CHC NEWS

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

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30 Drayton Park London N5 1PB Tel: 0171 609 8405 Fax: 0171 700 1152

NEWS

GPs: a looming crisis?

The BMA and Government have been engaged in an argument about whether or not GP numbers are set to fall, triggering a crisis in the family doctor service.

A BMA report has warned of an impending crisis in the service as fewer doctors decide to move into general practice and existing GPs are opting for early retirement. In some areas, it says, training schemes and some GP practices will fold. Inner cities, which tend to have a high proportion of doctors from overseas, are particularly at risk. In response, the Government has pointed out that GP numbers are at a record high at nearly 32,000 and that they are increasing by about 1% a year. List sizes fell from about 2,286 patients per GP in 1979 to about 1,900 in 1994. The BMA, in turn, insists that this is about to change and has called for the Government to freeze plans to add to the workload of GPs until extra resources are provided.

If the BMA's predictions are correct, the Government's assurances that list sizes are falling will be of small comfort. GPs, more of them working part-time and with more of their time spent on paper work, may indeed have smaller list sizes. But one cannot have smaller lists, fewer GPs and as many patients registered – something will have to give.

Guardian 22 February, Independent 23 February

Various factors have combined to reduce entrants to the service and the hours they want to work.

- Recruitment to GP training schemes fell from 2,165 to 1,840 between 1988 and 1994. The BMA blames this on disillusion with the extra burdens imposed by the NHS reforms and the increase in out-of-hours calls.
- Whereas in 1988 more men than women entered GP training, the opposite is now true. Many women enter the service because it offers the opportunity for periods out of work and part-time work while they raise families. As a result, it is estimated that 110 new GPs are needed to replace every 100 who retire. Women made up 15% of the GP service ten years ago, compared with 25% today.
- The NHS used to rely heavily on overseas doctors becoming GPs. Doctors from commonwealth countries could settle in the UK once they had satisfied the registration requirements. However in 1985 tighter immigration restrictions were introduced which prevent non-EU doctors from heading general practices. Since then, few have opted to come and practice in Britain. Thus, whereas over 40% of GPs aged 50-54 and around a third of older GPs were born outside the EU, the proportion among those aged under 35 has fallen to less than 6%. There has been a rise in doctors from other EU states qualifying as GPs in the UK, but most return home once they have qualified.

Waiting lists – towards a 12 month maximum

The number of patients on waiting lists for over 12 months had fallen to 20,892 by December 1995, representing 2% of those on lists. This compares with 20% of patients who waited over a year for treatment five years ago. Only three patients had been on waiting lists for over 18 months in December. In the last quarter of 1995, the total numbers on waiting lists rose by 1.3% to 1,054,560.

Commenting on the figures Anthony Harrison, a fellow at the King's Fund Institute, suggested that there is a link between the success over waiting lists and the problems of increased pressure on emergency admissions. In the past, an increase in emergency admissions (typically in the winter) would reduce the beds available for elective surgery – and so increase waiting times. However, more and more elective day surgery is carried out in dedicated units, which tend to be protected from being taken over by emergency admissions. The pressure of bed shortages is therefore increasingly felt on emergency admissions, and reflected in waits on trolleys and transfers between hospitals.

Independent 13 March

Emergency and intensive care beds

Health Secretary Stephen Dorrell has published guidelines on the provision of intensive care and high dependency beds and has required health authorities to make explicit plans for emergency services. He did not announce any extra funding in these areas.

On emergency services: in the short term, health authorities must show how they will manage resources to meet fluctuations in demand. They must also consider their use of admission wards, improving access to diagnostic facilities and their relations with social services departments. In the longer term, they must "strengthen the purchasing function" to focus on patient expectations and undertake more effective workforce planning. The chief executive of the NHS has been asked to review the scope for indicators of quality in emergency services. The chief medical officer has been asked to undertake a review of emergency care services outside hospital.

On intensive care provision: the guidelines on intensive care provision call for specific discussions between health authorities and trusts on the allocation of resources to intensive care. They also recommend that services should make provision for high dependency beds to relieve pressure on intensive care beds. The NHS Executive is to consider a proposal for a national database to improve the management of intensive care bed availability. The chief executive of the NHS has been asked to prepare a report on the implementation of plans for increasing the provision of paediatric intensive care beds.

Mr Dorrell's announcement received a cool reception from patients' groups and doctors' organisations which have said that without extra funding, any improvements will be erratic and insufficient. The Intensive Care Society estimates that there is a shortfall of 500 intensive care beds.

DoH press release 6 March, Independent 7 March

Hope for an underserved group, or a step towards privatisation?

A decision by the Chelsea and Westminster Hospital to offer IVF treatment at £800 a cycle has angered private IVF clinics and raised fears among those who believe that the NHS is moving towards privatisation.

The Department of Health has ruled that the hospital is not breaching NHS rules which disallow "hybridisation" – charging NHS patients for services except in specified cases, such as prescriptions. The Department has judged that the patients are private patients, although they are being treated in NHS time, because they meet the full costs of the services provided. Thus this scheme is allowable, whereas a proposed scheme at St Bartholomew's hospital in which NHS patients would have been asked to pay £300 towards the cost of IVF treatment was not.

The hospital can undercut private IVF clinics (which typically charge £1,500-£2,000) because the consultants do not charge a fee. Their time and that of other staff involved is costed by the hospital and incorporated into the £800 charge. Health authorities which purchase IVF treatment from the hospital are charged the same amount.

The scheme raises difficult issues. While it provides a cheaper option for those whose health authorities refuse to pay for IVF, it increases the likelihood that health authorities will further limit the purchase of this treatment and raises fears that payment might be introduced for other treatments. Whether this will happen will depend on the incentives operating within trusts and health authorities. It might be tempting for health authorities to cut back their allocations for certain treatments if they knew that those who could afford to pay could get relatively low cost treatment as private patients. In some respects it would make no financial difference to trusts whether they were paid a fee by a health authority or by a private patient. However, in cases like IVF, where NHS purchasing is very limited, having private patients allows trusts to increase the throughput of patients, thus improving the economics of individual units and increasing the scope for research. On the other hand, consultants who have private practices might not welcome a low-cost route for potential private clients.

Daily Telegraph 15 February, Independent 16&17 February

Wheelchairs

Extending availability

The Government is introducing two measures which will affect the provision of wheelchairs. The first, to be introduced on 1 April, will enable the NHS to provide powered indoor/outdoor wheelchairs for severely disabled people. These wheelchairs cost about £2000 to buy privately.

The second measure, a voucher scheme for wheelchair users who want to buy a wheelchair from the private sector, will be phased in over three to four years, subject to Parliamentary approval. Details of how the scheme will operate are yet to be worked out. The Department of Health plans to provide £50 million over the next four years to finance the two measures.

Department of Health press release 23 February

Red Cross to charge the NHS

The Red Cross is to charge for loans of wheelchairs to patients referred by the NHS, although it will continue to lend wheelchairs free of charge to individuals who need them for short-term social use. The NHS will be asked to pay either for individual referrals or through agreed contracts for loans – the income thus raised for the Red Cross could amount to £3 million a year. The move follows a steep rise in NHS referrals as patients are discharged earlier from hospital.

Guardian 20 February

Refund on return

Patients wanting to use wheelchairs at the Queen's Medical Centre in Nottingham will have to put a pound in the slot and return the wheelchair to the front entrance in order to reclaim their money – along the lines of similar devices used with supermarket trolleys (but, one hopes, with less fiddly mechanisms). The hospital says that the scheme should stop people leaving wheelchairs all over the place and should reduce theft. (The latter suggestion seems a little unlikely – a pound for a wheelchair would be more than a bargain.) Theft is a major problem in hospitals, with everything from ballcocks in cisterns to computers being targets – crime is estimated to cost the NHS as much as £600 million a year.

Observer 18 February

Inequities in cancer treatment

It depends where you live

Cash shortages are forcing NHS cancer centres to withhold a drug for ovarian cancer from patients whose health authorities will not meet the £9,000 cost. Women with the same condition and treated by the same consultant may receive the treatment on the basis of where they live. The new drug, Taxol, has been shown to extend survival in women with advanced ovarian cancer from two to three years: the *New England Journal of Medicine* has advised that it should be considered standard therapy for women with this condition.

Treatment offered varies not only within cancer centres, but also between them. A survey of the 12 largest cancer centres has identified wide variations in the levels of treatment and funding. Centres in Leeds, Newcastle upon Tyne, Birmingham, Cardiff, Bristol and Southampton are all thought to have overspent their budgets. In February, the Bristol Oncology Centre said that because of its £500,000 overspend it was turning away terminally ill patients and concentrating on those who might be cured. The centre at the Royal South Hampshire Hospital (with a £350,000 overspend) has closed beds, cut staff and limited bone marrow transplants.

Specialists say that the financial difficulties have arisen as consultants in local hospitals have increasingly realised that patients with common cancers can benefit from chemotherapy. They are referring patients who would not previously have been sent to cancer centres.

Times 29 February

Needs of ethnic minorities neglected

CancerLink has said people from ethnic minorities who have cancer face racism, inadequate interpreting services and a lack of cultural awareness. It has called for purchasing guidelines which would ensure that services at home, in day care and in hospital are culturally sensitive. It has also called for research on how cancer affects different ethnic groups.

Daily Telegraph 26 February

Struck off for smoking

Ian Farmer, a GP in Ashford, has struck a 75 year old patient from his list because she smokes heavily and he is "unable to tolerate the environment within [her] home". He said that since he could not spend the 20 minutes or so with her that he would want to during a visit, Mrs Pratt was not getting the treatment she deserved.

Mrs Pratt had been on Dr Farmer's list for six years and saw him once every two or three months in connection with her osteoarthritis. Mrs Pratt's daughter says that two alternative suggestions she made had been rejected: that she should take her mother to the surgery so that home visits were unnecessary, or that her mother should see another doctor at the surgery who does smoke.

The BMA said that a dislike of cigarettes was an "insufficient reason" for striking off a patient, though it offered the let-out clause that "other factors [may have] led to a break down of the doctor–patient relationship".

It is estimated that 85,000 patients were removed from GP lists in 1993/94.

Independent 26 February

Access to crash rooms

The A&E department at Queen Mary's University Hospital, Roehampton, is to allow relatives into previously out-of-bounds "crash" rooms where attempts are made to resuscitate patients. Doctors balloted on the proposal were divided. A majority, including most junior doctors, in fact voted against, but the plan is to be piloted since most of its supporters were senior doctors – it seems that nurses were not canvassed.

Supporters of allowing access believe that it will help relatives grieve if the patient dies, and make them appreciate how much is done to save lives, reducing the likelihood of litigation. They also said that television programmes such as *Casualty* and *ER* have made the general public familiar with the techniques used, so they are more likely to know what to expect (though one can't help feeling that viewers of *ER* will expect rather too much). Opponents believe in contrast that seeing how disorganised an attempted resuscitation can be will increase legal action. They were also concerned that relatives could become distressed, impede the medical team's work and oppose a decision to stop a resuscitation attempt.

Independent 5 March

An unequal partnership

The Department of Health and the BMA have jointly launched a campaign, Doctor Patient Partnership, to "encourage responsible use of GP services". Health authorities have been sent a briefing, couched in reassuring advertising-speak, giving "hints" on publicity and an article written by Stephen Dorrell to pass on to local newspapers.

Health authorities have been asked to set aside £20,000 each for the campaign. When doctors justify the campaign, they tend to talk about the increase in out-of-hours calls. In practice, however, patients are being asked to avoid "unnecessary" appointments with doctors even during surgery hours.

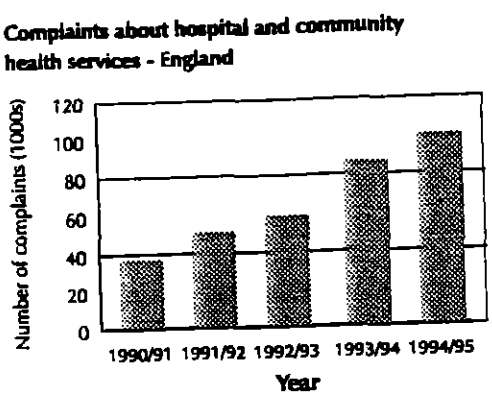
It is far from clear how any campaign can accurately target patients who make unnecessary use of GP services. Doubtless some people inappropriately ask for help from GPs – but will a campaign of this sort deter them? It is more likely that it will put off people who "don't like to be a burden" even though they may need treatment or have reasonable fears that a GP could allay. Doctors sometimes appear not to realise that part of the point of their long training is to help them make judgements about whether treatment is necessary and that it is perfectly reasonable for patients who are uncertain about what to do to ask a GP for an opinion.

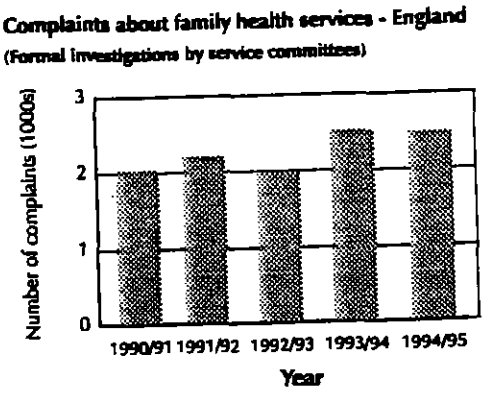
DOCTOR PATIENT PARTNERSHIP

The briefing materials stress that patients should feel that doctors will always be there in a genuine emergency. The campaign might be more convincing if it also acknowledged that there are GPs who fail to recognise and respond to the needs of some of their patients.

FROM PARLIAMENTARY ANSWERS

Misleading complaints figures





Harriet Harman asked how many complaints there had been about the NHS in each of the last five years. The Department of Health provided the figures for England shown in the graphs above. The figures for family health services are misleading. They represent only those complaints which reached the stage of formal investigation by service committees – only a tiny proportion of total complaints.

Hansard, 30 January, col 723

Revenue from NHS charges

The following figures were provided on **Revenue from NHS charges in England** (£million, cash terms)

Income from	1978/79	1994/95
Prescription charges	24.2	287.2
Dental charges (for general dental services)	55.4	383.3[1]
Dental examinations	0	60.0[2]

Notes:
[1] includes patient charge income from dental examinations.
[2] estimate, as the amount paid for individual procedures is not separately recorded.

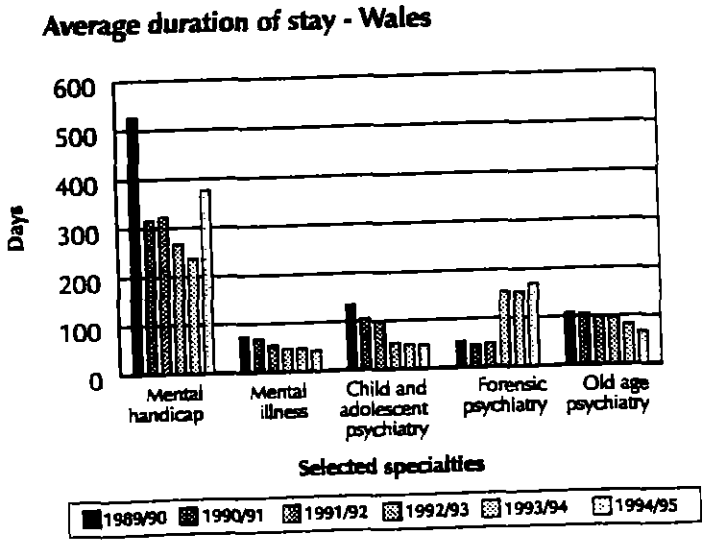
Hansard, 27 February, col 468

Bed occupancy and length of stay

A minister gave a figures on bed occupancy and durations of stay for a wide range of specialties in Wales. The figures on bed occupancy are difficult to interpret at the specialty-level without knowing how many beds are available in each case. Overall the numbers of acute in-patients per average daily available bed rose from 23.9 in 1989/90 to 30.5 in 1994/95.

The figures on durations of stay confirm some trends in NHS provision. Overall they fell from 11.7 days in 1989/90 to 9.2 days in 1994/95. Durations have fallen slightly in many specialties and risen in a few others. However, in mental health care they have fallen dramatically in all except one area: forensic psychiatry (see graph).

Hansard, 29 January, cols 595-8



NEWS FROM ACHCEW

Training for CHCs: May–July 1996

Chief officers have been sent course descriptions and a booking form for ACHCEW's summer training courses, which are being held throughout England and Wales. The course titles are:

1 Consultation procedures
2 Understanding the changing health service and the role of the CHC
3 Developing your links with local communities
4 Giving strength to patient feedback: understanding consumer audit techniques
5 Developing skills for CHC Chairs and Vice-Chairs
6 Continuing care: an overview
7 GP fundholders: in whose best interests?
8 Using the media effectively
9 Working with the media
10 Using the broadcast media effectively
11 Understanding how the CHC works
12 The new NHS complaints system and CHCs

Fees range from £55 to £95.

If you are interested in any of these courses, please send a booking form to ACHCEW. Courses are getting booked up, and **places will be allocated on a first come, first served basis.**

AROUND THE CHCs

Solihull CHC: defending its independence

The Chair of Solihull CHC has written to the Health Secretary, Stephen Dorrell, complaining of an attempt by Solihull Metropolitan Borough Council (MBC) to bully the CHC. The MBC has passed a resolution calling on Solihull CHC to:

> *"hold a public meeting in order to ensure that its response reflects the view of the community which it serves and that if the CHC fails to respond, its conduct should be brought to the attention of the Secretary of State".*

The dispute has arisen over the proposed merger of Solihull Hospital and Heartlands Hospital (in East Birmingham). The proposals are unpopular in Solihull, where members of the public fear that services will be drained away from Solihull Hospital and towards Heartlands. The CHC Chair argues that consultation on the proposals has in fact involved consultation on two separate issues: (1) the provision of services to be offered by a merged trust and (2) the management of the hospitals. The CHC says that it has a statutory obligation to consult the public on the former (an obligation which it believes it has fully discharged), but not on the latter. The letter to Stephen Dorrell argues that the CHC should offer an informed view on the management of the hospitals, and that it should not merely pass on the most vocal opinions of the public. On 9 January a statutory meeting of the CHC voted to offer to host a meeting at which the public could question Heartlands management directly, but voted not to hold a public meeting of its own on the issue. In the event, Heartlands turned down the CHC's offer to host a meeting.

About five members of Solihull CHC now favour a public meeting, but "an equal or larger number including the chairman and two vice chairmen remain of the view agreed at the statutory meeting of 9 January". These members believe that the MBC is trying to cow the CHC into changing its stance from "No to merger unless there is no alternative" to "No to merger at all costs". They believe that the MBC resolution represents an unwarranted attempt to subvert the independent role of the CHC.

Local Voices network

CHC officers from Rotherham (Lesley Dabell), Doncaster (Marilyn Merry) and Bristol & District (Tony Jones, direct line: 0117 987 3800) have been sharing ideas and experiences in order to develop their "local voices" work. Is there anyone in other CHCs doing similar work? If so, and if you would like to become part of their network, please contact any of the above.

"RARIO – NY: What, Who and Why"

The Regional Association of Research and Information Officers in the Northern & Yorkshire Region (RARIO - NY) exists because many Research and Information Officers (RIOs) working for CHCs feel isolated. Soon after the Northern & Yorkshire RHA had been formed RIOs in the region decided that a support group was a good idea. They came from far and wide, despite the appalling weather, to a meeting in February 1995.

An interesting debate on who should be eligible to attend the meetings concluded that they should be open to anyone, below chief officer, who had the slightest involvement with either research or information giving. This is not to say that chief officers would not be welcome: instead they would be invited to speak about research they were involved in.

Other conclusions of the first meeting were that:

- inviting other researchers from within the NHS would dilute the CHC presence;
- calls for agenda items would initially be from RIOs only. The agenda would go to RIOs only, while the newsletter produced after each meeting, *RARIO News*, would go to all CHCs;
- since most RIOs are on short-term contracts, meetings should be held every four months in various locations throughout the region;
- a database of actual and potential research projects should be set up, which everyone would have access to.

Everyone thought the meeting was useful, informative and productive. Most of all, everyone looked forward to the next RARIO meeting. Since then RARIO has come on by leaps and bounds. CHCs within the region are now more aware of what is happening in research and information from Cumbria to Leeds.

Due to pressures on support groups in the region, it was felt that protocols were needed to give RARIO a more formal structure. We needed to allay the worries of some CHCs who believed that RARIO offered " a nice day out", with no work of any value being done. After much discussion, these protocols have been adopted.

In the past year, the number of people coming to meetings has increased. It has been useful to share ideas. Being able to put a face to a name is useful, especially when you want to pick someone's brains for a piece of research or the production of a leaflet. Close links between RIOs means that the work carried out by individual CHCs will be enhanced. The skills, experience and talent of RIOs becomes available to all.

This first year has been "make or break", and fortunately for us we have made it. It has not all been plain sailing, but we believe that long after we are gone, RARIO will still be here!

For further information, please contact either of the authors below (phone and fax numbers in the ACHCEW directory).

Alan Burnside, North Tees CHC, and Kelsey Banks, Hartlepool CHC

CHC PUBLICATIONS

Casualty Watch: the second year
Greater London Association of CHCs, 7 pages

Casualty Watch involves visits to A&E departments on the last Monday of each month at 4:30 p.m. – a time when departments are moderately busy, but quiet enough for staff to be able to provide information. This (anonymous) information concerns all the patients currently in the department: the time they have been waiting, the time of a decision to admit, diagnosis, and so on. The information is faxed to Southwark CHC, which collates it. Southwark CHC is to continue to co-ordinate the project now that GLACHC's involvement has ended.

This reports covers: waits over 5 hours; the number of times A&E departments have been closed or ambulances have been asked to avoid them; and the provision of minor injuries units.

CHCs have successfully used information from Casualty Watch in their dicussions with health authorities. For example, Harrow CHC pointed out the apparent reasons behind some of the long waits. Since then, children are being seen more quickly by paediatric staff and women with possible miscarriages are being fast-tracked. The health authority is also looking into ways of freeing up beds currently occupied by people who are not discharged on Friday although they are ready because Friday counts as part of the weekend.

A survey of health care services, Borough of Christchurch

East Dorset CHC, 19 pages

For this 1995 survey, the CHC sent out 5000 questionnaires through a commercial organisation. Although 1367 were returned, this represented only a 27% response rate. In addition, the distributors undertook a "saturation coverage" of relatively few geographical areas, adding to the risk of bias. An earlier survey, in which 932 questionnaires had been personally distributed by CHC representatives to all parish council wards, achieved a 48% response rate.

The 1995 survey asked about use of and satisfaction with various parts of the health service. Among the findings are that 394 respondents (36%) reported waiting over five days to see their "own" GP. Use of many NHS services was high: 34% of respondents reported that someone in the household has received hospital in-patient care during the previous year, for example, and 32% reported that a household member had visited a chiropodist. In the latter case, strict eligibility criteria for NHS services mean that half of those receiving chiropody go to private providers.

Mental health survey of patients in the community

Oxfordshire CHC, 18 pages

For this survey, 95 people who regard themselves as having a mental health problem were contacted through voluntary organisations and health care professionals. Of these, 28 has previously been asked for their opinion on provision (and 14 of them felt that their views had made some difference to service). The CHC comments that this finding should be taken as an encouragement to continue the consultation process. Over half the respondents perceived their problems as "moderate" and almost half gave depression as their diagnosis, followed by schizophrenia. Asked about what additional services they needed, 30 respondents suggested services giving daily occupation and help with life skills.

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.

Report on patients' views and experiences of operation cancellation for non-clinical reasons

West Dorset CHC, 19 pages

This study, based on interviews with 39 patients, identified several practical measures hospitals could take to minimise patient frustration and disruption when the cancellation of operations is unavoidable. Indeed, it is extraordinary that some of them are not already routine. For example, patients asked to phone the ward early on the day of an operation to confirm bed availability were invariably told that staff could not confirm admission because doctors had not yet carried out ward rounds. Similarly, when a hospital car was provided, it routinely arrived at the patient's home before admission had been confirmed. Lack of effective communication and explanation adds to the emotional upset of a cancellation. The report also highlights the financial and other difficulties caused to people who have booked time off work or made arrangements for the care of children or relatives when operations are cancelled at short notice.

CHC PUBLICATIONS: LISTINGS

Notes of the 3rd round of cluster group meetings, January 1996
Mid Essex CHC, 15 pages

Preliminary report of the satisfaction survey of accident and emergency patients
Forth Valley Local Health Council, 25 pages

Women's health concerns in the over 64 years group
Chester & Ellesmere Port CHC, 8 pages

A report on a survey into a proposal to open an "out of hours" centre at Maiden Law Hospital
North Durham CHC, 22 pages

Special interest group report on substance abuse
Exeter & District CHC, 36 pages

Speech therapy report
Bath & District CHC, 13 pages

Specialist survey in Walsall 1996: a handbook for general practitioners
Walsall CHC, 17 pages

OFFICIAL PUBLICATIONS

By accident or design: improving A&E services in England and Wales
Audit Commission, HMSO, £15, 103 pages

Each year patients make almost 15 million visits to the 227 A&E departments in England and Wales. Although new attendances have increased by an average of 2% a year since 1981, total attendances (new and return) have increased only slightly. However, the workload of A&E departments has risen because of the burden imposed by emergency admission to hospital through A&E departments, which increased by 16% between 1988/89 and 1993/94. The patients involved are often acutely ill and they tend to stay longer in A&E than other patients, thus adding disproportionately to the pressures on nursing staff.

This detailed report looks at the characteristics of the A&E workload; waiting times; quality; working with other specialties; and future developments. The middle three sections identify scope for improvement of existing A&E facilities, without the need for increased funding, by:

- improving staff rostering
- expanding the scope of nursing practice
- co-ordinating more effectively with other specialties and support services
- improving discharge information.

Smaller units should be "reviewed"

The final section looks at some more fundamental changes needed to bring about: increases in specialist A&E staff; better access to specialist beds, including intensive care beds; and 24-hour on-site support from other specialists and support services. The report suggests that these improvements will be achieved only by concentrating full A&E services on fewer, larger sites. Decisions will need to strike a balance between access for all patients (easier with many smaller departments) and quality of treatment for seriously injured patients (improved by larger centres). Less than half a percent of A&E patients have life-threatening injuries. Many more have acute medical conditions: about 15% need to be admitted immediately as in-patients.

The report recommends that reviews are initiated of "small" A&E departments (say with less than 50,000 new attendances a year) where there is "good access" to alternative facilities (say within 10 miles). If half such departments were amalgamated, 31 A&E units would close. The report does point out that travel conditions need to be taken into account: it can take a long time to cover 10 miles in a built up area. What it does not explicitly point out is that many "small" units serve widely scattered populations a proportion of whom live a long way from the existing unit. Thus closing units would add to the distance of already long journeys. The report notes that "alternative local facilities for treating minor injuries and out-of-hours medical emergencies must be widely publicised and win public acceptance before plans to close a unit are finalised".

One recommendation to the Department of Health and the Welsh Office is that they should:

"take steps to meet the resource requirements of supporting an effective emergency service, in particular specialist staff and inpatient beds".

OFFICIAL PUBLICATIONS: LISTINGS

24 hour nursed care for people with severe and enduring mental illness
Health Service Guidelines from the NHS Executive, 39 pages. For copies ring the Health Literature Line on 0800 555777.

An audit pack for the care programme approach
Developed by the Royal College of Psychiatrists for the NHS Executive. For copies ring the Health Literature Line on 0800 555777.

Guidance on supervised discharge (after-care under supervision) and related provisions
Department of Health and Welsh Office, 27 pages. Available from DoH, PO Box 410, Wetherby, LS23 7LN; fax: 01937-845381

Practice-based complaints procedures: guidance for general practices
and
Complaints: listening ... acting ... improving. Guidance pack for general dental practitioners
NHS Executive, each 32 pages

These two substantially similar guides on the procedures to be put in place for 1 April have been distributed to GPs and General Dental Practitioners (GDPs). They contain information about the new NHS complaints system, set out the national criteria which practice-based procedures must adhere to and provide guidance. Sample forms, letters and so on are provided in ten appendices.

National criteria

The national criteria require that procedures are "practice owned". The health authority will be involved only if the procedure does not seem to meet the criteria or if one of the parties to a complaint asks for health authority involvement. Each practice must nominate a person (not necessarily a GP or GDP) to administer the procedure. Procedures must be publicised and written information made available to enquirers. Complaints should normally be acknowledged within two working days, and an explanation normally provided within ten working days.

Records of complaints

Practices are advised to keep records of complaints, investigations and outcomes, but they are for practice use only. If the health authority does become involved, it will not call in the practice's own records of complaints handling, although it will ask the practice for information about the action taken so far. It is recommended (but not required) that records of a complaint should be held separately from the patients medical/dental records. However, the guidance to dentists says that the existence of a complaints file should be noted in the patient's dental record.

CHC involvement

Both guides recommend that practices which need help in setting up procedures may like to approach the health authority complaints manager. No mention of CHCs is made in this regard.

The guides suggest that complainants should be told of the availability of help from CHCs and that patients who do not feel able to complain directly to the practice should be given a contact name/number in the health authority and the CHC.

GPs are told that the health authority may help with translating leaflets and notices into different languages and should be able to provide a list of interpreters. It also says that the CHC may be able to help with this and with making arrangements for complainants with special needs. Dentists are *not* told that they can call on the health authority to help, but instead that "for those whose first language is not English, the Community Health Council may be able to help".

Carers (Recognition and Services) Act 1995:
Policy guidance, *Department of Health, 11 pages*
Practice guide, *Social Services Inspectorate, 18 pages*

Available free of charge from DoH, PO Box 410, Wetherby, LS23 7LN; fax: 01937-845381

The Carers (Recognition and Services) Act is concerned with the assessment of carers. It also requires local authorities "to take the results of any carer's assessment into account when making decisions about services to be provided to the user". These two documents (contained in one pack) set out the Government's view of what local authorities should be doing to implement the Act and the Social Services Inspectorate's advice on how they should go about it.

Three groups of carers are identified in the Act: adults, children and young people, and parents caring for disabled children. The policy guide goes into some detail about the assessment of young carers as this has not been dealt with in earlier guidance.

IN BRIEF

Folic acid campaign materials
Health Education Authority

The folic acid campaign aims to raise public awareness of the importance of increasing folic acid intake prior to, and in the early stages, of pregnancy. The HEA has produced a poster, a 6-page guide for health professionals and a public information leaflet which are available from Shona Golightly at the HEA on 0171 413 2025.

Breastfeeding: good practice guidance for the NHS
Prepared by the Department of Health in consultation with the National Breastfeeding Working Group, 29 pages.

This guidance has been warmly recommended to ACHCEW, but it is proving difficult to get hold of copies. The National Breastfeeding Co-ordinator on the National Breastfeeding Working Group is asking the Department of health to send a copy to all CHCs.

Mental health services: patient's charter
NHS Executive. Available from the Health Literature Line on 0800 555777

A draft booklet on how the Patient's Charter applies to mental health services has been sent to all CHC chief officers. Responses to the draft are to be submitted by 26 April – ACHCEW would welcome any comments from CHCs.

The spectrum of care: local services for people with mental health problems
Health of the Nation Initiative, Department of Health, 12 pages
Available free of charge from DoH, PO Box 410, Wetherby, LS23 7LN; fax: 01937-845381

A guide for health authorities, NHS providers, social services and other agencies on strategic planning based on local needs assessment, implementation and monitoring. It stresses the need to make adequate provision for acute beds, local secure accommodation and 24-hour nursed residential accommodation.

IN BRIEF

GENERAL PUBLICATIONS

The power to change: commissioning health and social services with disabled people
Jenny Morris, Living Options Partnership, Partnership Paper No. 2, 46 pages (in large type)

Improving disability services: the way forward for health and social services
Nasa Begum and Sheila Fletcher, Living Options Partnership, Partnership Paper No. 3, 28 pages

Both published by the King's Fund Centre, 126 Albert Street, London NW1 7NF, phone: 0171 267 6111

Both of these publications cover similar ground, but with a different focus. *Improving disability services* aims to be a quick guide for senior managers in health and social services (both providers and commissioners), who may not have a detailed involvement at an operational level. Three sections cover: Access to services; Key components of disability services; and Developing services with disabled people.

The last of these sections is taken up in more detail and at an operational level in *Power to change*. It sets out guidelines for those commissioning health and social services for people with physical and/or sensory impairments aged between 16 and 65. It takes readers through the stages of the commissioning process: planning, service development, contracting for services and monitoring performance. Throughout, it stress that service users and their organisations want to work with commissioners, since how services are planned and purchased will determine the quality of many of their lives.

Access to information on treatment outcomes through a consumer health information service: a qualitative study

Prepared for the King's Fund Centre by Health Matters, 795 Avebury Boulevard, Central Milton Keynes, MK9 3NW, 33 pages

Health Matters runs a local service offering free information on health, disease, disability, treatments, services and support groups. In 1995 it surveyed 40 users in an attempt to identify barriers to people getting information. It found that the most frequent criticism of the service was lack of sufficient advertising.

Users tended to approach staff with a very general request for the information on a subject or to ask that staff should help in determining what information they should access. Thus staff need to spend a fair amount of time with customers if they are to meet their information needs.

The most common benefits of the service to customers were reduced anxiety and increased confidence personally and in dealing with their medical advisors. Just under half the respondents had also used the information to make decisions about treatment and/or to take a more proactive role in discussions with their doctor.

Purchasing for black populations

Laxmi Jamdagni, King's Fund Publishing, 11-13 Cavendish Square, London W1M 0AN phone: 0171 307 2686, 77 pages

This report on some opportunities for and barriers to improving health services to black populations through NHS commissioning mechanisms draws on lessons from six King's Fund projects in England. The projects showed that most was achieved where purchasers had good access to and relations with local black communities, where they showed political will and where they had a relationship of shared learning and trust with local providers. The report gives good practice guidance for the local level and makes four recommendations for the NHS Executive, namely that it:

- develops a Local Voices *implementation* strategy
- co-ordinates and assists in the transfer of good practice principles and service developments
- promotes the development of the black voluntary sector as potential providers of services
- promotes the development of independent advocates to ensure equal access to the health service.

Core health and race standards: good practice paper

Mike Silvera, Dave Miller and Carolyn Clarke, Share, King's Fund Development Centre, 11-13 Cavendish Square, London W1M 0AN, 11 pages

The London Health and Race Forum believes that health and race contract quality standards should complement a commissioning strategy which actively uses needs assessment, user involvement and service developments to secure better services for black and ethnic minority populations. It hopes that core standards will promote consistency in the approach purchasers (health commissioners and GP fundholders) employ in specifying quality standards. This paper, drawing on the experiences of health authorities over the past three years, offers practical guidance on developing and using standards.

Inner city mental health

Mental Health and Learning Disability Standing Committee of the NHS Trust Federation, 23 pages

Focusing on Inner London, this report is intended to be applicable to deprived inner city areas across the UK. It brings together recent data and the views of staff and patients. It outlines suggested causes of and solutions to the current crisis in mental health services, summarised in 14 recommendations on: the short and longer-term provision of acute, emergency and community services; recruitment; inquiries following a homicide; GP fundholding; and ethnic issues.

Listings

Animal-to-human transplants: the ethics of xenotransplantation
Nuffield Council on Bioethics, 28 Bedford Square, London WC1B 3EG; phone: 0171 631 0566; fax: 0171 323 4877, £10, 147 pages

Slim hopes: the results of a survey of slimming advertising
Sue Dibb, Claudia Grillo and Jenny Smith, National Food Alliance, 3rd Floor, 5-11 Worship Street, London EC2A 2BH; phone: 0171 628 2442; fax: 0171 628 9329, £25 (£7.50 to voluntary/ public interest organisations), 80 pages

Statement on a primary care led NHS
Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU; phone: 0171 581 3232; fax: 0171 225 3047, 2 pages

FROM THE VOLUNTARY SECTOR

The Public Law Project and CHCs

The Public Law Project (PLP) is a national legal charity which aims to improve access to public law remedies, such as judicial review, for people who are disadvantaged, for example because of poverty, discrimination or disability.

The Project has three fundamental objectives:

- to enhance the quality of public decision-making
- to increase the accountability of public decision-makers
- to improve access to justice.

A major focus of the PLP's attention today is the NHS. This work builds on the Project's successful community care programme which involved research, taking test cases to law, disseminating information and training. The charity is particularly interested in issues relating to **continuing care**, the operation of the new **complaints system, public accountability** and **public participation** in decision-making in relation to the NHS and the **impact of contracting out**, especially where service users are not party to the agreements by which services are supplied.

The PLP is keen to develop closer contacts with CHCs. It is eager to hear the views of CHCs on the above issues, to benefit from CHC information and to draw on CHCs' experience of working with patients, the public, health authorities, GPs and other health professionals. The Project has already been advising some CHCs on the use of public law remedies and is looking to extend this by identifying cases which test problematic areas. It would also like CHC help with the design of research projects and the preparation of information materials.

PLP is writing directly to CHCs with more details about possible areas of co-operation. The letter will also give information about a new PLP advice line on matters relating to the powers and duties of NHS bodies.

If there are issues you want to raise with PLP or if you think can assist PLP's work please contact: Helena Cook, Director of Policy and Research, or Stephen Cragg/Jean Gould, the Project Solicitors, at the PLP, Charles Clore House, 17 Russell Square, London WC1B 5DR; phone: 0171 467 9800; fax: 0171 467 9811.

Contraceptive information inadequate

A survey by the Contraceptive Education Service (CES – a joint initiative of the Family Planning Association and the Health Education Authority) has found that over a quarter of women were not satisfied with the amount of information they received from health professionals about their method of contraception. Of these 40% wanted to know more about possible side effects and 24% wanted more information on health risks such as thrombosis and effects of long-term use.

Advice line

The CES provides information to the public through free leaflets, a publicity program and a telephone advice line. The CES Enquiry Line answers queries on contraception and sexual health and provides details of local family planning clinics and other sources of help. It is open from 9 a.m. to 5 p.m. on **0171 636 7866.**

The CES is targeting information on primary health care teams. It has sent 20,000 information packs to GP practices in England and will be distributing leaflets to 4000 practices.

You and your doctor: a guide to help you get the best from family doctor services

The cassettes Health Rights has produced to help people make the best use of primary care services are now available in a number of languages:

- Bengali (Sylheti)
- Gujarati
- Hindi
- Punjabi
- Urdu
- Cantonese
- English

They explain how primary care services work, suggest ways to help people communicate effectively with their local primary care team and help those who have no basic knowledge of the health service in the UK.

They are available to CHCs for £10 per language (£50 per set of seven languages), with discounts for bulk orders. Phone Health Rights on 0171 501 9856 for details.

Contact a Family: for families of children with rare conditions

SmithKline Beecham has agreed to provide a three-year sponsorship (at £20,000 a year) of the work Contact a Family does for families whose children have rare conditions. About 1,200 children are born in the UK each year with a rare medical condition. Some of their parents never meet another family whose child has the same condition; some never find a doctor who can provide a diagnosis and all are faced with isolation and a lack of information. Campaigning for more understanding and help from doctors, schools and social services is hampered because families find it difficult to get together.

With its new funds Contact a Family will:

- highlight issues of concern for families and groups
- help in practical ways, such as helping parents find expert advice and information
- provide information on research
- link families (internationally if necessary)
- support parents in starting their own groups and networks.

For further information contact Harry March, Director, or Carol Youngs, Assistant Director, on 0171 383 3555.

INFORMATION WANTED

ACHCEW would like to hear from any CHCs with details of the adequacy of existing **medium-secure beds or beds in regional secure units.**

Southampton and SW Hampshire CHC has carried out a survey of **local dental practices** and, through the local media, has asked local people for their comments and experiences. The CHC would like to hear from any other CHCs which have carried out similar research. Please contact the Project Manager, Ms Chris March (direct line: 01703 678265 - mornings only).

Bristol & District CHC is undertaking a review of **community paediatric services** at four trusts in its area. Have any other CHCs done work on this topic and, in particular, do they have examples of good or bad practice?

Clwyd South CHC is dealing with a complaint in respect of **kidney problems following a hysterectomy operation.** It has been suggested that a link between this operation and subsequent kidney problems is not unusual. Has anybody any information on this matter?

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.

Northallerton & District CHC would like to hear from other CHCs which can suggest **indicators of the quality of nursing care on surgical wards.** The intention is for them to be used by CHC members.

Can any CHC which has investigated the scope for **different ways of handling the Chair's expenses** please contact Southport & Formby CHC.

Does any CHC know of an expert on **promoting continence in children with a learning disability**? Please contact Dudley CHC.

Barnet CHC faces a major series of changes to local health services over the next two to three years. Included within this is a Private Finance Initiative bid to build the second phase of Barnet General Hospital and sell the first phase to the PFI consortium. In addition to running most of the non-clinical services, the PFI consortium is seeking the transfer of surplus land at Barnet General and land at Edgware General. Barnet CHC would like to hear from any other CHCs which have examined whether **PFI bids are likely to result in a "substantial variation in provision"** and should be subject to public consultation under Regulation 19 of the CHC Regulations 1985. Please contact Denise Schulte, Chief Officer.

Could any CHCs with concerns about the **bookings/appointments systems for chiropody services** please contact NW Surrey CHC.

Do any CHCs have clients who have complained about **side-effects from Losec (omeprazole)**, a relatively new drug for gastric ulcers and/or reflux oesophagitis? A client at South Manchester CHC is trying to find out if there is anyone who has suffered from alopecia, diarrhoea, insomnia, increased sweats, blurred vision or taste disturbance. Please call Janet or Jenny on 0161 832 8183.

SW Surrey is compiling a **directory of local health-related services** for public use. Could any CHCs which have compiled similar directories please send copies to SW Surrey.

The training and development officer at North Tyneside CHC has a clause in her job description which says "To **establish links with the voluntary sector** and identify voluntary organisation representatives wishing to participate in **lay monitoring of heath services**". This could include linking with groups already visiting sections of the health service to exchange information and provide training and support, or it could be done by training volunteers to take part in specific types of visiting. Do CHCs have any information on the subject? Please contact Tanya O'Neil.

FORTHCOMING EVENTS

Medical Negligence: law, practice and procedure

- two-day basic course organised by Action for Victims of Medical Accidents
- suitable for CHC staff
- Friday 19 April and Saturday 20 April 1996
- at Nottingham University
- £191.49 +VAT (=£225) non residential
  £251.06 + VAT (=£295) residential
- HURRY, PLACES LIMITED

Mediation and Complaints: a review for lawyers

- one-day course organised by Action for Victims of Medical Accidents
- for legal and health care professionals who will be involved with both mediation and the new NHS complaints system
- Monday 29 April 1996
- in central London
- £170.22 + VAT (=£200)

Further info on both the above from:
Mike Hudson, AVMA
Phone: 0181 291 2793
Fax: 0181 699 0632

Growing old in the countryside

- conferences organised by Help the Aged and the Rural Development Commission
- Preston, 16 April
- London, 23 April
- £50 (£30 for voluntary organisations)

Further info from:
Lesley Phillips
Phone: 01367 240129

Crime and Public Health: framing the debate

- one-day conference organised by the Public Health Alliance
- on Wednesday 22 May 1996
- at Sandwell Education Development Centre, Sandwell, West Midlands
- £75 statutory and large voluntary organistions
- £60 PHA members and small voluntary organisations

Further info from:
Maggie Winters
Public Health Alliance
Phone: 0121 643 7628

Making It Happen: learning from local solutions

- conference organised by the King's Fund
- delegates will hear about lessons from the West End Health Resource Centre in Newcastle and the Arts, Community and Health programme in Gateshead
- on Tuesday 21 May 1996
- at Design Works, Gateshead
- £100 (some discounts available for community development projects)

Further info from:
Madeleine Rooke-Ley
Primary Care Group, King's Fund
Phone: 0171 307 2677
Fax: 0171 307 2801

Society of CHC Staff Training Programme 1996

Managing CHCs

- residential course
- mainly for newly-appointed chief officers, but also useful for experienced deputy chief officers
- 25–29 April 1996 at the University of Surrey
- October (date not yet fixed) in Leeds

Further info from:
Wendy Lockwood
South West Surrey CHC

Support staff course

- residential course
- for newly-appointed CHC staff
- 22–26 April 1996 at University of Central England, Birmingham
- £350 inc. accommodation and full board
- there will be another course in November

Further info from:
Joy Notter
Senior Research Fellow, UCE
Phone: 0121 331 6190 (not Weds)
Fax: 0121 331 6186

Working with Complainants

- one-day course
- Nottingham, 14 May 1996
- Manchester, 16 May 1996
- London, 23 May 1996
- £45 (yet to be confirmed)

Further info from:
Sue Hall
Customer Services Officer
Nottingham CHC

Holding the Fort

- one-day course
- for the one who is usually left to look after the office
- Liverpool, 5 September 1996
- Guildford, 12 September 1996
- Newcastle, 19 September 1996
- Exeter, 26 September 1996
- £45/50 (yet to be confirmed)

Further info from:
Wendy Lockwood
Chief Officer
South West Surrey CHC

College of Health Training Workshops on Consumer Audit Techniques

Overview course

- overview of observations, in-depth interviewing and focus groups
- 30 April 1996

Focus groups, basic course

- 30 May 1996

Focus groups, advanced course

- 26 June 1996

- £140 + £24.50 VAT for each course
- discount for small voluntary organisations
- all held at the College of Health in London

Further info from:
Francesca Avabara
College of Health
Phone: 0181 983 1225

DIRECTORY AMENDMENTS

Page iii West Midlands
David Mattocks
Administrative Secretary
Association of West Midlands CHCs
c/o Solihull CHC
Clarendon House
76/90 High Street
Solihull B91 3TA
Phone: 0121 705 6644
Fax: 0121 705 2989

Page 5 East Herts CHC
Change of address:
The Greyfriars Suite
The Priory
Ware
Herts SG12 9AL
Phone and fax unchanged

Page 6 Hillingdon CHC
Chief Officer: Charlie Roe

Page 7 North Hertfordshire CHC
Change of address:
19 Station Road
Letchworth
Herts SG6 3BB
Phone: 01462 487444
Fax: 01462 487888

Page 8 Tower Hamlets CHC
Change of address:
Units 1&2
Albion Yard
Whitechapel
London E1 1BW
Phone: 0171 375 1555
Fax: 0171 375 0700

West Essex CHC
Change of address:
1 West Square
The High
Harlow
Essex CM20 1JJ
Phone: 01279 443875
Fax: 01279 443924

Page 21 Isles of Scilly CHC
Phone: 01720 422097/422411
Fax: 01720 422860

Page 27 Mid Surrey CHC
Change of address:
CHC Office
Old Town Hall
The Parade
Epsom
Surrey KT18 5BY
Phone and fax unchanged
Chief Officer to be announced.

Page 32 Arfon-Dwyfor CHC
Fax: 01286 674961

Page 37 Dudley CHC
Fax: 01384 480960

Page 39 South Birmingham CHC
Acting Chief Officer: Colin Smith

Deadline

If you have items for *inclusion in April's CHC News* could you please get them to ACHCEW by 3 April.