficulties with this project as they would effectively have been eavesdropping. Bradford CHC members are interested in hearing from any CHC which has been working in the area, to help them find a way forward.

ACHCEW would like to hear about any initiatives taken by GPs to reduce **non-attendance for appointments at the doctor's surgery.**

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.

FORTHCOMING EVENTS

Complementary medicine: some key issues in training and practice

- organised by the BMA and BMJ
- on Friday 8 December 1995
- at 1 Great George Street Conference Centre, Westminster, London SW1
- £166 + £29.05 VAT (= £195.05)

Further info from:
BMA Conference Unit
PO Box 295
London WC1H 9TE
Phone: 0171 383 6605, Fax: 0171 383 6663

Training day for maternity services representatives

- organised by the National Childbirth Trust
- designed for consumers and people working with MSLCs, CHCs and other liaison groups
- on Saturday 18 November 1995
- at Mount Vernon Postgrad. Medical Centre, Rickmansworth Rd, Northwood, Middlesex
- £25 health professionals; £15 consumers
- N.B. no crèche facilities are available

Further information from:
Moira Johnson
2 Portland Square
Liss, Hants GU33 7LD
Phone: 01730 892102, Fax: 01730 895757
or
Linda Turner
16 Holyfield Avenue
London N11 3BY
Phone: 0181 368 0287

easier, easier, easier ....

- conference on making better use of information
- 7 workshops include Community Care Plans, Complaints and Running user groups
- organised by the National Development Team and People First
- for people with learning difficulties and people who work in services
- on Tuesday 21 November 1995
- at London Voluntary Sector Resource Centre, 365 Holloway Road, London N7
- £65 + VAT. There are a few free places for people with learning difficulties.

Further info from:
Di Whittaker
NDT, St Peter's Court, 8 Trumpet Street
Manchester M1 5LW

Pharmaceutical Community Care

- a briefing on how pharmacists can help patients living in the community manage their medicines
- organised by the Royal Pharmaceutical Society of Great Britain
- from 9 a.m. to 1.15 p.m. followed by lunch
- on Wednesday 15 November 1995
- at RPSGB, London SE1

Further info from:
Miss Amanda King
Public Relations Unit, RPSGB
1 Lambeth High Street
London SE1 7JN
Phone: 0171 735 9141

DIRECTORY AMENDMENTS

Page iii Trent
Delete both entries and insert:
Mr Mike Smith, Secretary
Trent Regional Association of CHCs
c/o Bassetlaw CHC
38 Watson Road
Worksop
Notts S80 2BQ
Phone: 01909 485257
Fax 01909 530425

Page 23 Swindon CHC
Add: email:
Swindonchc@cix.compulink.co.uk

Page 24 Brighton CHC
Chief Officer: Mike Collinson

Page 35 Rhymney Valley CHC
Fax: 01443 862188

Vale of Glamorgan CHC
Change of address:
Old Court
6 Station Road
Dinas Powys
South Glamorgan
CF64 4DE
Phone: 01222 515566
Fax: 01222 515120