CHC NEWS

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

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NEWS

A huge step towards privatisation

The Government has given the go-ahead for NHS trusts to market their own branded private health insurance. Health Minister Gerald Malone said that there was "no objection to NHS trusts offering branded insurance policies" subject to certain limitations. His comments appear to conflict with earlier comments from Stephen Dorrell that private health insurance schemes don't seem to be "part of the normal work of the health service".

About 30 NHS trusts have been discussing the possibility of such schemes with Universal Health Consultants (UHC), a private consultancy firm. The UHC chief executive outlined possible types of cover which would:

- give subscribers privileges such as additional, non-NHS clinics and shorter waiting times
- pay subscribers cash sums to cover time off work and family care responsibilities in the case of illness
- offer subscribers private treatment for conditions no longer purchased by health authorities
- offer subscribers comprehensive private care.

Not all of these options would be acceptable to the Government – at least for the time being. Gerald Malone has said that NHS trust-branded insurance policies must ensure that:

- there was no detriment to NHS services
- there was no unacceptable risk to public funds
- the services made a positive financial contribution which benefit the trust's work for NHS patients
- the insurance policy was in relation to future private treatment and did not confer any advantage in relation to NHS treatment.

These criteria would not allow insured patients to jump the queue for NHS treatment. However, the ability of NHS trusts to offer cover for private care could be just as damaging to the ideals of universal treatment free of charge. People may well want to take out insurance which would offer them private care for those treatments no longer available on the NHS. They would then have the option of NHS care where it was available and private care at the same trust where NHS care had been withdrawn. Trusts could presumably offer such cover at very competitive rates since the insurance would not need to cover basic NHS treatments. If substantial numbers of people took out trust-branded health insurance, health authorities might well feel less inhibited in further cutting back the treatments they will purchase, which would create more incentives for people to take out insurance ... and so the spiral would continue.

Guardian 24 March, 4 April

Privately owned NHS hospital to go ahead

The building of the first privately owned NHS hospital has been approved in principle by the Government. A private consortium, Octagon Healthcare, is to build a 700-bed, £170 million hospital in Norwich. The hospital will be leased to the NHS on a 60-year contract, with a review after 30 years. Health Minister John Horam has said that the Norwich NHS Trust will run the hospital without interference from Octagon. Professor Chris Ham, head of healthcare management at Birmingham University disagrees: he says that the plans will pit shareholders' interests against those of patients and that "there is little doubt that the effect of the initiative will be to privatise provision of care".

Times 4 April

More equal

GPs in Northern Ireland have won the right to make formal complaints against their patients. After an investigation, a patient can be "admonished where necessary". It seems that the "farsightedness" and "goodwill" of the Northern Ireland Department of Health and Social Security was in part responsible for this stride towards "equality". After all, up till now the poor neglected doctors have been restricted to the right of striking off patients without explanation. The reason why this sanction was so inadequate was made clear by the chairman of the Northern Ireland GMSC: welcoming the "major breakthrough" he said that once patients became aware of the change "they will be much less willing to make frivolous [sic] complaints about GPs".

Doctor 21 March, General Practitioner 22 March

Caught in the crossfire

GPs are being encouraged by the BMA to refuse to provide "extra" elements of care – from taking blood, through caring for patients in nursing and residential homes to undertaking vasectomies – unless they receive extra payment. The advice has been sent from the BMA to all GPs at a time when the Health Secretary is attempting to expand the role of GPs to cover work traditionally carried out by hospitals. In the meantime patients may get caught in the crossfire, with GPs refusing to provide care which it is inconvenient, difficult or impossible to obtain elsewhere.

GP leaders say that GPs are providing care which has "slid into" general practice. This includes care for high dependency patients in nursing homes who would previously have been in long-term hospital beds. They are also providing and monitoring complex and specialist treatments, providing care to mentally ill patients under supervision orders and carrying out minor surgical procedures. The BMA wants to define "core" services which are recognised as part of general practice. GPs should provide "non-core" services only if health authorities or other purchasers are willing to pay for them.

The BMA has chosen to issue the advice without seeking to negotiate a core contract with the Government, although it will presumably seek to use its definition of core services in any negotiations over an expanded GP role. There are risks to GPs in this strategy however. It may encourage the Government to push ahead even faster with the expansion of fundholding, and especially with "total fundholding", in which case the question of payment for non-core services would become an irrelevance. Furthermore, if health authorities were to accept responsibility for purchasing some "non-core" services, they might turn to other providers or demand more involvement in GPs' treatment decisions.

Independent 8, 29 March

Dental de-registrations

Over 1.1 million people in England have been de-registered by their dentists in the past 3½ years, according to a report from the Liberal Democrats. This represents about 1,200 people per working day. Three times as many patients have been de-registered in the south of England as in the north.

Guardian 12 March

Complaints system implemented

The new NHS complaints procedure is now in place. Final guidance on implementation has been issued (copies have been sent to CHCs). This guidance covers issues such as payments to panel members as clinical assessors. Guidance booklets have been sent to GPs and dentists (see *CHC News 111*) and will shortly be followed by one for opticians. The Health Service Commissioners (Amendment) Bill has received Royal Assent, so that the expanded role of the Ombudsman can come into force alongside the other changes.

There are concerns that the NHS is inadequately prepared to implement the new system. If complaints are to be handled well at the "local resolution" stage, frontline staff will need communications skills – and they need training to foster such skills. However, guidance on training arrived only in February and no new money has been made available for that purpose. Another concern highlighted by ACHCEW relates to the fact that a "convenor" from the organisation being complained about has the right to decide not to allow a complaint to go to independent review. Because of the perceived bias in the screening system, many complainants may appeal against convenors' refusals of hearings and take their cases to the Ombudsman. If the Ombudsman cannot handle the workload, new delays in complaints handling may set in.

The NHS Executive's Advisory Group on Complaints is to meet this autumn to take stock of the implementation of the new procedures.

A patient information leaflet on the system is being widely distributed. It is available in various languages from the Health Literature Line: 0800 555777. An ACHCEW Health Perspective on the system has been sent to CHCs.

Guardian 3 April, DoH press releases, Final guidance (EL(96)19)

AGM NEWS

It's time for our annual plea once more. Could anyone who is willing to help with this year's ***AGM News*** – writing, proof reading, photocopying, taking photos etc. – please contact ACHCEW.

All help is greatly appreciated.

FROM PARLIAMENTARY ANSWERS

Prescription charges

Labour MP Tony Banks was in typically combative form when he asked Health Minister Gerald Malone about prescription charge increases. Expressing mock surprise that there have been 16 increases since 1979, and pointing out that the prescription charge would be only 51p if it had risen in line within inflation since that date, he asked what "miserable, pathetic, cringing excuse" the minister had to offer. Mr Malone's unruffled response was equally familiar: that prescription charges will contribute £310 million to health service income next year and that the prescription charge of £5.50 represents two-thirds of the average cost of prescribed items (£9.30). In response to another question he said that the proportion of items prescribed free of charge is likely to increase next year from 80% to 85% – he didn't explain why. Could it be that there will be more people who are deemed to be unable to afford the charge?

Hansard, 12 March 1996, cols 776-77

Underestimating the problem

It may be the Government's wishful thinking – but more likely dodgy arithmetic – that led Health Minister, John Horam, to underestimate the problem of cancelled operations: "The national health service performs over 5 million operations annually. Fewer than 50,000 or less than 0.01 per cent [sic] were cancelled in 1994-95 and many of these would have been unavoidable".

In addition he explained that the figures relate to operations cancelled for non-medical reasons on the day patients are due to arrive in hospital or after arrival in hospital.

Hansard, 7 March 1996, col 324

FOCUS ON ... GP FUNDHOLDING

More GPs join

A further 3,000 GPs became fundholders on 1 April, bringing the proportion of the population covered by fundholding to over 50%. There are now over 13,400 fundholding GPs. "Total purchasing" is also on the increase. There are 51 total purchasing sites in England involving 897 GPs. Of these six sites have been purchasing "live" since April 1995; the rest are pilots. A further 30 practices are expected to join from April 1997. In Wales there are four sites, with a further four planned, and in Scotland there are six, though no more are currently planned.

Total purchasing and CHCs

In a Parliamentary Answer, Gerald Malone said that, in the same way as health authorities, total purchasing pilot projects **are required to consult CHCs about significant service changes**. They should also involve patients in the planning and development of services.

Varied interpretations

In a survey conducted by the National Association of Fundholding Practices (NAFP) of its members the great majority of respondents report at least some benefits of the fundholding scheme: new services for patients, reduced waiting times and improved quality of care. Overall 61% of practices thought that the scheme had a beneficial or neutral effect on their ability to deliver General Medical Services. Perhaps a more significant finding is that 20% of practices said that the scheme had had a "poor" effect.

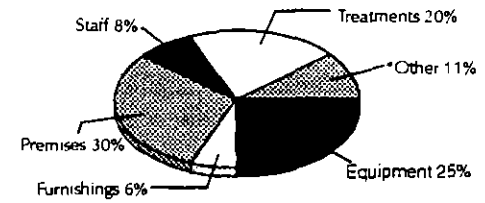
The last finding casts doubt on a claim by the chairman of the NAFP, who said that the number of doctors opting to become fundholders shows that the majority think it is the way to deliver the best care. An alternative explanation for the move towards fundholding is that GPs are unhappy at being on the wrong side of a two-tier service. A recent survey by Middlesex University found that 90% of London GPs believe that fundholders get priority when referring patients to consultants.

The same percentage said that it would be fairer if either all doctors were fundholding or all were non-fundholding.

"Few improvements"

The Audit Commission is soon to publish a major report on fundholding. A draft version says that fundholding has been costly to introduce, that it has brought few improvements and that 60% of savings have been used to improve surgery premises (see also the results of the NAFP survey shown in the pie chart).

Fundholders: planned use of accrued savings



*Other: clinical audit 3%; R&D 2%; Training 3%; Risk management 3%

Source: National Association of Fundholding Practices survey

A loophole closed

The Government is putting regulations in place which will prevent GP fundholders from leaving the scheme with a surplus from previous years while they have current losses. The loophole in earlier regulations came to light when a fundholding practice in Devon planned to resign from the scheme with a £50,000 surplus built up from 1991 to 1995, leaving the health authority to meet £60,000 losses for 1995/96. These regulations will make resigning practices use surpluses to discharge any outstanding liabilities, but they will not prevent practices from leaving the scheme with surpluses where there are no such liabilities.

Commissioning: a viable alternative?

The Labour party has launched a nation-wide consultation with GPs about its plans to replace fundholding with GP commissioning. At present its plans are:

- to accept no new applications for the fundholding scheme;
- to develop commissioning schemes appropriate to each district;
- to institute "fair funding" for all GPs; and
- to restore freedom of referral to all GPs.

All commissioning schemes would have to ensure that all GPs had the same access to hospitals for their patients and that GPs worked towards the public health plans of the community. Health authorities would be obliged to involve GPs in commissioning activities.

In the *Fundholding* journal, Alan Birchall, a Nottingham GP writes about the benefits of GP commissioning. The city's 79 non-fundholder practices have joined a group which was set up in 1992. According to Dr Birchall pressure from the group is at least in part responsible for dramatic cuts in waiting times and for improvements in communications between GPs and trusts.

At least one GP sits on the specialty contract negotiating teams alongside health authority negotiators. GP representatives visit providers and carry out spot checks of performance against contract quality criteria. The group has set up a system to give regular feedback to the health authority on GP satisfaction with services. Each GP has simple forms on which s/he records good or bad points about services. Each time a trust under-performs the GP notes the problem (recording the provider, the specialty and the responsible consultant) and sends the form to the quality team. If there is a recurrent or significant problem the team takes up the issue with the provider.

The group has not overcome problems with extra-contractual referrals. It also has poor knowledge of its own members' referral patterns. The NHS Executive has not responded to the group's bids for cash to pay for a networked computer system to log referral data.

Fundholder 21 February; Doctor 22 February; Hansard 5 March, col 182; BMJ 16 March; Guardian & Daily Telegraph 2 April

FROM THE JOURNALS

Improving A&E

The recent Audit Commission report on A&E services recommended the more efficient use of emergency nurse practitioners through better training and through nurse dispensing. It also recommended "more realistic" targets for waiting times. Both these issues are taken up in two *Nursing Times* articles. The first, by a member of the Audit Commission's external advisory group, urges nurses to use the report in their attempts to extend the scope of nurses' practice.

Waiting time targets

In the second article Gary Jones focuses on the effects of the English Patient's Charter standard on being seen immediately for initial assessment. He believes that the emphasis on a quantitative measure has in practice led to a loss of quality in some departments which already operated a total triage package. A department can achieve the Charter target (95% of patients being seen within five minutes of arrival) and yet offer an unacceptable quality of assessment (since it might not involve a physical examination) and long waiting times after the first five minutes. Those offering good quality assessment and short waits for medical attention may not achieve the Charter standard, and be penalised by purchasers.

Gary Jones suggests that safe assessment can be offered within a longer time-frame. To do this a nurse should have "visual access" to patients as they arrive. This would be followed by a physical assessment. The process would allow a triage system to be developed in which, for example, patients could be referred to X ray, leading to a reduction in total waiting times and to a more constructive use of medical staff time.

The difference between the two approaches is reflected in the English and Welsh Charters (for the new Welsh Charter see page 10). The former says "If you go to an accident and emergency department you can **expect** to be seen immediately and have your need for treatment assessed." The latter says "A doctor or nurse should see you within 10 minutes to judge how urgent your problem is. They will: ask you about the problem; examine you; give you any first-aid treatment you need; and talk to you about what will happen while you are in the department."

Nursing Times 13 March, pages 29-32

What debate?

The title of a *BMJ* article, "Health care rationing: the public's debate", is misleading. The article is not about a "debate" but about an exercise in which members of the public were asked to prioritise 12 broad categories of treatment and asked whether they agreed or disagreed with six statements about priorities.

"Treatments for children with life threatening illnesses" was ranked first, and "treatment for people aged 75 and over with life threatening illness" was ranked last. However, attitudes are not quite so straightforward as this might suggest. "Intensive care for premature babies who weigh less than 680g with only a slight chance of survival" was ranked ninth. Very possibly if people had been asked about an otherwise healthy 80 year old with a treatable cancer, that person would not have been relegated to the lowest priority.

The author argues that such a broad approach to measuring "baseline public opinions and values" is justified as a first step. If the values "seem to conflict with firm medical evidence on effectiveness or to be prejudiced against certain groups then open debate and the provision of sound, unbiased information for public consumption and education is even more essential". However it is questionable whether an exercise of this sort *does* measure "baseline values". People's values are complex – they may be related not so much to broad groups of the population as to the quality and length of life particular patients might expect, to balances between the suffering involved in treatment and non-treatment, to effectiveness and to treatment costs. It is unreasonable to ask people to make a few sweeping judgements and then suggest that unpalatable results may result from "prejudice". Furthermore, any "prejudice" revealed in broad opinion surveys may not be countered by "education", but simply accepted since it provides a convenient justification for giving low priority to vulnerable groups – after all health professionals and health service managers are members of the public too, and no more free of prejudice than the rest of us.

BMJ 16 March, pages 670-74

Inconclusive evidence

In the *Health Service Journal*, Wendy Moore asks whether *Working for Patients* has worked – and reaches no firm conclusions. Indeed, firm conclusions would hardly be possible even if there had been a systematic evaluation of the impact of the health service reforms since so many factors influence the NHS. As a result most supporters and critics of the reforms take up predictable positions: Government ministers, the NHS Trust Federation and many GP fundholders highlight falling waiting lists and increased activity levels, while ACHCEW, the Patient's Association and other patient groups welcome more information for patients but point out that patients still have little choice and that complaints are increasing.

Researchers and statisticians tend to remain sceptical, conceding that there may be have been some benefits, but at considerable cost. The director of health research at MORI says that satisfaction questionnaires tell us little about quality – they are "like a management drug. They distort your vision of reality and you should stop taking them". Although opinion polls invariably show high satisfaction ratings, closer questioning generally reveals widespread shortfalls in services. Equally statisticians point to flaws in waiting list and activity data.

That one's interpretation of the evidence depends on whom you represent is neatly illustrated by John Spiers. As chairman of Brighton Healthcare Trust and a member of the Prime Minister's advisory panel for the Citizen's Charter he was an enthusiastic advocate of the reforms. As recently appointed chair of the Patient's Association he is not quite so sure: "The rhetoric was to improve patient choice. The reality was to improve processes and control costs."

Health Service Journal, 28 March, pages 30-32

COMMUNITY HEALTH COUNCIL REGULATIONS 1996

Revised Community Health Council Regulations have been approved by Parliament. They are set out in Statutory Instrument 1996 No. 640, copies of which have been sent to CHCs.

The main changes

- The title of the CHC Secretary becomes Chief Officer.
- CHCs are allowed to appoint two vice-chairs.
- The CHC reporting year ends at 31 March.
- CHCs must be consulted about changes in the area they cover, the number of members and the provision of premises and services.
- The list of those ineligible to be a CHC member has been redefined.
- Members can be removed from membership after four months of non-attendance.
- Members removed from membership because of non-attendance or because "it is not in the interest of the health service for a person to continue as a member" cannot be reappointed for four years.
- The "eight year rule" has been redefined: a person who has been a member for eight or more consecutive years will not be eligible for reappointment, unless a period of at least four years has elapsed since s/he was last a member.

An accompanying letter explains that members can no longer extend their membership by resigning towards the end of a second term of office. Members "who have served for, or in any part of, eight consecutive years" cannot be reappointed without a four year gap. Note that this regulation refers to *reappointment:* members do not have to step down part way through a term of office on completion of eight years service (e.g. if they served for less than four years of a "casual vacancy" before two full terms of office).

Additional details for Wales

A Welsh Office circular (WHC (96) 23) gives additional details of establishment and membership arrangements for CHCs in Wales.

Key features

- All Welsh CHCs have been reconstituted as of 1 April 1996.
- The membership year runs to 31 March.
- CHCs must include the word "community" in their titles: all publications, correspondence and letterheads should reflect this.
- The maximum number of members of Welsh CHCs will be 20 (10 from local authorities, 8 from voluntary organisations and 2 appointed by the Secretary of State).

NEWS FROM ACHCEW

Difficulties in obtaining hospital food

The *Sunday Express* has taken up concerns raised by ACHCEW and the Relatives Association about the difficulties some hospital patients have in obtaining food. Two articles in the *Sunday Express* gave shocking examples of elderly patients dying after having lost a lot of weight in hospital. Their relatives believe that they died because they were not given enough help with eating. Younger patients have also reported problems. Common criticisms relate to food being placed out of reach and patients not being offered help when they haven't eaten a meal. Sheila West, North Birmingham CHC's Chief Officer, has pointed to the need for clear policies of responsibility for identifying people who need help with their food. Otherwise elderly people will leave their meals and staff will assume that they don't want them.

The newspaper articles have generated a lot of interest, and the *Sunday Express* is going to hand over its information to ACHCEW. Labour community care spokesman, Alan Milburn, has tabled a Parliamentary Question calling for an immediate enquiry into the issue. Some doctors and nurses recognise that there is a problem, blaming it on staffing levels, staff mix and changing nursing practices. The Royal College of Nursing, which is in touch with ACHCEW, is carrying out a separate inquiry. There is to be a debate on the issue at ACHCEW's AGM this July.

In February ACHCEW sent a letter to all CHCs asking for local experiences in order to find out the extent of the problem. The letter set a deadline of 12 April, but the Association would still be interested in further examples – as soon as possible please. We will be issuing a briefing in due course.

Sunday Express 24 & 31 March

Health Perspectives

CHCs have been sent copies of a Health Perspective on *The New NHS Complaints Procedure*.

Faint praise

CHCs have been a sent copy of a Health News Briefing, *The Financial Health of the NHS*, which is based on a survey of CHCs conducted towards the end of 1995. ACHCEW is grateful for the high response rate from CHCs.

The briefing has gone down well with the Health Secretary, Stephen Dorrell, who has already "with wry satisfaction" quoted one of its conclusions: that the NHS reforms had "partially succeeded in their aim of combating the sense of financial crisis in the NHS and the political pressures which this used to create". Needless to say, he did not quote the rider that "instead of long waiting lists and *ad hoc* and unplanned ward closures we now face explicit service restrictions, bed blocking and a dramatic rise in emergency admissions". Still, it's heartening to know that the Health Secretary reads our briefings – even if there is some amusement in the ACHCEW information team that they have presented him with such an easily culled quote at the end of a report cataloguing widespread ward closures and service cuts.

Meeting with John Horam

On 26 March ACHCEW's Honorary Officers had a meeting with John Horam MP, Parliamentary Under Secretary of State for Health. The meeting was friendly and cordial and it was agreed that there would be future meetings around twice a year. The minister hoped that at such meetings ACHCEW could give him "a general feel of the situation in the NHS from the point of view of CHCs". He would also be willing to discuss more specific points that ACHCEW wanted to raise.

At the recent meeting the topics were
- Establishing arrangements for CHCs
- Consultation and CHCs
- The new complaints arrangements
- Performance of health authorities and trusts
- The private finance initiative

A summary of the discussions has been sent to CHCs. If you would like more details please contact ACHCEW.

AROUND THE CHCs

South West Durham CHC has repeated its calls for the local health commission to put appropriate guidelines in place for the running of a new out-of-hours treatment centre following the death of a patient on the night the centre opened.

A 76 year old man died from a suspected heart condition after an ambulance from the South West Durham GP co-operative was delayed in reaching him because the ambulance staff got lost. Maps had been left at the treatment centre. Doctors have said that it is unlikely that the man's life could have been saved, but he could have been given pain-relieving treatment. Val Bryden, Chief officer of the CHC, said that the CHC had wanted assurances about protocols before the scheme started. The CHC has written to the health commission saying that the commission has a responsibility for ensuring that the scheme is offering value for money and that there are appropriate guidelines.

CHC PUBLICATIONS

Views of private nursing and residential homes on the hospital admission, in-patient care and discharge of their residents

South Birmingham CHC, 37 pages

The research on which this report is based involved in-depth interviews with staff from 27 private nursing and residential homes. The CHC considered that the study was necessary because of recent changes in the organisation of elderly care provision and the closure since late 1993 of 62 elderly care beds in South Birmingham.

Admission

Hospital admission presented few problems for most homes, though two homes reported serious delays for residents with acute mental illness.

In-patient care

The main areas of concern were the quality of in-patient care, communications between hospitals and homes, and the morale of hospital staff. The most common complaint about the quality of care was that patients are often discharged with pressure sores. One home linked pressure sores to poor nourishment – another frequent complaint. Over 30% of homes felt that their residents needed more help with eating and drinking while in hospital, some saying that a failure to provide such help had resulted in dehydration and weight loss. Both these shortcomings in in-patient care reflect a more general concern that staff are too pressurised to spend enough time with elderly patients. Almost a third of homes commented that the nursing needs of older people were better served by the community hospitals than the acute hospitals.

Given the shift towards care in private homes, it is worrying that 40% of homes felt that hospital staff failed to understand or had a negative impression of the role of independent homes. The CHC recommends that hospital medical and nursing staff should be required to visit residential and nursing homes (and *vice versa*) as part of their training.

Discharge arrangements

The discharge of new residents to homes and the discharge of existing residents throw up different, though overlapping sets of issues. Discharge information was widely criticised, though community liaison sisters and social workers were praised.

Pressure in hospitals to clear beds seems to have led to inappropriate discharge, particularly in the case of new residents. Some homes felt that undue pressure was put on families to choose a nursing home quickly during an already stressful period for them. One community hospital was praised for not doing this. Although staff in homes were not asked about early deaths after discharge, the issue emerged in 14 of the 27 interviews.

Several examples are given of residents being sent home in totally inappropriate clothes – often in night-clothes and sometimes unwashed. One case was so blatant that the ambulance crew has made a formal complaint to the hospital.

Guide to chemists

East Birmingham CHC, 67 pages

This useful guide lists chemists in the area, with details of addresses, opening hours, an indication of disabled access, bus route details and a list of which of 13 specified services/facilities are offered. The languages spoken by staff in each pharmacy are also listed.

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.

Respite care for the elderly: a survey of client and carer needs

Veronica Cuthbert for Wirral CHC

An independent researcher conducted a survey to identify and describe respite care for older people who are physically unwell, provided by both the health and the social services. The survey also aimed to identify the unmet needs of existing services users and those who have not been using services. Many carers appear to be "coping" with minimal support. The findings cast doubt on the view that community nurses can identify unmet needs, since most clients appear not be visited. It is suggested that the lack of information on respite care may reflect the lack of provision: excessive demand would swamp existing resources.

CHC PUBLICATIONS: LISTINGS

Local health services – "Where now?" Report of the views of the public
Bury CHC, 16 pages

From policy into practice: user and carer perceptions of care management in the Southern Health and Social Services Board's Area
Executive summary, 20 pages (showing key findings in graphs and a little text)
Southern Health and Social Services Council, 16 Church Street, Portadown, Craigavon, Co Armagh BT62 3LQ; phone: 01762 351165; fax: 01762 351493

General practitioner survey
Report on the survey, *32 pages*
Panel members' replies to qualitative questions, *87 pages*
Health Watch, Warrington CHC

Acute mental health services for East Birmingham residents 1995/6
Quality project Number 4: follow-up study,
East Birmingham CHC, 70 pages

Survey of the accident and emergency department, Basildon & Thurrock Hospital, Essex
Basildon & Thurrock CHC, 35 pages

Report on mixed-sex wards
Clwyd South CHC, 8 pages

Sign posting project
Wakefield CHC & Pontefract CHC, 81 pages

A directory of nursing and residential homes in North Tyneside, 1995
North Tyneside CHC, 162 pages

OFFICIAL PUBLICATIONS

The protection and use of patient information

Guidance from the Department of Health, 24 pages
Guidance from the Welsh Office, 23 pages
Copies have been sent to CHCs

These two documents are virtually identical. They represent a considerable amendment of the consultation document which was issued in 1994, although the changes have more to do with the presentation and organisation of the guidance than with the essential points it makes.

It stresses the duty of confidence of NHS bodies, those who work for or with the NHS and those to whom information is passed. NHS bodies are strongly advised to include a confidentiality clause in employment contracts or other documents setting out terms and conditions.

No requirement to gain explicit consent

Personal information about patients may be used for various purposes apart from delivering personal care, such as clinical audit, protecting public health, co-ordinating NHS care with other agencies and administration. ACHCEW had objected to the assumption in the draft document that patients gave "implied consent" to information about them being used for these purposes. The final guidance does not use the words "implied consent" and lays considerable stress on informing patients of how personal information may be used. However, it does not impose a general requirement for patients to be offered the opportunity to agree to, or refuse, the use of information about them for various purposes. It *does* state that, with a few specified exceptions, patients can refuse to have information passed on to "someone who might otherwise have received it in connection with his or her care or treatment" and to social services and other agencies.

Under the guidance, information about patients can be used for audit and research (the latter subject to clearance from the Local Research Ethics Committee) without asking for the patient's consent at any stage. The agreement of patients would be sought only if any published research findings would identify them. ACHCEW believes that this is inadequate and that patients should be offered the opportunity to refuse to have information used in this way, perhaps when first signing on at a GP practice, unless there was a strong public interest case in overriding the refusal.

The NHS information management and technology security manual

NHS Executive (HSG(96)15), 86 pages
Copies available from DoH, PO Box 410, Wetherby LS23 7LN; fax: 01937 845 381.

Copies of this manual have *not* been sent to CHCs although it applies to the whole NHS. **All NHS organisations should review their security arrangements against the requirements set out in the manual by the end of July 1996,** with any remedial action being implemented by November 1996.

The manual sets out security requirements for, and additional advice on, a security policy designed to preserve the confidentiality, integrity and availability of information. It builds on the requirements of *Protection and use of patient information* (see above), but does not cover the exchange of information between organisations.

The Patient's Charter: a charter for patients in Wales

Welsh Office, 32 pages. For availability details ring Health Information Wales on 0800 665544

The 1996 Patient's Charter for Wales has six new standards. Two of these concern mixed-sex wards and response times under the new complaints system. The others are::

- You will receive a coronary artery by-pass (or similar treatment for blocked coronary arteries) within a year of being diagnosed as needing one.
- Whether or not you are admitted [from A&E] you should not normally have to spend longer than four hours in the accident and emergency or casualty department.
- If you have to go into hospital , you can expect to be given written information about hospital facilities, e.g. visiting times, catering services and security, before or when you go into hospital. It is good practice for the written information you receive to include details of your treatment.
- If you have a serious mental health problem you will be encouraged to work with a carer of your choice and your local community mental health team to agree a plan to help you get the care and support you need. You can keep a copy of this plan.

Children's services planning: guidance

Department of Health and the Department for Education and Employment, 16 pages.
Copies have been sent to health authorities and trusts, but no other availability details are given.

This guidance applies to England. In March 1996 the Secretary of State for Health made an Order requiring local authorities to assess the need for provision in their area of services under Part III of the Children Act; to consult with various bodies in planning how to meet that need; and to publish the resulting plans.

This guidance offers advice on services which *must* feature in Children's Service Plans (services for children "in need") and on other services which could be included. It sets out requirements for consultation and inter-agency co-operation and a suggested framework within which planning can take place.

OFFICIAL PUBLICATIONS: LISTINGS

High security psychiatric services: changes from April 1996
6-page leaflet, NHS Executive. For copies phone the Health Literature line: 0800 555 777

The Patient's Charter: services for children and young people
30-page booklet and poster, NHS Executive
Copies should have gone to CHCs. For further copies phone the Health Literature line: 0800 555 777

A range of materials on **help with NHS charges** has been produced by the Department of Health:
- A general promotional poster – available in various languages (HC10)
- *Are you entitled to help with health costs?* (HC11). A 24-page booklet
- *NHS charges and optical voucher values* (HC12). A 4-page leaflet.
- *Adviser's guide to help with health costs* (leaflets – available from May 1996)
- A dispenser to display leaflets (HC15)
- Application form for exemption on medical grounds (FP92A)

Copies available from DoH, PO Box 410, Wetherby LS 23 7LN; fax: 01937 845 381.

The National Health Service (Appointment of Consultants) Regulations 1996: good practice guidance
NHS Executive. Copies available from DoH, PO Box 410, Wetherby LS 23 7LN; fax: 01937 845 381.

GENERAL PUBLICATIONS

Working together: health and advice services
Proceedings of a conference

Southern Area Office of the National Association of Citizens Advice Bureaux, Units 1 and 2, Anchor Business Centre, School Lane, Chandlers Ford, Eastleigh, Hants, SO53 4UB, 63 pages

Since the late 1980s CABx have become involved in working with NHS staff to set up advice services in community health facilities. This conference heard from projects set up in Birmingham, Tyneside and Dorset. Appendices to the report include detailed information on an agreement between the Health Commission in Dorset and the local CAB to provide advice in General Practice.

It is a shame that "working together" does not seem to extend to CHCs, which do not appear to get a mention in the report. Much of the report is concerned with services which CABx are particularly well-placed to offer – advice on issues such as benefit rights – and which they feel will reach more people if CAB staff can operate in GP premises. However, CABx are also considering the possibilities of working with particular client/patient groups – in the field of mental health advocacy, for example. This is an area in which CHCs have a lot to offer, and it would be strange if CABx were to ignore their experience or their statutory rights and obligations in such areas.

Myths about the NHS and rationing health care

Health Policy Network, National Health Service Consultants' Association and NHS Support Federation
12 pages. Available from NHSCA, Hill House, Great Bourton, Banbury, OX17 1QH, £3.

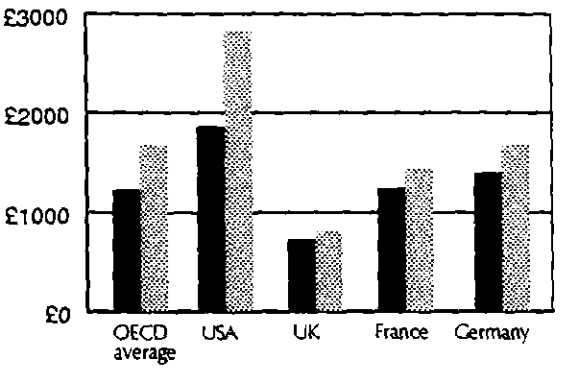
In the run-up to last autumn's budget, the media focused on the likely size of tax cuts rather than whether any increase in NHS funding was possible. Within the health sector, recent discussion has revolved around rationing rather than the share of national income going to health care. This is curious given that, for a developed country, the UK spends little on health care, whether this is measured by total expenditure or public expenditure, and it has a relatively low tax burden compared to other major western-style economies in the G7 group.

This document sets out brief but clear graphs and figures which suggest that the UK could well afford to spend more on health care if it had the political will to do so. It suggests three reasons why we have been diverted into debating rationing: (1) the NHS market has encouraged discussion of *local* purchasing priorities, (2) influential organisations have set the same agenda and (3) people have been seduced by the myth that the demand for health care is infinite.

The discussion closes with a consideration of remedies. It accepts that the NHS needs to cut out avoidable waste – waste caused by unnecessary bureaucracy as well as that caused by ineffective treatments. It also says that hospitals should be documenting undue stresses in their services (with suitable outside monitoring). Every opportunity should be used to make the public aware of the low levels of spending on health care and public spending in general. This should help to focus attention both on the needs of the health service and on the needs of wider economic reform to address the poverty which leads to ill health.

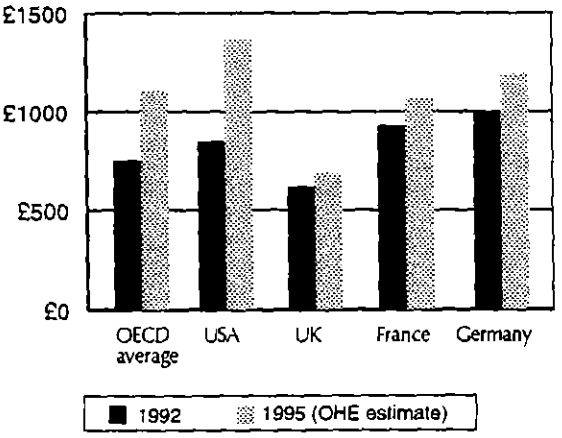
Total health expenditure per person

(public and private, £ sterling, cash terms)



Public health expenditure per person

(£ sterling, cash terms)



Source: OECD, IMF, WHO and OHE, compiled by the Office of Health Economics

GENERAL PUBLICATIONS: LISTINGS

Taking care of doctors' health:
reducing avoidable stress and improving services for doctors who fall ill
Nuffield Provincial Hospitals Trust, 59 New Cavendish Street, London W1M 7RD, 35 pages, £10

Sight problems: a short guide to sources of help
An 8-page RNIB leaflet

An associated book on services and products, *You and your sight*, is published by HMSO
The print version of the book is available from bookshops for £4.95
The leaflet and tape and braille versions of the book (also £4.95) are available from RNIB Customer Services, PO Box 173, Peterborough PE2 6WS; phone: 0345 023153.

Children with severe asthma at school:
helping to ensure that your child gets the most out of school
National Asthma Campaign, Providence House, Providence Place, London N1 0NT; phone: 0171 226 2260; fax: 0171 704 0740; 8 pages

FORTHCOMING EVENTS

Out of Harms Way?

- a conference on the appropriate care and treatment of mentally disordered offenders
- organised by MIND
- 22 May 1996
- at Regent's College, London NW1
- £85, £70 MIND members, some free places for users (details from Conference Office)

Further info from:

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

Promoting the Health of Children: working together to reduce inequalities

- conference organised by the National Children's Bureau in association with the British Association for Community Child Health
- at etc limited, Consultancy Courses Centre, London SE1
- on 13 June 1996
- voluntary sector: Bureau members £88.12; non-members £99.87
- other: Bureau members £117.50; non-members £146.87

Further info from:

Conference Office
8 Wakley Street, London EC1V 7QE
Phone: 0171 843 6041/2
Fax: 0171 843 6039

Consulting the Public on Health Care: panels, surveys and focus groups

- a two-day workshop organised by School for Policy Studies
- on 6–7 June 1996
- at School for Policy Studies, University of Bristol
- £275 (inc. meals and accommodation)
- some bursaries available

Further info from:

Paul Burton or Lyn Harrison for details of content:
Phone: 0117 974 1117
Deborah Marriott for booking details:
Direct line: 0117 946 6984
Fax: 0117 973 7308

Equity in Healthcare for Older People

- conference to raise awareness of the problems many older people experience in access to and the equity of health care
- organised by Age Concern England
- at Royal Society of Medicine, London W1
- on Tuesday 16 July 1996
- £80, reduced rates for voluntary organisations, unwaged and retired people and students

Further info from:

Clare Brooke
Age Concern England
Phone: 0181 679 8000
Fax: 0171 307 2801

But Will it Work, Doctor? 1996

- two-day conference on the improvement of public access to evidence about the effectiveness of health care
- on 22–23 May 1996
- at Swallow Hotel, Northampton
- two days + accommodation on 22 May £200; two days, no accommodation £140; one day £100; some sponsored places available for £75
- **booking deadline: 20 April**

Further info from:

But Will it Work Doctor?
PO Box 777
Oxford OX3 7LF
Phone: 01865 226873
Fax: 01865 226959

INFORMATION WANTED

ACHCEW would appreciate copies of any documentation on the establishment of joint committees between CHCs, e.g. Terms of Reference, Constitution and Standing Orders.

DIRECTORY AMENDMENTS

The recent request for Directory amendments had an excellent response. A new Directory incorporating the changes will be issued soon. In the meantime, we list CHCs which have changed their name:

Previous name	New name
Aberconwy	Conwy
Arfon Dwyfor	Gogledd Gwynedd
Clwyd North	Dyffryn Clwyd
Clwyd South	North East Wales
Crewe	Cheshire Central
South Durham	South Durham and Weardale
East Glamorgan	Taff Ely and Rhondda
Halton District	Halton
Hounslow & Spelthorne	Hounslow
Kingston & Esher	Kingston
Lancaster	Lancaster & Morecombe
Northallerton	Northallerton & District
Ogwr	Bridgend Country Borough
Rhymney Valley	Caerphilly
Richmond, Twickenham & Roehampton	Richmond & Twickenham
Swansea/Lliw Valley	Swansea
Torbay District	Torbay & District

CHC NEWS

CHC News is set to change.

From May we will be sending out copies of a new-look *CHC News* for all CHC members.

CHC News will be shorter at 8 pages – we think that will be a welcome change! We will send a separate *CHC Listings*, covering forthcoming events, information wanted, publications received and so on, to CHC offices.

The new *CHC News* aims to keep members up to date with national health service news and let them know more about what is going on in CHCs and in ACHCEW.

We are keen to increase the news about CHC activities. If you have projects you would like to write about, or opinions you want to air, please send us contributions for the newsletter.

Would you be willing to write short reviews of books and reports which interest you? ACHCEW receives a mass of surveys and reports each month. There are plenty of CHC members and staff with knowledge of and interest in the topics they cover. If you would be willing to contribute reviews to *CHC News*, please let us know what your areas of interest are. We can then contact you if we are sent something which you might like to write about.

The deadline for next month's *CHC News* and *CHC Listings* is 7 May.

Please contribute to the new *CHC News* to make it a lively read for everyone.