CHC NEWS

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

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NEWS

Free prescriptions extended

The Government has agreed to provide free NHS prescriptions for men aged 60 and over following a ruling from the European Court of Justice. The ruling relied on a European directive which provides for equal treatment of men and women in social security systems except in limited circumstances.

The ruling is retrospective. In theory it could be backdated to 1984, when the directive took effect. However, the Government has announced that it will reimburse prescription charges for eligible men only for the last three months. Lawyers have explained that the European Court usually allows member governments to set national time limits. If an individual wants to claim a refund for charges paid more than three months ago, he will have to bring a new case to the European Court.

The provision of free prescriptions to men aged from 60 to 64 will cost the Government £30 million a year. It is estimated that the claims for refunds could cost £10 million.

Guardian, Times 20 October

Price fixing review

The Office of Fair Trading is to review an agreement which allows drug manufacturers to set minimum retail prices for over-the-counter medicines and other non-prescription preparations. The Asda chain of supermarkets has already broken the agreement by cutting the price of many vitamin and mineral supplements.

The "Resale Price Maintenance" agreement on medicaments has been in effect since 1970 when the Restrictive Practices Court allowed price fixing in this sector (as it had done for books) on the grounds that without such a system fewer medicines would be offered for sale and many small pharmacies would close. The National Pharmaceutical Association still holds this view, saying that local pharmacies will be unable to compete with large supermarkets if the latter are free to cut prices. The Director General of Fair Trading, John Bridgeman, has said that the decision to review the agreement "is in no way prejudging the outcome". However he has also said that "In general, resale price maintenance gives [consumers] a bad deal".

Daily Telegraph, Times 21 October

DoH acknowledges health divide

The Department of Health is to provide £2.4 million for research into the causes of variations in health between population groups and how to reduce them. The pledge came after a DoH report (see *Official Publications*) acknowledged that poor people are more likely to suffer ill health than rich people. Among the findings are that life expectancy at birth is seven years higher among professionals (Social Class 1) than among manual workers (Social Class 5). Even though women in Social Class 1 are 1.5 times more likely to develop breast cancer than women in Social Class 5, the death rate is higher among the latter group.

The report says that lifestyle factors, such as smoking, drinking and diet, cannot explain all the differences. For example, such factors account for only a third of the differences in coronary heart disease between social classes.

Guardian 24 October

Rationing

Advice to go private for cervical smears

A GP practice in Berkshire has written to women on its list saying that it can provide cervical smears on the NHS every five years and not more frequently. Having stated that "We would recommend a cervical smear every three years", the letter goes on to say that women following this advice should attend a private clinic. It offers to give women details about private services. A local councillor says that private smears cost about £15 to £20. A 1992 report from the National Audit Office estimated that, while screening every five years could reduce the incidence of cervical cancer by 84%, screening every three years would reduce it by 91%.

Guardian 4 November

Further limits to free abortions

The North & Mid Hampshire health commission has written to GPs in the district saying that it will no longer automatically provide free abortions for women under 18 years of age. No women are to be told by their GPs that they can receive an abortion free of charge. The commission's contract with the British Pregnancy Advisory Service for 300 abortions a year is expected to be fulfilled three months before the year end.

Guardian 28 October

Removals from GP lists

For financial reasons

A GP in Powys has thought better of his plan to remove eight children from his practice list because their parents refused to have them immunised.

In July to September this year Dr John Goodall-Copestake had 29 children due for immunisation on his list. When the parents of three of these children refused the immunisations he fell below the target 90% immunisation rate which attracts the top rate of payment. He would lose £500 for each quarter in which he fell below the 90% target. He wrote to the parents saying that he would remove the children from his list, and when they still refused the immunisations, he carried out his threat. He says he had been advised by the FHSA that he could legally do so. However he changed his mind after the BMA warned that he risked being disciplined by the General Medical Council for refusing treatment for financial reasons. The Department of Health also described his behaviour as "unacceptable".

Independent on Sunday 5 November, Times 7 November

National survey

A survey from Kent FHSA has looked at removals from GP lists both nationally and, in more detail, in Kent. Results differed widely between the 35 (of 97) FHSAs which responded to the survey. At the top end of the scale, Croydon GPs removed 10.93 patients per GP per year, while at the bottom end, Powys GPs remove 0.05 per GP per year. While some FHSAs reported a decrease in removals over the last five years, many more reported an increase. In North Yorkshire removals have decreased dramatically, from 2584 in 1990 to 364 in 1994. Nationwide, 11.5% of patients removed in 1994 had been removed from a GP list in the area on a previous occasion.

FHSA area offices and GPs in Kent were surveyed and asked about reasons for removal. GPs were most likely to cite violence/abuse, followed by inappropriate use of services. All three FHSA area offices mentioned drug/alcohol abuse and excessive demand for out of hours visits, though one office added that the latter is usually a hidden reason for removal. Cultural differences, inadequately supported mentally ill patients and requests for home visits to elderly people were also mentioned. The survey in Kent did not find that removals were correlated with fundholding status.

Of patients surveyed, 65% had received no explanation before being informed that they had been removed. Over 75% would be willing to accept conciliation in an attempt to re-establish the doctor/patient relationship, but almost half were reluctant to consult their new GP due to a fear of being removed again.

Removed from Care, Kent FHSA (phone: 01622 655000)

Private GP service

The health insurers, BUPA, have launched a private GP service in Berkshire, South Oxfordshire and Northamptonshire. In return for an annual fee of £72 subscribers will have access to unlimited telephone advice 24 hours a day and will be able to ask for a home visit at a time which suits them. They will pay £30 per visit and will have to pay for the full cost of any drugs prescribed since they cannot be prescribed on the NHS. The service is intended to deal with minor illnesses: people who use it for chronic conditions will be referred back to their GPs. BUPA expects that the scheme will be of particular use to people with long working days who find it difficult to attend GP surgeries.

The cost of the BUPA service gives an indication of the good value for money offered by the NHS family doctor service. A Northamptonshire GP has estimated that the cost of running his GP practice is £50 per patient per year.

ACHCEW is concerned that NHS family doctor services could break down in some parts of the country as dental services have done. If this happens, patients may be under considerable pressure to subscribe to a private GP service.

Times 16 October, Pulse 4 November

Shortages of health staff

Low uptake of GP training

GP leaders have warned that there is a shortfall in doctors willing to train as GPs. In Wales half of 80 training posts and in Yorkshire 78 of 300 training posts remain vacant. There are similar problems in the North Midlands, East Anglia and the West Country. Dr Jamie Bahrami, who advises on GP training in Yorkshire, says that applications per vacancy fell from 30 in 1989 to five in 1992. One result is that trainees are being recruited from the European Union. Another, according to Dr Bahrami, is that the long-term quality of training is being put at risk since doctors who a few years ago would not have got a job are now being recruited onto training schemes.

The Department of Health accepts that there are issues which need to be addressed in the medium- to long-term, but denies that there is an immediate problem. There were about 1400 trainees in England in 1995 – "a significantly higher number than is needed to sustain the number of GPs". In the late 1980s the numbers of trainees did not fall below 2100.

Independent 30 October

Professions Allied to Medicine

A survey of the paramedical professions shows that vacancy rates are rising dramatically, particularly in physiotherapy and occupational therapy (which have vacancy rates of 11.8% and 14.7% respectively). NHS staff shortages have increased by a third over the last two years and staff turnover has reached 20% per year in some of the professions. The survey report from Professions Allied to Medicine says that the health care professionals it represents are increasingly looking for jobs in the private sector when they qualify.

Daily Telegraph 30 October

Psychiatric hospital closures

The closure of psychiatric hospitals has accelerated since the mid-1980s and is likely to accelerate further, according to research carried out at Birmingham University. Fifty-three psychiatric hospitals (with about 11,000 beds) are expected to close over the next five years, compared with 45 closures over the last 30 years

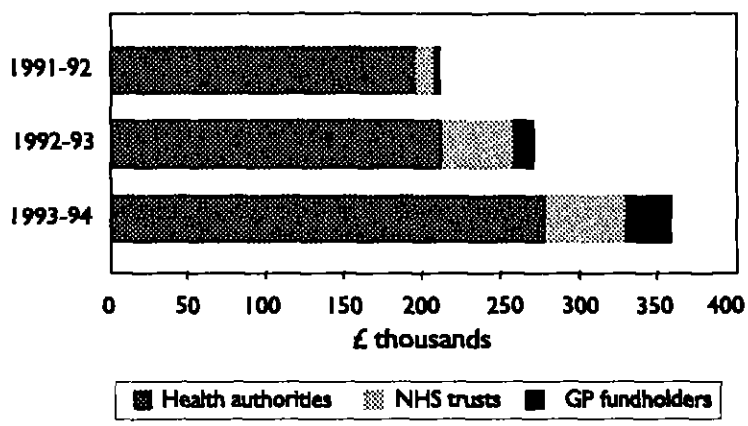
The Government says that for every bed that has closed in a large mental institution since 1982 another has opened elsewhere. Many of the new places are in the private sector where beds increased by 800% between 1982 and 1992.

When hospitals close, some patients are transferred to similar nearby facilities. However, some patients are being transferred much further afield. Camden & Islington Health Authority cannot provide locally for all psychiatric patients in the district who need secure accommodation, in part because of the high cost of local care. It sends about half of the patients who need secure accommodation to hospitals in the South East and in Wales. It is estimated that the authority spends about £4 million a year on private places for psychiatric patients.

Daily Telegraph 20 October, Times 30 October

FROM PARLIAMENTARY ANSWERS

Purchase of health care from non-NHS providers in England



Hansard, 17 October, Col 201

FOCUS ON ... THE BLOOD TRANSFUSION SERVICE

The Blood Transfusion Service has been in the news again following disclosures about profits being made abroad from blood donated in the UK. Questions are being asked about whether changes in the Blood Transfusion Service are part of a trend towards commercialisation, and perhaps even privatisation. Support in this country for the freedom of the multi-billion dollar world market in blood products raises concerns about safety.

A *Sunday Times Magazine* article reports that there is a behind-the-scenes debate about whether the transfusion services should be privatised. Hospitals currently pay a "collection and handling charge" for all blood products. It would be easy to add a mark-up for profit and thus convert the supply of blood products into a fully commercial business. Richard Walker, the chief executive of Bio Products Laboratory (BPL – see box), has made his view clear: "We are a manufacturing enterprise and manufacturing is a private sector activity."

In some respects, BPL has already developed a more commercial outlook. It can produce about 30% more albumin than the NHS needs. BPL processes the surplus and sells it abroad. Richard Walker has proposed that, in partnership with private firms, the laboratory should process imported plasma obtained from paid donors.

Blood products: some facts

- The national stock of blood has been slowly declining over recent years.
- Demand for blood products is increasing by 4% a year.
- 2.4 million donations are received each year from about 5% of the population.
- National Blood Authority (NBA) has a budget of £135 million and is looking for savings of £10 million.
- About 2% of blood is given to patients as whole blood.
- The rest is separated into:
  red cells – used in volume transfusions and oxygenation;
  platelets – used to treat leukaemia;
  plasma – which is further broken down to produce clotting factors (e.g. Factor VIII used to treat haemophilia), albumin and immunoglobulin.
- There is a high demand for red cells in the UK, but there are surpluses of plasma.
- Much of the processing of plasma takes place at the government-owned Bio Products Laboratory.

A gift or a product?

Donors have been angered by recent revelations that blood products are sold overseas. Since World War II British people have regarded blood as a gift. This attitude was demonstrated this summer when donors turned out in droves after hearing about the crisis in supply caused by the withdrawal of faulty Tuta bags. A senior manager at the Oxford Transfusion Centre says that there is a deluge of complaints whenever donors hear rumours of possible charges for blood, saying that if charges are to be made they will charge the transfusion service for their donation. Service managers estimate that, were donors paid for their blood, about 80% of current donors would withdraw. On the other hand, paid donors could make bigger and more regular donations, and could be asked to attend centres at the buyer's convenience.

There is plenty of evidence to show that paid-for donations are more likely to be contaminated with viruses than donations from unpaid volunteers. Although known viruses can generally be inactivated, there is always the risk that unrecognised viruses could be spread via donated blood products before their danger is appreciated. The World Health Organisation has urged members to develop national services based on unpaid donations. Nevertheless, about a third of the factor VIII used to treat haemophiliacs in England and Wales comes from imports, mostly collected from paid donors.

Exports to Turkey

While Britain is importing Factor VIII for use at home, it is also exporting the product. Factor VIII supplied from the UK is on sale in Turkey for up to four times the price paid by UK hospitals. BPL says it makes no profit from the trade, but makes a charge to "recover costs". Turkish Government records suggest that BPL is exporting blood products to Turkey at twice the UK price. At least part of the remaining differences in price is due to the "exchange rate"

applied by the Turkish Government, a 10% import tax and profits for businesses which handle the products.

The British Government and the NBA say that they have no control on what profits are made overseas once the blood products have been exported. However, Alex Carlile, the Liberal Democrat health spokesman, has pointed out that it is quite normal for international contracts to contain restrictive conditions on what should happen to the product being sold.

BPL says that its only options are to burn the surpluses or offer them for sale. It does not mention a third option: to give surpluses to poor countries. Donated supplies of factor VIII for developing countries are welcomed by the World Federation of Haemophiliacs, for example. It is estimated that some 120,000 haemophiliacs world-wide receive no treatment. Some of the blood on the world market comes from the poorest people in the poorest countries of the world, but is exported despite the fact that it is needed by sick people in those countries.

Why tell the donors?

Few donors have been aware of the sale of British surpluses, which is said to have begun about 10 years ago. Asked why the arrangements had not been explained to donors, an NBA spokesman asked in return "Is there really a necessity to?"

Staff exodus

Qualified staff are leaving transfusion centres, a third of which face the prospect of closure. In September 1994 the NBA proposed closing five of the 15 regional centres. Since then, Lancaster has lost 25 of its 40 qualified staff, Liverpool a third and Brentwood & Essex two-fifths. Staff at the centres say that the system is now under stress. It takes two years to train replacements – in the meantime they need more supervision to ensure that they do not miss things. Although all staff say that they ensure that blood is safe, there must be concerns for the future. The post of quality assurance manager in Oxford became vacant in February. It has not be filled because of an embargo on recruiting senior staff.

"Consultation"

ACHCEW has registered grave concern about flaws in the NBA "consultation" on the proposed changes: its initial failure to consult CHCs, the short time allowed for comments, the implementation of change in advance of consultation, the poor quality of the consultation document and its failure to set out alternative proposals. Among other objections to the proposals are the lack of evidence that donors' views have been taken into account and doubts about whether the proposed system would be able to respond adequately to major accidents or emergencies.

Sunday Times Magazine, Independent 9 & 20 October

FROM THE JOURNALS

Fourth national morbidity study

The fourth national study of morbidity statistics (report published by HMSO) covered about 500,000 patients registered with 60 practices in England and Wales. The results from 1991-92 can be compared with studies in 1955-56, 1971-72 and 1981-82. The results can be used for health care planning, targeting heath education and research. An article in *Health Trends* briefly outlines the methods and results of the survey.

Doctors and nurses in the relevant practices recorded details of every face to face contact with NHS patients over a year. Interviews were held with all registered patients.

Among the findings are that an increasing proportion of people use GP services at least once a year, particularly for reasons other than illness, such as immunisation and screening. Ten per cent of all contacts occurred in the patient's home (rising to 65% for patients aged 85 and over).

Prevalence rates of certain conditions (the proportion of people suffering from the condition) are available from all four studies. Incidence rates (the proportion newly diagnosed with a condition) are available from the last two. These show, for example, that the prevalence of asthma increased from 89 to 429 per 100,000 in males between 1955-56 and 1991-92 and from 81 to 422 per 100,000 in females. However, between 1981-82 and 1991-92 the proportion of people consulting for asthma for the first time increased only among children aged under five.

Health Trends 27(2), pp 34-35

Public consultation

Two BMJ articles cast doubt on the usefulness of questionnaires in eliciting the public's views about priority setting in the NHS, but for different reasons.

Valuing self interest

Interviews with patients in a London general practice found that none of the patients were fully convinced that allocating priorities in the NHS should happen at all. If such decisions had to be made, they should be made by doctors rather than by politicians or the public.

Some general principles did emerge from interviews. Equity was seen as important: interviewees consistently denied that any group or individual should be seen as more deserving than another. Some discrimination on the grounds of age did, however, appear to be acceptable. Interviewees were unwilling to justify their opinions on the basis of personal need. Instead they tended to refer to the actual or potential needs of others.

The findings also have implications for the interpretation of questionnaire findings. If a service was perceived to be fulfilling its current expectations it became less of a priority. Conversely, interviewees said that contact with visible unmet need (e.g. encounters with people who are mentally ill) influenced their opinions.

The authors appear to believe that the tendency of the population to take "a collectivist approach to health care provision" in some way disqualifies them from having an important role in consultation about resource allocation. To have such a role they need to "accept that [it] requires them to express personal preferences". Further, the authors imply that these personal preferences should be based on self interest: "[The fact that] interviewees felt ill equipped to become involved in the process and were reluctant to give opinions based on self interest ... means that highly structured questionnaires must have doubtful validity." The authors seem to suggest that opinions based on a "social ethos of equity" should not be given prominence in allocation decisions, but they do not explain why.

BMJ, 28 October, pp 1137-39

Exploring complex issues

Somerset Health Authority has been eliciting public views on priority setting through focus groups – an approach which, it concludes, enables participants to express considered judgements about complex issues. Unlike the authors of the above article, the authors of this one see the tendency of groups to focus on common, rather than individual, benefits as a positive advantage.

Eight panels have been set up. They meet three times a year, with four of the 12 panel members being replaced at each meeting. Members are selected to ensure a spread of characteristics. Transport is arranged and attenders are paid £10 to cover expenses.

> "It's much better than if you were to stop and ask someone in the street 'What do you think?'"
>
> *Panel member*

Topics are selected from "live" issues which are of genuine concern to the DHA and which involve value judgements. Issues debated so far include clinically unnecessary antenatal visits, out-of-county referrals and night medical centres.

Participants are sent brief background information before the meeting which they are encouraged to discuss with family and friends. They are given fuller information at the meeting which outlines the nature of the problem, the numbers of people affected, costs of provision and a note of controversial issues.

Experienced facilitators lead the meetings. The information on each topic is read through and options outlined. Panels are encouraged to discuss their detailed responses and the beliefs which underpin them. The discussions are tape recorded, transcribed and analysed, enabling much information to be gained on participants' thinking and values. Members are also given voting sheets which remain anonymous.

The sessions held so far have been well attended. Participants have welcomed the information provided and the opportunity to refine their thinking on difficult questions.

The different panels have raised similar issues and have tended to vote in similar ways, giving the researchers some confidence in the validity of the findings. They conclude that they have obtained much richer information than they could through a conventional structured survey.

BMJ, 28 October, pp 1155-58

NEWS FROM ACHCEW

ACHCEW training: The Wilson Complaints System and CHCs

ACHCEW has organised this one-day training course for CHC staff in conjunction with the Society of CHC Staff. It is being held in 19 locations throughout England and Wales during March. The fee of £42 has been kept to a minimum and reflects only direct costs. Since demand is expected to be high, it is important for CHCs to apply for places as soon as possible. Details and booking forms have been sent to CHCs.

Disillusioned

Some CHC members did not regard it as their business to consult the public over health matters – that, they thought, was up to the health authority.

Some members thought that only local authority councillors could represent the public on health matters – gaining information through their surgeries and "walking their electoral wards". The implication (and the stated opinion of at least one participant) was that other CHC members had nothing valuable to contribute.

One or two members were quite offensive in the way they talked about psychiatric patients and continued in the same vein even when challenged to recognise that psychiatric patients had views too.

One member expressed the view that although the officers/staff of that member's CHC were alright, as were local authority elected members, CHC members in general were basically a waste of time.

More could have been gained from this day.

It could have been so good – instead all we got was a lot of in-fighting. I did learn some things, but it was clouded by being upset and angry.

I felt cross when I thought of all the resources that had gone into the workshop and the special arrangements people had made, only for the day to be spoilt by a few noisy people.

ACHCEW comments: We received these comments from a member who attended one of our workshops. We were very concerned to hear about the negative attitudes of some of the participants on this day. Training is a two-way process. Although the trainer has a responsibility to ensure that the training environment is conducive to learning, the participants have a responsibility to interact with their colleagues in a respectful manner.

AROUND THE CHCs

Growing Old and Needing Care

Research commissioned by Southport & Formby CHC in 1993 has been published by the Avebury Studies of Care in the Community as a piece of definitive research into the problems of growing old and needing care.

Published in 1995 by Avebury (ISBN 1 859 72 102 8), the book *Growing Old and Needing Care* has been sold internationally. At 373 pages, it is both weighty in content and pricey. The research on which it is based, however, has been available from the CHC since 1994 at a nominal price of £15 to cover photocopying and postage.

The research document remains a working paper in Sefton and is used by both health and social services. Sadly, however, many of its recommendations cannot be funded in the present financial climate.

CHC PUBLICATIONS

A review of the resource allocation formula for the NHS with particular reference to the needs of inner city districts outside of London and the South East
South Birmingham CHC with contributions from Professor David Mayston and Professor Roy Carr-Hill, 48 pages

This review was submitted to the Health Select Committee of the House of Commons. Its recommendations are backed up by arguments presented in four appendices.

Zero weighting. Twenty-four per cent of resource allocation is "zero weighted", i.e. based on the size and age structure of the population and not otherwise weighted for need. Zero weighting applies to programmes which have not been allocated to acute or psychiatric care; in particular it applies to community health services. The paper argues that the funding of such services should also be weighted for need.

Age structure. All allocation of budgets is strongly influenced by the age structure of the population. Age-related weightings are based on the needs of different age groups averaged across the country. However, these *average* needs may not reflect needs in individual districts. In particular, in deprived areas people are likely to suffer severe medical conditions at a younger age. In addition people in such areas are likely to die earlier, thus reducing the proportion of the population which is deemed to need especially high funding. In essence a population which is healthier and survives longer will attract more funding than a population which is less healthy and dies younger. The report recommends pilot studies to evaluate the use of condition-related costing for diseases which have high early morbidity and mortality in some areas.

The Market Forces Factor. The MFF is applied to the allocation formula to reflect different costs, especially labour costs, across the country. The staff MFF is not based on actual NHS labour costs, but on an assumption that NHS labour costs will rise to those of the local labour market. The calculations can, in addition, be criticised for statistical bias. The paper argues that the MFF protects London and the South East from the effects of market forces at the expense of other parts of the country and that it will eventually lead to a stratified service.

Capital charges. The paper calls for an urgent review of the capital charging system. Capital charges represent a substantial fixed overhead which hospitals are required to pass on in contract prices. If they are set too high, a hospital may find that purchasers decrease the volume of services they will buy. With fixed overheads, this will further increase the average cost per patient and a spiral of decline may set in. Professor Mayston argues that the system for calculating the value of hospital buildings overestimates the value of older buildings (when compared with their open market value), with the result that areas with large and ageing hospitals are penalised by excessive capital charges.

CHC publications: Listings

Report of a survey of the Accident & Emergency Department, Manor Hospital, Walsall
Walsall CHC, 12 pages

A review of health promotion in primary care: from the GP health promotion contract to promoting health with local committees
Jill Russell, GLACHC, 356 Holloway Road, London N7 6PA; phone: 0171 700 0100, 62 pages

Report of the survey of mental health services
Health Watch Project, Warrington CHC, 60 pages

'Out' of sight, but not 'out' of mind: lesbians, gay men and bisexuals and the mental health services
A discussion report written and compiled on behalf of Chester & Ellesmere Port CHC, 20 pages

"Local voices" Barnburgh Report
Marilyn Merry and Karen Purvis, Doncaster CHC, 32 pages

GENERAL PUBLICATIONS

St Vincent Joint Task Force for Diabetes

Department of Health and the British Diabetic Association, 31 pages
Available from Avon Direct Mail Services Ltd, Unit 12-14, The Old Mill Road, Portershead, Bristol, BS20 9EG; freephone 0800 585088

The St Vincent Declaration was the outcome of a meeting in which health professionals, government departments and people with diabetes from throughout Europe formulated recommendations for improving the health and quality of life for people with diabetes. Following the Declaration, the Department of Health and the British Diabetic Association set up a task force, which has now produced its final report on the implementation of the St Vincent recommendations. It sets out key facts and the priority needs identified by 11 advisory subgroups, which considered issues such as planning services, preventing various complications of diabetes and patient-centred care. It has identified three initial priority areas for consideration by the Clinical Outcomes Group for Diabetes which is to formulate purchasing guidance and advise on the development of clinical guidelines. These are the reduction of three complications of diabetes: blindness, foot/leg diseases which lead to amputation and kidney failure.

Guidance on local diabetes services advisory groups

British Diabetic Association, 43 pages
Available from Avon Direct Mail Services as above

Local diabetes services advisory groups (LDSAGs) bring together health care providers, people with diabetes, their carers, health services managers and commissioners. The British Diabetic Association believes that they are essential for the successful and systematic achievement of the St Vincent goals (see above). This guidance document draws on responses to a survey of directors of public health and FHSA chief executives. It also incorporates the experience of existing LDSAGs. The document provides suggestions on the role and responsibilities of LDSAGs and their membership, notes on how to set up a group and details of resource materials.

Pharmacy in a new age: developing a strategy for the future of pharmacy

Royal Pharmaceutical Society of Great Britain, free copies from Pharmacy in a New Age Helpdesk, 1 Lambeth High Street, London SE1 7JN, 10 pages

This discussion document is aimed at pharmacists, but ACHCEW has also be sent a copy for comment. The aim of the process is to map out a path for the future of pharmacy. The Society gives reasons why standing still is not an option and sets out principles which should govern the changes to come. It presents three possible future scenarios and invites more. Could CHCs please get any comments on the document to ACHCEW by the end of February 1996.

Duties of a doctor

Guidance of the General Medical Council, 178-202 Great Portland Street, London W1N 6JE

The GMC has issued four booklets to replace the "Blue Book" which has hitherto provided guidance to doctors on ethical dilemmas. The new booklets place more emphasis on relationships with patients and colleagues, while also stressing the need for doctors to keep professional skills up to date and to recognise the limits of their competence. The booklets are clearly written, laid out and indexed, so that it will be easy for doctors, and their patients, to use them. Copies are to be sent to all registered doctors. The guidance pack contains booklets on:

- Good medical practice
- HIV and AIDS: the ethical considerations
- Confidentiality
- Advertising

General publications: listings

The hidden cost: an investigation into severe asthma

National Asthma Campaign, Providence House, Providence Place, London N1 0NT; phone: 0171 226 2260; £10; 45 pages

One in ten: a report into suicide and unnatural deaths involving people with schizophrenia, April 1991 to July 1995

Gary Hogman and Richard Meier, National Schizophrenia Fellowship, National Office, 28 Castle Street, Kingston upon Thames, Surrey KT1 1SS, phone: 0181 547 3937; fax: 0181 547 3862, 31 pages

OFFICIAL PUBLICATIONS

Building bridges: a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people.
Full Guide, 112 pages, Executive Summary, 16 pages
HSG(95)56, Health of the Nation Initiative, NHS Executive
Available from DoH, PO Box 410, Wetherby LS23 7LN; phone: 01937 840 250; fax 01937 845 381

Methods to promote the implementation of research findings in the NHS: priorities for evaluation
Department of Health, 65 pages

Identifying R&D priorities for the NHS on asthma management: report to the NHS Central Research and Development Committee
Department of Health, 55 pages

Report of the NHS Health Technology Assessment Programme, October 1995
Department of Health, 53 pages

The above three reports available from: Ms Lisa Rees, R&D Directorate, NHS Executive, Room GW59, Quarry House, Leeds, LS2 7UE; phone: 0113 2546191; fax: 0113 2546197

Variations in health: What can the Department of Health and the NHS do?
HSG(95)54, Health of the Nation Initiative, Department of Health, 147 pages
Available from DoH Mailings, c/o Two-Ten Communications Ltd, Building 150, Thorp Arch Trading Estate, Wetherby, West Yorks, LS23 7EH

On the state of the public health 1994: the annual report of the Chief Medical Officer
Department of Health, 250 pages, £16.50, HMSO

INFORMATION WANTED

ACHCEW would like to hear from:
- CHCs that are involved with their DHA in monitoring contracts
- CHCs that are aware of voluntary organisations that have contracts with DHAs to monitor contracts
- CHCs that have worked jointly with other CHCs in monitoring providers
- CHCs that know of GP practices redrawing the boundaries of their catchment areas and then removing the patients who now fall outside the new area.

Darlington CHC would like to receive examples of leaflets produced by CHCs to:
- explain how the NHS works, and
- to inform the public about the health services available in their area.

Arfon-Dwyfor CHC reports that a local university sends to new student entrants GP registration forms with the name of one local General Practice. Only that practice is allowed to attend the students' Registration Day. Have any other CHCs come across similar situations?

For our files

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

FROM THE INFORMAL SECTOR

How to Work with your Doctor
Patient Information Initiative

The Patients' Liaison Group of the Royal College of General Practitioners has set up this project with Department of Health funding.

How to Work with your Doctor is a programme to provide patients with information about their healthcare and how to use the NHS more effectively. It aims to:

- reinforce the policy of empowering patients to take more responsibility for their own healthcare
- achieve a more appropriate use of the GP and pharmacy services
- encourage the appropriate use of over-the-counter medicines.

Research by the RCGP has indicated that some patients who are demanding more of the GPs are also less satisfied with the service they receive. This tendency, which the College believes stems in part from a poor understanding of the family practitioner service, leads to poor morale and stress for doctors and patients alike. The situation does not encourage the mutual respect and trust which is the heart of an effective doctor–patient relationship.

How to Work with your Doctor is analysing a wide range of patient information leaflets. In March 1996 a conference bringing together practitioners and patient groups will assess the information collected and advise on the production of patient information materials.

The project will produce:

- model leaflets which will be piloted in a few practices
- a video incorporating key messages which will be made available to general practices and hospitals
- a project report.

For further information about the initiative please contact:

Katherine Gaskin
Project Researcher
22 Leicester Road
Billesdon, Leics LE7 9AQ
Phone: 0116 259 6767

or

Charlotte Williamson
Chair, Patients' Liaison Group, RCGP
154 Princes Gate, London SW7 1PU
Phone: 0171 581 3232

DIRECTORY AMENDMENTS

Page ii **Northern & Yorkshire**
Delete first entry and insert:
Ms Fiona Sherburn
Administrative Officer
Northern & Yorkshire CHCs
Regional Office
Clarendon House
9 Victoria Avenue
Harrogate
HG1 1DY
Phone: 01423 500066

Page 6 **Mid Essex CHC**
Fax: 01245 262891

Page 13 **Stockport CHC**
Change of address:
Brookfield House
193/195 Wellington Road South
Stockport
SK2 6NG
Phone and fax unchanged.

Deadline

If you have items for inclusion in December/January's *CHC News* could you please get them to ACHCEW by 9 January.

FORTHCOMING EVENTS

Three seminars organised by the Patients Association

Accident and Emergency Services: the patient perspective

- ✦ on **Tuesday 5 December**
- ✦ focusing on "inappropriate" attendance and admissions
- ✦ speakers include representatives from the Audit Commission, an NHS trust and Linda Lamont of the Patients Association

Clinical Outcomes: what the patient needs to know

- ✦ on Wednesday 28 February
- ✦ looking out how patients can be better involved in research , monitoring and information exchange needed for effective clinical outcomes
- ✦ speakers will include John Spiers, Health Advisor to the Social Market Foundation

Confidentiality and Openness: whose problem is it?

- ✦ on Wednesday 12 June
- ✦ looking at the impact of information technology and its implications for the security of patient records and at how access to records is actually working for patients
- ✦ speakers will include Maurice Frankel of the Campaign for Freedom of Information

- ✧ Each of the seminars starts at 1.30 p.m. with lunch in the Picture Gallery at the Thomas Coram Foundation, 40 Brunswick Square, London WC1N 1AZ
- ✧ Fees £80 per seminar (£50 for affiliates)

Further info from:
Steve Pickles
The Patients Association
8 Guilford Street
London WC1N 1DT
Phone: 0171 242 3460
Fax: 0171 242 3461

Patient Partnership – Patient Empowerment

- ✦ a conference on the integration of local voices into the planning system
- ✦ organised by Gate House
- ✦ on **Thursday 7 December 1995**
- ✦ at Royal College of Physicians, Bartholomew Close, Regent's Park, London NW1
- ✦ £229.13 (inc VAT)

Further info from:
Gate House
St Bartholomew's Hospital Medical College
Charterhouse Square, London EC1M 6BQ
Phone: 0171 726 4311

You're Nicked!

Are you inadvertently breaking the law? This training day will look at legal issues arising in the provision of health information: copyright, legal liability, and employing volunteers.

- ✦ organised by the Consumer Health Information Consortium
- ✦ on Thursday 29 February 1996
- ✦ at London Voluntary Sector Resource Centre, 356 Holloway Road, London N7
- ✦ £40 CHIC members, £65 non-members

Further info from:
Jean Harding
Phone: 0181 593 8353
Fax: 0181 592 0250
or
Alexandra Martin
Phone: 0114 276 8776

Two workshops organised by the Office for Public Management

Local Voices in a Primary Care-Led Purchasing System

- ✦ on 8 February 1996

Re-energising the Community Health Council

- ✦ on 18 January 1996

- ✧ Each workshop costs £215 + VAT
- ✧ Venue: Office for Public Management, 252a Gray's Inn Road, London WC1

Further info from:
OPM at above address
Phone: 0171 833 1973
Fax: 0171 837 5800