CHC NEWS

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

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CONTENTS

CONTENTS

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NEWS

Whistle-blowing – the right balance?

The Department of Health has published draft guidelines which set out the steps NHS employees should take if they have concerns about the NHS. They stress that staff should have the right to put concerns to every level of line management without fear of penalty. While this is a laudable aim, the guidelines do not provide mechanisms to ensure that it is fulfilled. It is arguable that the guidelines will act as a deterrent to staff who are nervous of raising issues with their immediate managers. There is no requirement to provide access to an independent body, for example at regional level, to which staff could turn in such circumstances. There is also no mention of mechanisms to deal with victimisation, should it occur. If an issue remains unresolved having been referred through the management chain, there would be little a member of staff could do. The guidelines state that staff who contact the media without the consent of their employer would be breaking their contracts and would be liable to disciplinary action. Yet surely it is difficult to imagine management authorising contacts with the media if it has not addressed the original concern. In effect this provision would put put NHS staff on the same footing as employees of private companies, who have 'an implied duty of confidence and fidelity to their employer'. However, in the NHS, there could be a conflict of interest between loyalty to patients and loyalty to employers; the guidance does not address how such a conflict might be resolved.

Freedom of speech for NHS staff – draft guidance, DoH; Health Service Journal, 22 October

GP superfund

More than 100 GP fundholders in Kingston & Esher District are planning to band together to form a 'superfund' with a budget of up to £20 million. The group would cover 75% of the district's population and control nearly a third of the budget of the health authority. The rationale behind the plan is that it would enable GPs to pool resources, employ experienced negotiators and 'put the GPs in the driving seat'. Although GPs would retain the right to refer where they chose, the plan inevitably raises questions about whether it undermines competition among practices and effective choices for patients, which was an important justification for the introduction of the fundholding scheme. The chief executive of Kingston & Esher Health Authority has said that the size of the fund could threaten the authority's capacity to deliver Government objectives, for example on waiting times, the Patient's Charter and community care. It will also presumably intensify questions about the equitable treatment of those who are patients at non-fundholding practices.

Times, 10 November

The bill for opting out

In answer to a Parliamentary Question, the Government has released figures on the cost to taxpayers of preparing NHS provider units for trust status. £12.5 million was spent on the first wave, £26.6 million on the second wave, and so far £2.1 million has been spent on the third wave. Of the £40 million total, by far the greatest proportion was in the form of one-off payments to prospective trusts during their 'shadow' running period (i.e. prior to the date on which they became trusts) to cover 'shadow board costs, legal expenses connected with the transfer of assets, employment of staff and other miscellaneous expenses'. Smaller amounts were allocated for consultation and conveyancing costs. The Department of Health was unable to reveal the cost of employing management consultants in the preparation of trust applications. Labour MP Alan Milburn has called for an independent investigation of the spending, saying that it could have paid for 3555 nurses, 1282 junior doctors or 1282 ambulances.

Hansard, 3 November, col 180; Guardian, 30 October

BMA backs 'right to die' card

The BMA has welcomed the idea of a card which people could carry setting out a wish not to be kept alive on a life-support machine if there was no hope of recovery. The card, similar to the ones used in the kidney donor

scheme, would give the 'advance directives' of people who had made a living will. Drafting the directives would be the responsibility of the patient and would be regarded as a method of informed consent. The BMA recommends that this should be done after medical advice and counselling and that directives should be reviewed at least every five years.

Telegraph/Independent, 11 November

Infertility treatment being cut back

It is becoming increasingly difficult to get infertility treatment on the NHS. There are some 2 million infertile couples in Britain, yet an already limited service is low on the list of priorities for many purchasers. At the Royal Victoria Infirmary in Newcastle, patients have to wait up to five years for IVF (*in vitro* fertilisation) or Gift (gamete intra-fallopian transfer). In the Norfolk and Norwich Hospital, doctors have been told not to accept new patients for these treatments. In London the Hammersmith Hospital recently closed its waiting list and Queen Charlotte's Hospital, which offers infertility services, is under threat. Bradford and York refuse to purchase IVF on the grounds that it is 'still experimental with a poor success rate'. At St Mary's Hospital in Manchester (one of three regionally funded NHS units) patients face a 'prohibitively restrictive' set of entry criteria. The situation in Britain contrasts with that in France, Belgium and Germany, where treatment is available free.

Independent, 2 November

Waiting lists grow

Provisional figures for the three months to 30 September show that waiting lists rose by 1.4%, reversing the decline at the beginning of the year. This breaks down into a rise of 1.9% in the up-to-a-year waiting list and a fall of 3% in the 1–2-year list. The Department of Health claims that only five people had been waiting for more than two years, all in the NE Thames Region. However, specialist hospitals still have 646 people in this category. In three out of the 14 regions (East Anglia, Oxford and SE Thames) the waiting lists were cut further in the quarter; in all others they rose, with a rise of 8.9% in SW Thames.

Telegraph/Guardian, 12 November

Prison psychiatric care

Prison governors are to adopt a new code of psychiatric care in response to widespread criticisms of the punitive regime of much of the Prison Medical Service. The minimum standards will include: allocating a named doctor and health care worker to each patient; ensuring that patients have as much time as possible outside their cells; ensuring that there is care after the patient is released or transferred. The code also covers staff training and improved qualifications. In addition to these standards, there are to be pilot schemes to foster a closer alignment with the NHS and the buying in of the expertise of civilian doctors and nurses. It is estimated that a quarter of the prison population has psychiatric problems, yet the service has been isolated from mainstream medicine. The changes have been welcomed as far as they go, but criticised for not going far enough. Ian Bynoe, the legal director of Mind, commented 'Staff must be accountable to prisoner patients in new and effective ways, ensuring that they get NHS specialist treatment when they need this.'

Independent, 27 October

Cot death campaign a success

OPCS figures show that unexplained infant deaths fell by 46% in the first quarter of 1992 compared with 1991. This is seen as the direct result of a campaign promoting the safer sleeping position for babies – on the side or back rather than the stomach. It also recommended the use of lightweight blankets and avoiding a smoky atmosphere. The number of cot deaths had fallen by 37% between 1988 and 1991. Although formal advice had not been issued by the Government at this stage, health visitors and doctors had been advising the safer position for some time. The campaign in late 1991 followed the experience in New Zealand and the Netherlands, where the cot death rate fell dramatically after similar advice had been issued.

Despite this welcome news, 10 babies still die from unexplained causes each week. The Foundation for the Study of Infant Deaths has launched a leaflet advising doctors and health visitors on how to deal with the tragedy of a cot death.

Telegraph, 9 October; Independent, 4 November

FROM THE COURTS

Income Support precedent

A threat to the benefits of thousands of people in residential and nursing homes has been lifted by the ruling in a test case. Twelve elderly people formerly receiving in-patient hospital care had moved to a nursing home in East Sussex on the grounds that it would provide a more suitable environment for them. It had been agreed that the health authority would pay the home a top-up fee of £140 per week per resident to cover the gap between the Income Support rate and the home's fees. The Department of Social Security turned down the residents' claim for Income Support, arguing that they were still in-patients of a 'hospital or similar institution'. The DSS decided that they were eligible only for an in-patient allowance of £13.55.

The DSS's decision was overturned, first at a social security appeal tribunal, and again by a social security commissioner. The DSS was ordered to pay the residents Income Support, backdated to March 1991. The ruling sets a precedent for thousands of residents and has been welcomed as a crucial decision by Mind, which fought the case.

Guardian, 15 October

Limit on woman's right to refuse treatment

In another case setting a precedent, a High Court Judge has ruled that a woman's right to refuse a caesarean operation could be overridden on the grounds that her baby's life might be saved. In a 23 minute hearing, the court decided that a woman who had refused a caesarean for religious reasons should undergo the operation even though there was no question of mental incapacity. Doctors had informed the court that this was the only way the lives of the mother and the baby might be saved. In the event, the baby died, but the mother survived and is in a serious condition. The ruling calls into question the application of National Charter Standard No. 1 which states that there should be 'respect for pivacy, dignity and religious and cultural beliefs' of patients. It also sets an important precedent: this is the first time that an English court has tested the question of whether a patient's right to refuse treatment persists where another life is at stake.

Times, 14 & 27 October

Communications review at Guy's

A coroner in South London has ordered a review into communications procedures at Guy's Hospital following the deaths of two babies. In both cases, the jury returned verdicts of death by natural causes: both of the babies had undergone heart surgery and both had also been infected with klebsiella bacteria. The parents had been given conflicting information on the role of the infection in their children's deaths, leaving them confused and angry. The coroner called for a review of 'the policy and guidelines to convey information to families immediately after the death certificate is issued'.

Times, 7 November

FROM THE COURTS

Call for improved neonatal surgery

About 1500 new-born babies require surgery each year, yet only Mersey Region provides an adequate service according to a report from the Royal College of Surgeons. The report says that new-born babies should always be operated on by specialists, not by general surgeons, and that operations should take place in specialist centres with full facilities and support services. In a region-by-region analysis, the report finds that West Midlands has fewer than half the specialists it needs, but some other regions could provide an adequate service by bringing specialists together into single units. A consultant paediatric surgeon at St James's University Hospital in Leeds says that neonatal surgery is cost-effective and that the overwhelming majority of babies they treat go on to lead lives of normal quality.

Independent, 22 October

Poor people go hungry

Many poor people in Britain have insufficient money to feed themselves properly, according to a report from the National Consumer Council. People under the age of 25 who are out of work receive lower rates of Income Support than older people (even if they are pregnant or are under 18 and have children), and 16 and 17 year olds are not eligible for Income Support in most circumstances. Homeless young people are the most vulnerable; their daily intake of energy is a third of what it should be and is deficient in vitamins, iron, protein and calcium. The report states that going without food for one to three days is normal. Mothers are also at risk, as they often cut down on their own food in order to give their children enough: a quarter of women on low incomes fall below deficiency levels for eight essential nutrients.

These difficulties are not necessarily caused by unwise buying. The Family Welfare Association has found that 47% of families asking for help did not have enough money for food after paying for rent, fuel and other necessities. In addition, the NCC report states, poor people get more nutrients per penny than those who are better off. But in order to get enough energy in their food they buy items such as crisps and biscuits, for example, rather than bananas and apples. This type of diet makes them more vulnerable to cancer and heart disease in later life. *Your food: whose choice?* is available from HMSO for £10.95.

Indepenent, 6 November

GPs confused about menopause treatment

A survey of 3000 women has found that GPs do not give the best possible treatment to women in their menopause. Many are confused about hormone replacement therapy (HRT) and make decisions on the basis of out-of-date information, which could lead to dangerous prescriptions. GP consultations for a first HRT prescription lasted an average of 7 minutes, compared to 35 minutes for women seen in hospital clinics. In addition, GPs were reluctant to prescribe different treatments to patients who suffered side-effects on one course. The Amarant Trust, which carried out the survey, is a charity which promotes greater understanding of menopause and HRT.

Telegraph, 13 October

FOCUS ON ... LONDON

999 failure

An inquiry has been called into the failure of the London Ambulance Service's (LAS's) new computer system to meet the demands placed on it. On 4 November, the system reverted to full manual control after staff noticed that the system response was slowing despite the fact that demand was low. A week earlier the system had broken down as a result of operational congestion. The National Union of Public Employees claimed on that occasion that up to 20 lives may have been lost as a result.

LAS executives have admitted that the £1.5 million computer system could not cope. The managing partner of a computer company specialising in emergency services has claimed that, when the system was purchased, tenders from experienced providers were ignored in favour of the lowest bid.

The inquiry is to be led by the chief executive of South Yorkshire Ambulance Service who is joined by the former chief conciliation officer of the Advisory Conciliation and Arbirtration Service (ACAS) and a specialist in computer audit and fraud. They will investigate the original specification for the system; why it was chosen; how it has operated since installation; communications between management and staff; and the high levels of absenteeism in the LAS. The inquiry has been welcomed by NUPE, and its report is expected by mid-February.

Recently released figures show that, in the three months from July, only half of LAS crews arrived at the scene of an emergency within the 14 minute Charter standard, compared with two in three crews for the same period last year.

Times, 5 November; Independent, 7 November; Guardian, 10 November

The Tomlinson report

The Tomlinson report on the future of health services in London has now been published. As expected, it recommends a shift of priority from hospital care to community-based services – a shift which would entail the closure of several London hospitals (see box). Hospital beds would be cut by 2500 and medical, nursing and other staff reduced. The report calls for an extra £150 million for general practice and community services, with savings from hospital mergers being ploughed into these services.

London has a large number of specialist hospitals crowded into a relatively small area. Their costs are high, putting them at a disadvantage in the new market-oriented NHS, with the result that 1700 beds are currently closed. The report estimates that demand for beds will fall by a further 2000 to 7000 by the end of the century. At the same time, GP and community health services are underdeveloped in the capital: Professor Jarman, professor of health policy at St Mary's medical school, estimates that 46% of GP premises in inner London are below Government minimum standards, often with no washbasins or lavatories and insufficient space and furniture (the situation is even worse in some areas of outer London). Nearly a quarter of inner London's GPs are working single-handedly – twice the national rate – and, unlike the rest of the country, their list sizes are increasing. As well as working in these difficult conditions, London GPs are relatively badly off, with an average income of less than £30 000, a level 25% below the national average.

In place of this dichotomised pattern of provision, Sir Bernard Tomlinson would prefer to see primary care responding to local needs. He praises the Lambeth community care centre as a model for the future. The centre provides a day centre, with multi-disciplinary input from health and social services. It also has an in-patient unit providing 20 residential beds and a day unit for non-emergency cases. This is staffed by nurses, with emergency cover provided by GPs.

On the subject of medical schools, Sir Bernard recommends that eight of the nine schools be merged into four faculties of medicine within the University of London. More undergraduate teaching should be carried out in primary settings and in peripheral hospitals.

Proposed hospital closures and mergers

- Merge Bart's and the Royal London closing Bart's site
- Merge St Thomas's and Guy's using one site for alternative healthcare purposes
- Merge Middlesex, Royal National Throat Nose and Ear Hospital and the Hospital for Tropical Diseases with Univesity College Hospital closing Middlesex site
- Merge St Mark's and Northwick Park closing St Mark's site
- Merge Royal Marsden and Royal Brompton and Charing Cross on Charing Cross Hospital site or close Charing Cross
- Close Queen Charlotte's Hospital

Critics of the report have expressed concerns over its implications for accident and emergency cover and for staff redundancies. Sir Bernard denies that emergency units would be spread too thinly. He does however acknowledge that there will be difficulties for staff: 'sensitive arrangements will have to be worked out for the redeployment or retraining of staff in areas and skills appropriate to the new NHS in London'. Given that he estimates that London teaching hospitals have 450–680 extra consultants compared with similar hospitals in other parts of the country, this will be a daunting task as regards doctors. The Royal College of Nursing recognises the need for redeployment from hospital to community nursing, but stresses that 'London needs all its nurses'.

Commenting on the report, the *Health Service Journal* urges readers and the Health Department not to regard it as relevant only to London. The scale of London's imbalance between hospital and community care may be greater than elsewhere, but the imbalance exists in other parts of the country. Some of the report's recommendations suggest ways of preventing hospitals from hijacking community funds, for example by enhancing the power of FHSAs and making FHSAs coterminous with health authorities. Such recommendations are equally applicable nationwide.

Health Service Journal, 29 October; Telegraph, 24 October; Times, 23 October; Guardian, 7 October

FROM THE JOURNALS

Mixed wards

There are mixed feelings about mixed wards, and a feature article in *The Times* seeks to explore some of the arguments. Some patients are distressed at having to share wards with members of the opposite sex, particularly when they are already feeling vulnerable. And it is not just a question of 'old-fashioned values': the Patients' Association receives complaints from elderly people and teenagers alike. As a spokeswoman for the Association points out, the Patient's Charter says that hospitals should 'respect patients' privacy, dignity and religious and cultural beliefs'. For many, this will include having the choice of single-sex wards.

Hospital managers point out that mixed wards increase efficiency by reducing the risk of beds lying idle in one ward while another is over-subscribed. They also say that some patients prefer mixed wards, and many hospitals attempt to meet the patient's preference. In any case, there are often separate bays in mixed wards and separate toilet facilities. However, the assistant director of nursing policy at the Royal College of Nursing claims that 'the separation is not always adhered to for reasons of convenience, cost-effectiveness and because people are not thoughtful'. Another argument from some geriatricians is that some women patients get better when men are around, an argument the Patients' Association dismisses.

Psychiatric wards present particular problems. On the one hand, mixing the wards helps to break down the stereotype of psychiatric patients being dangerous people who are out of control and avoids the artificial institutionalisation of rigid sex separation. On the other hand, many women feel threatened in mixed wards, especially if they have been abused in the past.

Another approach is to question the whole assumption of shared wards. In Europe, there is much more emphasis on single rooms. Many people want more privacy than can be offered by screens, whether from men or women. In an increasingly market-oriented health service, future hospital designs may come to resemble what patients would expect if they were booking a holiday in a hotel.

Times, 5 November

Discharge crisis

It is widely recognised that the period after being discharged from psychiatric care can be difficult for patients and their families. Approaches to discharge planning have been developed which aim to alleviate the problems. This small study shows that the knowledge and work is not always put into practice. Twenty patients who had been discharged from a short-stay psychiatric hospital within the last year were given a short questionnaire in which they answered 'yes', 'no' or 'unsure' to 13 questions concerning the planning of their discharge. Very few of the answers were 'unsure', and a disturbing number of 'no's' indicated that discharge procedures were inadequate. Only seven, for example, thought they had been informed about how to obtain help should they begin to feel unwell again and only one patient felt informed about the availability of support organisations in the community.

The survey has prompted action in the unit. A checklist has been drawn up and is included in each patient's nursing profile. It aims to improve communication between unit staff and patients and families; it covers consultation, provision of information on other departments, and referrals. A leaflet has been drafted which gives helpful details that patients can take away with them. A resource folder has also been put together and staff can refer to it to provide patients and their families with information on support organisations.

Nursing Times, 21 October

Planning mental health provision

An article in *Community Care* attempts to divine what is going to happen to the planning of provision for people with mental illnesses as Care in the Community is implemented. Provision currently comes from a range of sources: health authority, local authority, voluntary, private and various combinations of these – the private sector accounts for 40% of places. The balance is going to change: local authorities are not planning new provision as social services departments (SSDs) move into their purchasing role; health authorities are at present planning increased provision in the

community, as they run down psychiatric hospitals; the voluntary sector is active, but mainly where it is working jointly with a statutory agency. There are considerable uncertainties amidst all this activity, in particular for health authorities. Many are finding that they are having to maintain hospital premises while they attempt to develop community provision. After April, they will depend on SSDs for allocating the funds transferred from the social security budget. However, if the services provided are defined as health rather than social care, access to alternative funding may cease altogether and health authorities will be responsible for revenue funding.

With all this uncertainty it is essential, the author argues, for the various sectors involved to talk to each other. The locality planning approach recently advocated by the Audit Commission might provide the necessary coordination if residential care is not to 'reap the consequences of unplanned change'.

Community Care, 22 October

Caring for children affected by HIV

Children affected by HIV include not only those who have tested positive, but also those with parents or siblings who have the infection. The care they need is much wider than work confined to infected individuals, and requires a broader-based family approach. As a National Children's Bureau (NCB) report points out, this has implications for training. In this article, Nicholas Murray looks at what some of those implications are. A number of elements are required in the training, including specific guidance on confidentiality, awareness of HIV transmission and long-term care planning. However, HIV should not been seen as competing for resources; rather it should be integrated into good child care practice. As Naomi Honigsbaum, author of the NCB report, points out: 'HIV exposes weaknesses that already exist – confidentiality for example is a burning issue that is more powerfully addressed in the area of HIV. HIV sharpens your thinking on all these issues.' She believes the training will not be effective unless it is integrated into practice, together with staff development and support. Too often it is seen as 'something that happens elsewhere'.

Community Care, 15 October

Hospital infections

It is estimated that as many as one in ten patients currently in hospital are there because of an infection or illness they have acquired after being admitted. If all these infections were prevented, 160 000 extra hospital beds would be released each year. Not all cross-infections could in fact be prevented, but microbiologists estimate that a third could be. There has been no national survey on the problem since 1980, but anecdotal evidence indicates that there is often a failure to adhere to basic hygiene standards – a failure exacerbated by staff shortages. One study in NHS hospitals found that nurses wash their hands only once every three times after bathing around a patient's catheter. Complaints from mothers at maternity hospitals included blood on toilet seats, an absence of soap and disinfectant and filthy bathing facilities. Babies and mothers are especially vulnerable to hospital-induced infection, and a survey carried out for the National Childbirth Trust showed that one in five mothers picked up an infection in hospital. This rose to one in three of those whose babies were delivered using forceps and half of those who had caesarean births.

Observer Magazine, 18 October

Family planning

Reaching young people

A study of 1633 family planning clinics carried out by the Family Planning Association found that only half offer special sessions for young people. Opening times could pose additional problems for this group: only half of the clinics are open in the evenings, and 2% at weekends.

The recent Government White Paper set the target of reducing pregnancies among under 16 year olds by half within eight years. This will require a considerable effort: conception rates among young women aged between 15 and 19 rose from 59 to 69 per 1000 during the eighties, and over half of 16 year olds say they have had sexual intercourse. Recently, many clinics have closed and more women have been visiting their GPs for contraceptive services, but this may prove a barrier for some young people. Addressing a conference on new directions in family planning services, the director of the FPA called for GPs to offer a health check to all 16 year olds to introduce them to

available services. The Under-Secretary of State for Health, Tom Sackville, called for action on a number of fronts. He suggested that all districts should have at least two family planning sessions a week dedicated to young people; there should be a single well-publicised phone number; and particular problems for ethnic minorities should be addressed. He also called on GPs and receptionists to give potential users a friendly welcome, saying that there was evidence of teenagers being put off by a 'frosty reception' at surgeries.

Independent, 6 November

Role for pharmacists

A Pharmacy Healthcare scheme leaflet *A guide to male and female condoms* has recently been launched, and should be an important source of information for customers at pharmacies who are embarrassed to ask for advice. This is suggested by the results of a survey of 104 pharmacists and 224 consumers. Seventy-four per cent of condom users said they bought condoms from a pharmacy, and 46% of respondents said they would like more advice from a pharmacist about contraception and safer sex. The most important factor in asking for this advice would be a quiet area in the pharmacy. Of the pharmacists questioned, 60% said they had a quiet area, though in some cases this was a store room or dispensary. For people who would like to get their information from leaflets, it would be important to have them available away from the counter. The same applies to condoms themselves: buying condoms was considered embarrassing by 28% of consumers questioned, and moving displays away from counter tops to self-selection areas could be helpful.

The Pharmaceutical Journal, 31 October, p563

Choosing between clinics and GPs

... family planning

A survey from Portsmouth and South East Hampshire found that different groups of women had various reasons for their choice between family planning clinics and GPs. The former are likely to have women staff and on-site supplies, whereas GPs are perceived as giving personal attention. Clinics tend to be chosen by younger women who are single and childless, whereas older women with children are more likely to go to GPs. A similar survey by Newcastle CHC found that women have positive reasons for choosing family planning clinics. These include women doctors; staff being specialists; availability of a wider range of methods; greater anonymity; the opportunity to attend without an appointment; and evening sessions. Both surveys point to the importance of maintaining family planning clinic provision as a choice for women needing contraceptive services.

Family Planning Today, 3rd Quarter 1992

... and child health

As with family planning provision, there is an increasing emphasis on child health surveillance being carried out by GPs. An article in *Health Visitor* examines the reasons why parents opt for GP or health authority child health clinics. Among those who chose the GP clinic, the main reason given for the choice was the presence of the GP (52%). In contrast, the main reason given for attending a health authority clinic was because it was closest to home (37.8%). Another important reason was the presence of the health visitor (23.7%) or a request by a health visitor (9.6%).

When asked why they attended child health clinics, 93.2% of parents said that it was to have their children weighed. The next most important reason was for a development check at 75.5% (more than one option could be ticked). This confirms other studies which have found that weighing can act as a trigger for attendance at a clinic at which other preventive services can be provided.

Commenting on the methodology, the authors note that they could not assess reasons for non-attendance because of the low numbers of non-attenders who responded. A different approach would be needed to reach this group.

Health Visitor, October 1992

Deadline

There will be no *CHC News* in December. Items for inclusion in the next issue should reach ACHCEW by 6 January 1993.

NEWS FROM ACHCEW

Two new staff members

Nigel Ellis joins as Information and Research Officer, filling the vacancy created by the departure of Clare Collins for the Lord Chancellor's Department. Nigel previously worked at RADAR and will be joining the other two members of the Information, Research and Development Team: **Angeline Burke** and **Ben Griffith.**

Susan Bonici is the new Training and Development Assistant. This is a part-time post, funded by the NHS Management Executive for six months to assist ACHCEW in running a number of training workshops and seminars. Susan spent some time working at Haringey CHC as part of her degree course.

Training workshops

ACHCEW is putting on a series of training workshops for CHC members and staff with the assistance of funding from the NHS Management Executive. Two day-long workshops on Facilitation Skills running in November were oversubscribed, as are five day-long workshops on Media Skills running from December to February. It is hoped that we can run more of these workshops. Sessions are also planned on Chairing Skills and on HIV/AIDS Awareness – details are being sent to CHCs.

AROUND THE CHCs

In the run-up to the introduction of Patient's Charter standards for primary health care services, **Manchester CHCs** and Greater Manchester Radio decided to give local people an opportunity to make their own suggestions for the new local Charter. A radio debate was held in the CHC offices, and broadcast live. The programme attracted a capacity audience, lasted an hour and a half and was a great success. Some of the issues raised included 24-hour GP cover, GPs and their treatment of children, appointment systems, receptionists and what happens when someone is struck off a GP list. A full report will be produced at at later date.

In September, **Chichester CHC** organised an Open Day for voluntary organisations. The aim was to promote greater public awareness of the valuable work carried out by voluntary organisations and to advise on the services they and the CHC offer. It was also an opportunity for all involved to find out more about each other. Over 20 organisations participated – offering advice and giving demonstrations of their work to members of the public. The day was opened by the Mayor of Bognor who spent time talking to those who took part. The CHC considered the day a success and has received favourable comments from those involved.

CHC PUBLICATIONS

Users' views of the chiropody service provided at Shropshire clinics

Shropshire CHC, 11 pages

Shropshire CHC found very high levels of satisfaction among users of chiropody services at clinics. It is encouraging to hear for once of patients who feel they are receiving a personal service and all the information they need, helped by the fact that appointments last long enough for clients to ask questions. Nevertheless some shortcomings and points to watch for the future are identified. The system for the cancellation of appointments and the form of written information both need attention. Access is difficult in some clinics, and it is possible that people living in rural areas are not using the service because they are unable to get to clinics. The service has set up an assessment system in which people are seen relatively quickly for a first appointment. However, 60% then have to wait 8–12 weeks for a second appointment, and a third of patients felt they had to wait too long between appointments. An important aspect of the service is that 42% of patients were self-referred, a fact that many of them valued highly. The CHC hopes to monitor the effect of GP fundholding on this facility

Younger people with a physical disability

Dudley CHC, 9 pages

This consumer audit specifically set out to canvass the views of younger people with a disability (under 65 years old), and not those of carers. Members of the Community Services Working Group found the exercise a useful learning experience for themselves and, among other things, recommend that the CHC should take steps to ensure that this group of people is represented among the CHC membership. Their discussions led to 11 recommendations including, for example, that more work is needed to establish an information service for people with a physical disability, and that such work should be taken forward with the aid of potential clients of such a service.

Some interesting differences emerged between those people contacted through the Crossroads care scheme, and those contacted through the occupational therapy service. Over half of the Crossroads respondents wanted to see at least one person from a statutory agency whom they had not seen in the last six months, whereas this was the case for only 16% of the occupational therapy respondents. Whereas 46% of the former group wanted a visit from the physiotherapist, only 3% of the latter group wanted one. It would seem that regular contact with any statutory agency brings a higher level of satisfaction. It may also suggest that once people are in contact with one statutory agency (other than GP, whom 90% of people had seen) they are more likely to receive the services they need from other agencies.

Despite the enlightened philosophy expressed in the *Joint Strategy for the Development of Service for Younger People with a Disability* and despite the interest expressed by respondents to this audit, the group found that user representation on the Joint Services Development Group is weak in practice. The CHC has offered to facilitate improvements by holding a meeting of those people with a disability who have expressed an interest in planning future services.

If you want to obtain copies of any CHC publications, could you please contact the relevant CHCs direct (see directory for phone numbers) and not ACHCEW.

County Show survey

Kent CHCs, 16 pages

The CHCs in Kent got together to carry out a survey at the County Show, with the joint aims of increasing awareness of the role of CHCs and taking a 'straw poll' of public opinion on health service priorities. Interviews were conducted with 509 attenders at the show. While this did not represent a random sample of the local population, the findings do give a picture of what people think is important and CHC members appreciated the opportunity for making contact with a diverse group of local residents.

The most marked finding was that although just over half of those surveyed had heard about CHCs (this is an improvement on previous figures), an overwhelming 96% felt that there was a need for an independent local watchdog body within the NHS to look after patients' interests. The issues considered important by interviewees were fairly predictable, with waiting lists/times, funding and hospital services coming top of the list for national priority issues. Respondents were also asked about issues of importance locally, and their responses are presented by district of residence. The results show variations between the districts and differences from the national issues. Funding, for example, falls back in importance in this context, with relatively higher priority given to specific elements of service provision.

Hospital discharge survey 1992

East Herts CHC, 30 pages

The CHC surveyed patients discharged from two wards at the QEII Hospital. The report gives detailed results from a questionnaire used by interviewers. Considerable dissatisfaction was expressed (44% of respondents), and the situation appears to have worsened since a survey in 1990. The hospital is already aware of some problems in discharge procedures and has designed a new checklist for use by nursing staff. It is hoped that this will improve communications between staff and patients and, in particular, ensure that staff do not simply assume that carers are available to provide transport and help and that the patient's home situation is satisfactory. The CHC intends to run another survey after the checklist has been piloted for two months.

IN BRIEF

Hearing aid project *Salford CHC, 3 pages*	An information leaflet, for people with hearing problems, on the local NHS system for the provision and maintenance of hearing aids and on aids available from other sources.
Choosing a residential/nursing home *Wakefield CHC, 8 pages*	A booklet to help people in making the correct choice. Consists mainly of checklists of questions to ask.
QEII Hospital A&E Department Survey 1992 *East Herts CHC, 27 pages*	Questionnaire survey of attendants at the department over a week in January. Gives aggregated results, with discussion; a comparison with an earlier survey; and recommendations.
Report of a 24-hour observation visit to the A&E Department, Victoria Hospital, Blackpool *Blackpool, Wyre & Fylde CHC, 27 pages*	An encouraging survey of an efficiently run department which has improved since previous visits. A new triage system is being used to good effect. The main problems concerned security, especially after 9 p.m.

IN BRIEF

Survey of GP views on hospital discharge information in East Hertfordshire

East Herts NHS Trust and East Herts CHC, 23 pages

This useful survey canvassed the views of all GPs in East Hertfordshire on the information they receive from the East Herts Trust when their patients are discharged from hospital. It achieved a 61% response rate, and identified some specific areas where there is room for improvement. There was a higher level of overall satisfaction with the long discharge summary than with the short discharge letter. Problems with the latter included legibility (there was 'an assortment of emphatic remarks about how deplorable the handwriting was'); timing of discharge information; recommendations; referral to district nursing; and (with the lowest rating) whether the patient and/or relatives were aware of the condition. Many GPs had experienced problems with telephone communications if they needed to get further information, because of difficulties with the hospital switchboard and getting hold of the right person. The registered GP, the referring GP and the GP who sees the patient most often are not necessarily the same person. Of the 75 respondents, 55 indicated that they would prefer discharge information to go to the referring GP.

Having your baby at home: a local issue

North West Surrey CHC, 25 pages, £4.41

This is the first in a series of 'local issues' papers which the CHC intends to produce. It is based on focus group discussions held with local women who have sought a home confinement. A presentation of the discussions is rounded off with a six-point 'Charter for choice'. This includes what the authors consider to be the most important of the comments made in the recent Select Committee report on maternity services – that (in the words of this report): 'No woman or her family should be refused care by a GP, or be removed from the ongoing care of that GP, for suggesting a preference for home confinement'.

Maternity survey, Weston Area Health Trust

Weston CHC, 12 pages

A simple questionnaire asked pregnant women about where they intended to give birth, and their reasons for their choice. Of those who were intending to go to the larger unit at Bristol, 68% would have been happy to use the unit at Weston if the necessary medical facilities were available to cope with complications. The authors suggest that epidurals should be available at the smaller unit, and paediatric cover improved.

OFFICIAL PUBLICATIONS

Assessing the effects of health technologies: principles, practice, proposals

Research & Development Division, Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS, phone: 071 210 5556, 28 pages

Too often effective health technologies have been developed, but are used unevenly, depending on arbitrary factors such as which GP one goes to or which country one lives in. Other technologies may be widely used, but ultimately be shown to be ineffective or harmful. This publication seeks to outline what is required if technologies are to be properly assessed and the results of such assessments effectively disseminated.

'Technology' is defined to include inputs as diverse as health promotion, diagnostic techniques and types of syringe. The outcomes to be considered in assessment include health improvements, safety, costs and ethical and social implications. Four chapters cover: outcomes; research designs; using evidence; and fostering proper assessment of technologies. Each chapter is rounded off with a short list of recommendations.

GENERAL PUBLICATIONS

From home to a home

Counsel & Care, Twyman House, 16 Bonny Street, London NW1 9PG, phone: 071 485 1550, fax: 071 267 6877, 35 pages, £5

For many older people, the prospect of moving into a nursing or residential home is greeted with fear. Yet, the level of satisfaction expressed by older people actually living in a home is often quite positive. This interesting report sheds light on some of the reasons for this gap. Three possible reasons are considered: that residents of homes may be afraid to express negative views of their care for fear of reprisals; that residential care, which may be good, suffers from a public relations problem; and that the needs (and therefore hopes) of older people living in their own homes may be different from those of people in residential care (for example because they are less frail). The reality is probably a mixture of all three.

The report is not simply a theoretical exercise, but deals with concrete issues of choice and independence: having one's own room, social activities and control of money, for example. The discrepancies between preferences, expectations and reality are assessed by interviewing three groups of elderly people. One sample was made up of 100 people living in their own homes and attending day care. They were asked about their 'ideal home' should they need to move into residential care. A similar sample was asked about their expectations regarding various features of the life they would lead should they go into residential care. The answers of these two groups are set alongside the expectations and actual experiences of 100 people living in residential or nursing homes.

The preferences of those living in their own homes demonstrate a widespread desire for independence and choice, though they often do not expect their wishes to be met. The reality of what people experience is patchy, but on most points falls behind the hopes of prospective residents. The reality is, however, sometimes an improvement on what people not yet in homes believe will be the case. Once people are living in homes, their expectations change. In some cases this may be because their needs genuinely change, but more often they seem to lower their hopes in line with what they believe will be provided.

The report ends with a list of issues to be addressed. In most cases these are calls for the clear wishes of residents and prospective residents to be met: allowing personal furniture and providing leisure activities for example. In other cases, for example regarding pets and smoking, they call for clear policies in each home so people moving into homes can make a choice. It also discusses ways of extending user consultation, recognising that a variety of approaches is needed at all levels from the individual homes to the Government.

Leaving hospital: elderly people and their discharge to community care

June Neill and Jenny Williams, National Institute for Social Work. A report to the Deapartment of Health published by HMSO, 169 pages, £9.95

This substantial report is based on four surveys offering different perspectives about the discharge from hospital of very old people who require continuing care in the community from the home help service. The research was not intended to be comprehensive: although a wide range of people were surveyed, including a variety of professionals and service users, the sample sizes were small. As a result the report identifies issues and traces possible impacts of packages of services. It does not aim to give a statistical survey of the current situation.

There isn't enough room here to describe all the conclusions, although the recommendations for practice might be useful to CHCs which want to investigate and influence local practice on discharge. The issues raised are clearly important in the context of shortening hospital stays and the introduction of care in the community. The findings, policy implications and recommendations are listed under three headings: Pre-discharge planning and hospital discharge schemes; The discharge process; and Care in the community.

Mental health user groups: a survey of funding arrangements

Good Practices in Mental Health, 380–84 Harrow Road, London W9 2HU, phone: 071 289 2034, 37 pages, £4.95

This is a report on research into the funding situation of London user groups in mental health field. The study aimed to find out which groups were getting how much funding (including help in kind), from what sources and for what purposes. It emerges that groups lack information on a wide range of funding sources. They tend to ask for very modest amounts of funding, and are more likely to be successful when asking for specified items of equipment than for funds to meet running costs. Health authorities provide only a tiny fraction of the funding available and tend to put large demands on groups' resources during any consultation exercise.

The authors comment that, when the work of groups is facilitated by CHCs, the groups experience fewer problems concerning independence than is the case when they deal with statutory bodies or with local Mind groups. The CHCs' input is welcomed by the report, which calls on statutory agencies to provide CHCs with the funds necessary for the continuation of this work.

IN BRIEF

How to involve users and carers: guidelines on involvement in planning, running and monitoring care services

National Schizophrenia Fellowship, 28 Castle St, Kingston Upon Thames, Surrey, KT1 1SS, phone: 081 547 3937, fax: 081 547 3862
14 pages, 1/10/50/100 copies £2/£18/£80/£150 inc p&p

Seven guidelines on: meeting with users and carers; collaboration between service providers; planning services; individual care plans; care managers and key workers; education and training; quality services.

Getting the best from the health service
8 pages
Getting the best from your GP
6 pages
2 leaflets from Women's Health, 52 Featherstone Street, London EC1Y 8RT, phone: 071 251 6580
Send 40p per leaflet and a stamped addressed envelope

These leaflets give details of access; rights; services available; responsibilities; complaints; and a resource list.The GP leaflet has a long section on 'Getting the best from the consultation', and gives helpful advice on preparing for a consultation as well as information on rights. Both leaflets explain relevant recent changes in the NHS.

IN BRIEF

Patient feedback project for practice managers in the Merton, Sutton & Wandsworth FHSA

College of Health, St Margaret's House, 21 Old Ford Road, London E2 9PL, phone: 081 983 1225, 36 pages, £6.50

In this project the College of Health ran a series of training sessions with practice managers to introduce them to the concept and importance of patient feedback and to encourage them to develop their own projects. The report gives a brief description of the seven training sessions, with some of the training materials presented in appendices. Each of the nine projects undertaken by practice managers is described, with the main outcomes where the project has been completed. The scheme has received a very enthusiastic response from the practice managers, who found that it provided them with the opportunity and encouragement to do something which they know is important. The most useful projects were the ones which focused on single issues, such as demand for an asthma clinic, and 'achievable' options, such as a review of the appointment system. In its overall assessment, the College of Health concludes that in the future it would place more emphasis on alternative feedback techniques in addition to questionnaires and would provide advice on the presentation of findings and follow-up of outcomes.

FROM THE VOLUNTARY SECTOR

A new support group has been set up for people who are suffering from the side effects of radiotherapy treatment. Radiotherapy Action Group Exposure (**RAGE National**) is coordinated by a group of women who, while not offering medical advice, are themselves suffering the serious side effects of treatment. Having had to come to terms with new disabilities, pressure on relationships and a sense of isolation, they feel they are in a position to empathise with people in a similar position. The group keeps in touch through newsletters and personal letters. It also intends to campaign for pain relief experts, research and a proper counselling service. For further information, please contact Ms Vicky Parker, 24 Lockett Gardens, Trinity Salford, Lancs M3 6BJ, phone: 061 839 2927.

There are more than 400 self-help and support groups for people with cancer throughout Britain, but even so there is a need for more comprehensive coordination of individual support, particularly in rural areas and for people with a rare form of cancer or needing unusual treatment. To fill this gap, **CancerLink** is setting up a national register of people who are offering one-to-one support. The register will take into account type of cancer, type of treatment and other relevant aspects, such as ethnic background, sexuality, considering oneself terminally ill and having cancer while pregnant.

Cancerlink has produced a booklet: *Giving support one-to-one*. Copies and further information available from: Michael Stuart, Cancerlink, 17 Britannia Street, London WC1X 9JN, phone: 071 833 2451 or 031 228 5557.

BACUP, Autumn 1992

INFORMATION WANTED

Judy Deft, information officer with Lancaster CHC (phone: 0524 847887), would like to hear of any research that has been/is being carried out on the provision of information by health professionals about a patient's treatment and condition, both to the patient and to his/her relatives and friends (Patient's Charter Right 5; National Standard 3).

Merton & Sutton CHC would like to know if any other CHC has experienced problems with obtaining approvals for ECRs to psychotherapy services. The Henderson Hospital in Sutton has only 29 beds but serves a national catchment area. It is a therapeutic community for young adults with personality disorders. People are referred from numerous sources including the probation service. The Henderson has conducted a marvellous marketing exercise and increased its referrals. Problems have occurred with purchasers who have raised every possible barrier to referral, which results in delays of up to six months. The Henderson may have to close next year despite the increased referrals because it cannot keep a full occupancy rate. Any other CHCs' experiences concerning similar services would be welcome.

FORTHCOMING EVENTS

Health services in London: shaping the future

- one-day conference at which speakers will include Sir Bernard Tomlinson and representatives of key London purchasers and providers and GLACHC
- organised by NAHAT and the King's Fund Centre
- on 7 December 1992
- at Kensington Town Hall, London
- £141 NAHAT members/£158.63 non-members

Further info and booking forms asap from:
NAHAT
Birmingham Research Park
Vincent Drive
Birmingham B15 2SQ
021 414 1536

Relationships and vulnerability

- one-day conference for users and providers of services for people with learning difficulties
- organised by One To One (Wandsworth)
- on 8 March 1993
- at Church House Conference Centre, Westminster, London SW1
- £80/£25 unwaged

Further information from:
Steve Morris or Trevor Joslin
170 Garratt Lane
Wandsworth
London SW18 4DA
081 877 9992 or 081 870 7171

Marketing and the NHS: the £32 billion market

- one-day conference at which speakers will include Baroness Cumberlege, the chief executive of Trent RHA and the deputy chairman of British Telecom
- organised by NAHAT
- on 28 January 1993
- at Institution of Civil Engineers, Great George Street, London

Further information as above.

Training day for new CHC members

- training for full members and co-optees
- organised by GLACHC
- on 29 January 1993
- at National Children's Bureau, London EC1
- £55/£45 GLACHC members and associates

Further information and booking forms from:
Daniel Jakob
Greater London Association of CHCs
100 Park Village East
London NW1 3SR

Whose Health?
The individual's or the population's?

- conference to discuss: purchasing for quality; health promotion; care in the community; and the use of annual reports to assess health and health care needs
- organised by the Faculty of Public Health Medicine of the Royal Colleges of Physicians and the Royal College of General Practitioners
- on 10 February 1993
- at the Royal College of Physicians of London
- £85

Further information from:
Corporate Development Unit
RCGP
14 Princes Gate
Hyde Park
London SW7 1PU
Phone: 071 823 9703
Fax: 071 225 3047

DIRECTORY AMENDMENTS

Page ii **East Anglia**

Miss Carol Johnson
Hon Secretary
East Anglian Regional Association of CHCs
c/o East Sussex CHC
Ivry Lodge
Ivry Street
Ipswich
Suffolk IP1 3QW
Tel: 0473 226820

Page iii **South West**

Mrs Linda Stapleton
Secretary
South Western Association of CHCs
c/o North Devon CHC
24 Castle Street
Barnstaple
North Devon EX1 1DR
Tel: 0271 73739 or 78034

Page 2 **South West Durham CHC**

Fax: 0388 608903

Page 11 **Barking, Havering & Brentwood CHC**

Change of address:
The Victoria Centre
Pettits Lane
Romford RM1 4HP
Tel: unchanged

Page 13 **Camberwell CHC**

Fax: 071 277 1805

Page 28 **Salford CHC**

Fax: 061 788 9872

CORRECTION

October 1992, Number 77

Page 7 Column 1
Paragraph 4 should read 'Kensington, Chelsea & Westminster FHSA', *not* 'Parkside FHSA'.