Annual Report 1988/89

Association of CHCs for England & Wales

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THE NHS AFTER THE WHITE PAPER

There has been a striking degree of unanimity amongst organisations responding to the Government's White Paper, "Working for Patients". Almost all have expressed deep concern about its implications or its practicality. CHCs when they met at a Special General Meeting in April 1989 voted by a margin of seven or eight to one to record their general opposition to the White Paper proposals and their view that "Working for Patients" was in fact likely to lead to a worsening in standards of service for patients and less rather than more patient choice.

Nothing is said in the White Paper about the overall level of resourcing of the NHS in the future, even though this was the issue that precipitated the NHS Review in the first place. Yet, even though the Government has increased the money available for the health service, the message from CHCs (see pages 2 to 5 of this report) continues to be, that in many areas at least, there are still insufficient resources to provide the quantity and quality of service expected and needed by users of service.

Waiting lists are still too long. According to recent Department of Health figures the number of people waiting for hospital treatment in England rose by more than 50,000 to 900,000 by September 1988. The number waiting for in-patient treatment rose by nearly 30,000 to 691,000 which is the highest level for four years.

There are serious staff shortages and poor morale in many areas. This leads to operations being cancelled at short notice or patients being discharged earlier than they should be. However, the overall effect of the White Paper proposals are designed to promote cost containment. The effects of the internal markets being proposed will be that the incentive will be on service providers to reduce their costs so as to win contracts, and the incentive on those placing contracts will be only to seek those with the lowest price so as to stay within cash budgets. There will be little or no incentive to promote better quality services, responsive to the needs of those who use them. Certainly, little money will be devoted to service quality if the result is a higher contract cost.

This will work in a variety of ways. One can predict, for example, even greater pressure to discharge patients earlier than at present to improve bed through-put and reduce costs. This is already a problem, but in the future liaison with community services will be more difficult. This is because patients will be expected to travel further from their home areas for treatment to those services with lower costs and, hopefully, shorter waiting lists.

The White Paper fails to address this problem adequately. There are, of course, a number of measures which will undoubtedly be beneficial to service users, but they are peripheral to the general thrust of the White Paper and could be implemented independently of the central proposals in it. Indeed, many of them, such as better information for patients and improved organisation of clinic waiting times, have been repeatedly called for by CHCs over the last fifteen years.

Unless some major counter-vailing pressure is introduced into the system, cost containment is going to prevail over quality of service. It is for that reason that organisations, such as the Institute of Health Services Management, have argued that CHCs need to be strengthened so that they have "a far greater capacity to take an informed view of health service provision in their locality".

This requires amongst other things that it be recognised that CHCs have an essential role in validating the work done by health authorities on the quality of the services they provide and purchase. Without this, it becomes too easy for the process to be management or professional led. Unless user representatives are involved and consulted in the planning and methodology of surveys and in the interpretation of their results, then it is likely that the surveys will simply confirm the intention of those who manage the services. Unless user representatives are involved in visiting facilities and in planning new facilities, it is likely that the patient perspective will not be adequately recognised. Above all, the experience and knowledge of their communities and local services that CHCs bring should be welcomed as invaluable to those with a responsibility for service quality.

All of this means that in the framing of the draft legislation, the Department of Health need to go beyond the very brief reference that there is to CHCs in the White Paper. CHC's existing rights to visit facilities, to receive information and to be consulted on changes to services and on future plans should be confirmed and extended.

In particular, as the boundary between the public and private sector is blurred, CHCs should have a responsibility for monitoring all of the health care provided in their districts. It also needs to be recognised that they should have the right to visit and inspect services provided outside their area, to which NHS patients are sent under contract by their DHA or by local doctors. There must also be a close involvement in the contractual arrangements. The Government clearly envisages that the contract specification will be an important element in seeking to maintain service quality. It will only fulfil this role if CHCs, representing the interests of users, are consulted fully on the content of that specification.

The CHC role will become more complex as the NHS becomes increasingly fragmented. It will be harder to co-ordinate initiatives and take coherent planning decisions, as more and more hospital services and GPs fall outside the DHA/FPC structure. Patient care will be governed by a complicated web of contracts and complaints procedures will need to be revised to take account of this. This will require that CHCs are better resourced to protect the interests of patients.

At present the average CHC has a budget of only £35,000, out of which it is expected to pay its staff (usually two full-timers), rent its offices, service a Council of 18 to 24 members with a range of Committees and Working Parties, monitor the quality of local health services, assess the views of patients, and respond to an increasing flow of consultative and planning documents. You cannot have effective consumer protection and representation on the cheap. If patients' needs are to be paramount, as the White Paper has promised, their interests need to be protected and represented. CHCs have tried to do that job for 15 years with inadequate resources. Now is the time to make sure that they can do that job properly so that the needs of the patients really can be put first.

THE PUBLIC's WORRIES & COMPLAINTS IN 1988/89

Community Health Councils have a statutory duty to monitor the National Health Service and to represent the interests and views of service users in their districts. Many also take on the role of 'patients' friend' in advising and assisting users of local health services both individually and collectively with enquiries and complaints. They are, therefore, in an ideal position to gauge the types of problems users of health services face.

This section of the Annual Report summarises examples of these problems, as reported by CHCs. Mostly people contact CHCs for information and advice, but often also to complain either formally or informally about some aspects of the service they have received or not received. For example, one CHC told us that it recorded 1,827 individual contacts with the public in 1988. 319 of these were complaints, the most common being about hospital services, although a large number were also about General Practitioner services. The remaining contacts were enquiries and requests for information of different kinds, including 78 on cancer services and 27 on mastectomy.

Rather than ask CHCs to give us detailed statistical information about the numbers and kinds of complaints and enquiries they receive, we asked them to illustrate typical problems and issues raised by the communities they represent. We also asked them to indicate who makes each kind of complaint and how frequently they occur in the following four areas: **Family Practitioner Services** (GPS, dentists, opticians etc), **Hospital Services** — including waiting times, staff shortages, transport and discharge arrangements, **Community Health Services** including community care and **Private Residential and Nursing Homes.** The quotations come from the CHCs themselves.

General Practitioners (Family Doctors)

The new draft GP contract circulated by Kenneth Clarke in February 1989 to all GPs, states that there is to be no change in the arrangements or requirements in respect of home visits, despite this being a major cause of dissatisfaction amongst patients.

"A child with abdominal pain and a high temperature was seen by the family GP, he was uncertain of the diagnosis but prescribed for the child and asked the mother to contact him again should the condition change. Over the following 36 hours the child's condition worsened. The mother telephoned the practice out of hours and spoke to another doctor, seeking a home visit, who suggested a warm bath and aspirin. The mother took the child to hospital where appendicitis was diagnosed."

"GPs seem less willing to visit, even when children are ill. One complaint which went to a service committee hearing concerned a GP who refused to visit for 11 days in spite of the mother taking the child to A & E and calling out a deputising service twice. When the doctor eventually called he said it was flu and that the mother was making the child think he was still ill. The child was ill for 4 weeks before the mother took him to the children's hospital where it was eventually diagnosed as a form of rheumatism".

"Refusal of GPs to carry out emergency visits, usually in the early morning hours; often this is not the patients' own doctor but the doctor providing out-of-hours cover."

A very large number of complaints stem from poor communication and professional manners. GPs in particular are criticised for being brusque, unsympathetic and often rude. CHCs welcome the Government's aim of making GPs more responsive to users but fail to see how increasing the size of GPs' lists and, therefore, increasing their workload and decreasing the amount of time they can spend with each patient, will facilitate a more considerate approach and overcome the following types of problem:

"Attitude of GPs towards patients is often brusque, uninformative, dismissive or jocular. FPC does try to have a quiet word with 'persistent offenders' but there is little that can be done, unless people believe they have been put at risk. It is time that GPs were made to realise that their patients are human beings with fears, beliefs and intelligence, and should be treated accordingly."

"Complaints about GPs' manners, vary from straightforward rudeness to downright offensiveness. We try to get the FPC to set up informal hearings.....but the outcome is never really satisfactory because a GPs manner does not form part of his terms of service."

What makes this problem particularly worrying is its frequency — CHCs told us that it is one they deal with every week.

For patients who are unhappy with their doctor, "Working for Patients" promises to make the procedures for changing GPs easier. This would be welcomed if it were the procedures which caused the problems, however CHCs describe far more complicated situations:

"There are difficulties changing GPs within a certain area as GPs do not accept patients from colleagues' practices. This is of course officially denied!"

"Elderly people are removed from GPs' lists and they suspect it is because they are old. It is always difficult for someone elderly, chronically sick or needing drug maintenance to be accepted on to a list. The FPC says they do not have the right to ask a GP why patients are removed from lists but will assist with allocations wherever needed."

"Some GPs are unwilling to take on 'difficult' patients who end up being moved from list to list. Often it seems to be those patients who call the doctor out for home visits."

"Removal of not just the patient but relatives, from a GP's list whenever a complaint is made. In a recent case a neighbour was crossed off a GPs list because she was present at a house, comforting a mother with an ill baby and the mother subsequently complained about the GP. The neighbour's husband was also crossed off and he was not even there!"

Only a small number of dissatisfied patients actually lodge complaints about their GP with the Family Practitioner Committee. CHCs suspect that the reasons for this are firstly that there is very little public information about how to complain, but also that the procedures are not seen to work by patients. For example in 1987 only 1027 formal complaints were lodged by patients and of these only 220 (21%) were upheld. CHCs report that because of the limited nature of the GP contract there is actually very little a patient can formally complain about.

Family Practitioner Committees are also criticised for having a negative attitude towards complaints:

"We have recently experienced the case of an FPC failing to respond to a complainant and giving information only when it was demanded. There should be a simpler, quicker system for resolving patients' complaints."

"The majority of complainants are incensed by the FPC's rigid interpretation of the rules."

Dental Services

1988/89 has seen a substantial increase in the number of enquiries and complaints received by CHCs about dentists. (22% of all complaints about family practitioner services.) Users are anxious and confused by the system and scale of dental charges.

"Utter bewilderment with NHS charges system and dismay at astronomical bill."

"We have been contacted by members of the public who have been dismayed and surprised by the size of their bill for dental treatment. In every case the treatment charge was correct."

"Dental charges are becoming a real problem, the public is becoming more and more anxious and confused. It is clear that many patients are declining treatment once they have been given an indication of the cost."

This situation is made worse because there is no obligation on dentists to discuss their charges with patients before commencing treatment. One CHC told us it encountered this problem 3 or 4 times a week.

"Dentists not giving proper estimates before commencing treatment — £100 for a course of NHS treatment may seem cheap to the dentist but it is a lot of money to the patient."

"A number of dentists are changing to private practice. They neglect to inform the patients, who are told at bill-paying stage, that the onus is on them to make sure they specify NHS treatment at the outset.'

"Often individuals are not given the voucher form (for help with dental costs) until after their checkup and they may pay for treatment before the voucher comes. It is then too late, as Dentists do not have to refund money already paid. (The good ones do — but not all)."

Many CHC are now calling for price lists to be displayed in dental surgeries and an obligation placed on dentists to provide clear explanations and estimates in advance of the treatment.

"Patients are complaining that the onus is put on them to find out from the dentist the likely cost of treatment — many patients find it difficult to ask these things and we feel the initiative should come from the dentists."

Elderly people experience particular problems with bad quality dental work:

"When an elderly person has a total extraction and is fitted with dentures they often experience difficulty and discomfort, due to gum changes after extraction. When they have to make repeated trips to the dentist for easing or adjustment and they have to be continually paying, they complain. The problem would be overcome if dentists spelt out clearly what happens after extraction."

Hospital Staffing

Complaints received by CHCs from members of the public about hospital services show that the level of resourcing and quality of care are almost inextricably linked. The shortage of funding adversely affects quality of care in terms of staffing levels, waiting times and time available for staff to communicate with patients, all resulting in unnecessary distress and pain.

The nurses/midwives pay review has, it seems, done little to arrest the apparent flow of nurses out of the NHS. The acrimony surrounding the re-grading exercise seems to have alienated many nurses and midwives and this has impacted on quality of care.

"Morale in the NHS is very low and is reflected back onto the patients. The re-grading has not helped and much of the dedication and caring has been lost...we can only monitor the situation and hope that staffing will improve."

"There is a serious shortage of trained nurses in wards, seriously ill patients are looked after by untrained staff."

"A number of apparently serious complaints might have been avoided if medical and nursing staff had taken more time to talk to patients and their families at the time, thus avoiding misunderstandings related to likely chances of survival or the actual cause of death."

Maternity care has been highlighted as a particular problem area. There is a nationwide shortage of midwives with vacancies currently running at 17 per cent. In addition, small GP maternity units are being closed despite offering personal care for many women in rural areas.

"The quality of postnatal care on the maternity unit has suffered. Partly due to pressure on midwives, design of the unit, lack of resources and conflicting views of what is required."

"There are considerable staff shortages and mothers perceive the heavy workload and feel guilty about asking for help/advice. The Health Authority has great difficulty in recruiting and retaining all types of staff as the local area is so expensive to live in and NHS pay is not enough!"

"One postnatal ward is shut, but the workload has increased. Women are sent home after a few hours, often prematurely, because the beds are needed. More staff are needed."

Waiting Lists

CHCs tell us that the numbers of people contacting them about long waiting lists has increased steadily over the last year. Nearly a third of CHCs mentioned complaints about either waiting lists, waiting times or the effect on quality of care.

"Long waiting times, lack of information about admissions, last minute cancellations, unco-ordinated discharge, increasing problems due to pressure on beds."

"One person has been given three admission dates — all cancelled at the last minute due to the bed being used for emergency admission."

"Hospitals have had a very large cut in acute beds and operating sessions were also severely cut for six months. This has made the waiting list rise by 67 per cent."

CHCs also highlighted instances of consultants being told to reduce, or stop altogether, certain operations because the money had literally run out:

"The acute unit management instructed the orthopaedic consultants that they were not to do any more knee joint replacements because they had used up the funding for this particular type of operation. So people who had expected to go into hospital in July, as they reached the top of the list were being told it was February."

Central to the whole debate and the concerns expressed over the diminishing availability and standard of care is that of chronic under-funding, an issue that the White Paper "Working for Patients" fails to address. As one CHC states:

"Because of a history of underfunding dating back to the opening of a new hospital five years ago, during the past year and a half, surgical wards have been closed and in order to make the most use of beds, every ward contains mixed specialities....patients were not necessarily nursed by staff who had expertise in their particular problem."

Hospital Discharge

CHCs have described many examples of people discharged too early after surgery only to be re-admitted with complications at a later date. These problems are largely due to the enormous pressure on beds and the fact that more patients are being treated without an increase in resources.

"Patients being discharged into the community without adequate assessment. Back-up services not being immediately available. Patients unfit for discharge, being re-admitted due to complications or worsening of original condition."

"Our DGH continues to discharge at short notice and on Fridays, which is mostly due to pressure on beds and the consequent need to juggle patients and discharge them."

Sometimes it seems like just bad management:

"Discharges often appear to be unco-ordinated and what is planned often does not materialise. We know of people who have slept all night in a chair because the nurse had not come. People are also discharged and have to be re-admitted again very quickly as they were sent home prematurely."

The problems arise most acutely when hospitals discharge elderly people without the levels of back-up services they need. More often than not, the hospitals presume that relatives will care for them until services can be arranged or increasingly, a place in a private nursing/residential home can be found.

CHCs receive many complaints from relatives who often have no choice but to look after an elderly relative at home, despite their other commitments.

"Pressure is put on carers to accept the care of their relative following hospital discharge too early. Carers consider their relative too ill/dependent for them to care for. Better discharge procedures are needed and less pressure on beds."

A number of CHCs noted that although they received many calls on this problem they felt that this was "just the tip of the iceberg."

Hospital Transport

The majority of complaints CHCs receive about hospital transport relate to bad organisation, with people being kept waiting for long periods often unnecessarily.

"The Ambulance Service cannot meet their existing commitments on the non-emergency side. Patients are told to get ready at 8.30 a.m. and not picked up until 11.30 a.m. It makes a hospital visit more distressing than it need be."

And again.....

"Lack of transport causes elderly people great anxiety and makes outpatients a torture."

"Waiting for hours to be taken home, sometimes after distressing treatment."

With the increasing centralisation of hospital services, transport becomes even more essential, especially for people who live in outlying areas.

"The new hospital opened last year about three miles from the DGH site. The local bus company have taken off the mini shuttle which was provided initially and now patients have to use the normal bus routes which can mean a thirty minute journey from city centre to the hospital. Patients living in the townships have to change buses....and this can entail a one and a half hour journey each way."

"People experience considerable difficulty in attending outpatients appointments. We are a rural area, the hospital car service has been reduced and non-emergency ambulances are stretched, buses have been de-regulated."

CHCs report that increasingly, people who need hospital transport are denied it.

"Transport is often refused even though great difficulty is experienced in reaching hospital under their own steam. The CHC would like to see a complete rethink of transport provision for healthcare."

Community Health Services

Since the publication in February 1988 of the Griffiths report into care in the community, it would appear that community care policies and community health services generally have, in many areas, been held in limbo, whilst Health Authorities and Social Services departments wait for the Government's response. At the time of writing this has still not emerged.

In the meantime CHCs have witnessed the increasing pressure on poorly funded services:

"We are well on the way to transition to care in the community. We get all sorts of indications that the 'community' is still not equipped or ready to provide an alternative service. Examples include shortage of speech therapists for special schools and incontinence services for the elderly. The exponential growth of nursing/residential homes means that community nursing resources are seriously stretched."

Community care is in essence about enabling individuals to remain at home wherever possible — the implication is that some of the most vulnerable groups in society should be able to lead independent and dignified lives. The reality as reported by CHCs is often very different:

"Our HA used to provide incontinent people with all the aids they needed. They also provided special schools supplies for pupils but this has now stopped. They have also decided to provide people with only half of their need up to a limited maximum number of pads etc. This is causing financial hardship and problems in trying to obtain supplies of more specialised aids. The CHC thinks this is a grossly unkind cut...incontinence can be the thing which finally causes informal care to break down."

"Lack of funding to provide an adequate number of chiropodists. Also withdrawal of chiropody services where there is no proper chiropody chair available. The CHC has had to advise Unit General Manager as to which charities he might apply to for £1500 to purchase a chair!"

"Bathing for elderly people for social reasons, appears to be a thing of the past. Community Nursing Services are extremely over stretched."

"Night nursing service is inadequate. There is no professional sensitivity with the timing of visits — patients are left in the products of their incontinence for many hours."

One CHC told us that it received complaints at least once a fortnight from relatives and carers about the lack of availability of home helps and district nurses in the last year.

Lack of funding for community services is having a very direct effect on the quality of those services and the quality of life of the people who need them.

"Nobody provides respite care for physically disabled people and their carers either on a planned or crisis basis, other than inappropriate ward placements. Respite care for children with physical disabilities is provided in the same setting as that for mentally handicapped children."

Often it is anxious relatives and carers who turn to the CHC for help. This CHC told us it dealt with this kind of problem at least once a week:

"Carers of elderly relatives often want help and do not know how to go about getting it. In many cases their home situation has recently worsened, triggering the need for help for an elderly carer or alternative support. We try to get people 'into the system' but most services are in very short supply so they may not get all they need."

Private Nursing/Residential Homes

The kinds of problems that CHCs are trying to deal with in this area can only increase as community care rapidly disintegrates into a two-tier system: those who can afford private residential care and those who cannot. CHCs are concerned at the lack of effective regulation and monitoring of standards in both private and Local Authority homes.

"CHC members have begun visiting homes and visited one which smelt horrible and was in chaos. The members have been shocked to discover how difficult it is to close a home or get things changed easily."

Another had:

"Minimum levels of staff and lack of maturity"

Increasingly, families are having to find private residential care for their elderly relatives. This has created many problems.

"The gap in private care funding is a real problem. Families are finding that "Mother's money is running out" and the gap is growing to fifty pounds a week. People are trying to find cheaper accommodation and shared rooms."

This complaint was reiterated time and time again:

"There are nursing homes where the level of benefit does not cover the cost of the services provided. Relatives are having to subsidise the short-fall in fees.

In one case a daughter, who was a pensioner herself was having to make up the shortfall, buying incontinence pads, toiletries and clothes.

CONCLUSIONS

We have sought by means of this 'snapshot' survey to highlight the kinds of problems and worries that users of the health service bring to CHCs. These are frequently resource related: there is simply not enough of a particular service to go around or the quality of service expected by patients and staff cannot be maintained. Sometimes the difficulties can be overcome by better organisation and management and sometimes by greater sensitivity on the part of the providers of services towards those who use them. However, there is no doubt that there is much for CHCs to do in assisting individuals with problems and promoting a better understanding of patients needs within their local NHS. Only by the full involvement of the users' representatives in the planning, organisation and monitoring of services can the quality of services be improved and the patients' interests protected.

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Aylesbury Vale CHC became aware in 1985 of problems facing ethnic minority women seeking health care, because of language barriers. Although an English as a second language scheme was in operation, it was obvious that this did not meet the needs of the district. The CHC lobbied the Health Authority and social services for an interpreter scheme, but to no avail. Working with the local Council for Racial Equality a CHC member, with an interpreter, visited 62 minority ethnic families in their home and discussed with them their perceptions of the medical care they received. The greatest need was for a link worker. The CHC convened a meeting between CHC, CRE, Family Practitioner Committee and DHA. As a result a joint pilot project is being funded by the FPC and DHA to fund a link worker for one year.

Bromley CHC was approached by Bromley Homeopathic Group to help obtain the provision of homeopathic treatment in a Bromley hospital under the NHS. Bromley residents currently have to travel to London or Tunbridge Wells for NHS treatment where the waiting list is over 2 years. The CHC helped the group prepare proposals to the Health Authority, including background evidence of demand and details of what would be required. After a publicity day the CHC received over 2000 letters of support and the HA has now agreed to give consideration to the need and feasibility of providing an NHS homeopathic outpatient clinic in Bromley.

Harrow CHC initiated and organised with the Health Education Department, Family Practitioner Committee and Environmental Health Department a Health Fair to promote preventative health issues. More than 600 members of the public attended and stalls covered dental health, foot care, stress, incontinence, back strains, prevention of accidents, environmental health, exercise, alcohol and nutrition plus information on community services, the FPC and the CHC.

Isle of Anglesey CHC has been actively campaigning for improvements in local voluntary sector services and during the year has seen the establishment of a MIND group on the island and a new Crossroads Care Attendant Scheme.

In 1987 **Leeds Western CHC** agreed to the closure of a geriatric hospital. It was agreed that a research assistant should be employed by the CHC to monitor the closure period of the hospital and the reprovided services, from the patients' point of view. This work enabled the CHC to ensure that patients' moves, both individual and ward based, have been handled sensitively and with the maximum amount possible of self-determination by patients. The reprovided service within hospitals, the community and residential care has also been examined and patients' views obtained.

Winchester & Central Hampshire CHC has been active in the setting up of Winchester Mental Health Action Group, for users (& some staff) of local mental health services. The CHC secretary acted as secretary for the first 12 months and gave office support. This post has now been taken over by a user and a successful bid for joint finance has been made. The views of users are gradually being passed to the Health Authority and the group intends to hold a study day to give users and professionals an opportunity to communicate face to face.

Bolton CHC developed a Mental Handicap Forum of a range of voluntary organisations from all parts of the Borough and are now negotiating with the Health Authority to get it formally recognised, with input into joint planning and resources to service it.

Newcastle CHC is currently involved in a campaign to promote Newcastle as a "Health City by the Year 2000". The CHC, District Health Authority, Local Authority and Community Volunteer Service have formed a city-wide committee also drawing on the business community and academics, and have taken the 38 World Health Organisation targets as goals for the future. The campaign is based on community involvement at a neighbourhood level encouraging collaboration between service users and providers. Recent initiatives include a community conference on healthy cities; a child accident prevention seminar; healthy eating policies in the workplace and anti-smoking strategies. Newcastle intends to put professionals 'on tap' rather than 'on top' for consumers!

Rotherham CHC has spearheaded an Out Patient Services Initiative. The aim is to improve services for patients by collective action with all levels of the service involved: from domestic staff to clinicians. The outpatients service manager now has responsibility for the initiative but patients and the community have an input. The CHC participates in discussions and has recently undertaken a patient satisfaction survey in order to make recommendations for service improvement.

North Birmingham CHC delivered to (almost) every household in the district a leaflet explaining the role and work of the CHC and how it could help local people with problems relating to the Health Service. On the back of the leaflet was a tear off slip which could be returned to the CHC with comments; many were received and all were acknowledged. As a result the CHC was able to help a number of people with specific problems/complaints relating to local health services.

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Authority plans and users' pro- l of valuable and constructive al Report records some of the unfortunately space prohibits amples CHCs sent us.

Rochdale CHC together with interested social workers and occupational therapists set up a series of three workshop- type meetings to facilitate the expression of physically disabl- ed younger people's and their carers' opinions, about all aspects of local health and social service provision.

Last year **Hampstead CHC** embarked upon a project to assess how suitable access to local GP surgeries is for people with physical disabilities. The CHC contacted GPs in the area to see if they would be willing to take part in the survey. A number of GPs completed and returned the sample question- naire but the Local Medical Council expressed opposition to the survey on the grounds that it would be directional to pa- tients and the FPC also declined to give its support. Despite this the CHC went ahead and just over 50% of GPs agreed to co-operate. A questionnaire was drawn up in consulta- tion with a local group representing disabled people in Camden and volunteers went along to look at the width of doorways, presence of steps and availability of car parking, etc.

When the District Health Authority proposed a reduction of family planning clinic sessions from 47 to 20 a month and a reduction of venues from 9 to 4, **Basildon & Thurrock CHC** formally objected and mounted a local campaign. A compromise proposal was accepted by the DHA to retain all 9 venues but cut the number of sessions to 30. A multi- disciplinary committee has been set up to attempt to co- ordinate services provided both by GPs and the DHA.

rmouth & Waveney CHC held a seminar in April 1988 d "What is needed for disabled LIVING in Gt Yarmouth /aveney?" The seminar was planned by disabled people disabled people and was a great success with interesting d inspiring speakers. The Gt Yarmouth Joint Consultative ommittee is beginning to set up a Joint Planning Team for ervices for younger disabled people and a copy of the CHC seminar report was presented to the JCC, DHA, Family Prac- titioner Committee, County Council and District Councils. All discussed it at length and welcomed it. The seminar report contained recommendations for action by the relevant authorities and by disabled people themselves. Local disabled people have also taken seriously the recommendations. An Access Group has been formed in Gt. Yarmouth as well as a Carers and Supporters Group. The main value of this work has been that it enabled a united voice of local disabled peo- ple and groups to be heard loud and clear.

W Surrey & NE Hampshire CHC has been involved in establishing a new Day Centre for people recovering from mental illness. A club already existed in Farnham (Surrey) for the mentally ill in the community but was very over- subscribed. Additionally, about 50% of the users came from NE Hampshire and experienced problems getting free transport. The CHC called a meeting of representatives from Hampshire and Surrey Social Services Department, the Day Centre and the National Schizophrenia Fellowship. It also contacted local GPs and Community Psychiatric Nurses about the need for another such club. These joint discussions led to agreement to set up a day centre in Farnborough (Hants) and a Joint Funding grant application was successfully made, with Hants County Council taking over financial responsibili- ty after five years.

Since August 1989 **Warrington CHC** has issued more than 200 copies of a Guide to Residential and Nursing Homes in Warrington. This was published in response to enquiries from the general public about the availability of private care for elderly people, very little information was available — not even to social work staff or nursing staff at the DGH. The guide has been very well received and seems to have fulfill- ed a need.

Exeter CHC in conjunction with the Family Planning Association and local Women's Centre has worked hard to make access to termination facilities easier and less traumatic. Problems exist with both the GP and hospital ser- vices. However, the Health Authority has now acknowledged the difficulties and is carrying out a review of Obstetrics & Gynaecology and the Family Practitioner Committee has been asked to ensure that GPs are not dismissive or obstruc- tive when asked to perform pregnancy tests before 10 weeks. The issue has been brought into the open and received much media attention. It has also helped to inform women about the facilities that do exist and the role of the CHC in direc- ting them to someone who can help.

Pontefract CHC was able, as a result of representing the views of bereaved relatives after stillbirth, to work in con- junction with management and redraft the District Health Authority's policy on this subject.

In March 1988 Bexley Health Authority consulted **Bexley CHC** on its proposal to join with the Local Authority to pro- vide a joint service for people with learning difficulties. In order to maximise the income, the HA proposed to contract the management of the residential services to a newly formed private non-profit making company. Since the CHC was not satisfied that the rights of the service's users would be safeguarded and since it was unhappy with the management of the company, it formally objected to the proposals. The Authorities have now agreed to the CHC setting up a Con- sumer Forum to advise them on the users' views of the com- pany's performance and the company has agreed to a member of the local Mencap joining the management board.

Leeds East CHC has been active in forming a steering group and making a successful funding application for a citizen ad- vocacy project for people with learning difficulties. The pro- ject received $50,000 and is now up and running. The CHC provided initial financial and administrative assistance to en- sure that potential users of the advocacy project could par- ticipate in designing the proposal.

THE WORK OF ACHCEW 1988/9

The Association has set itself the general objectives of providing information, advisory and support services to member CHCs and of representing the interests of health services users at national level. With the continued support of members CHCs, these objectives have meant a busy year for ACHCEW and its staff.

Membership of the Association

The number of CHCs who are members of the Association has continued to increase slightly. In 1988 there were 185 member CHCs. One has withdrawn from membership for 1989/90, having given one year's notice of its intention to do as required by the Constitution. Two other CHCs have merged, following the merger of it's DHAs. However, these have been more than balanced by seven CHCs which have rejoined the Association. This gives the prospect of 190 CHCs (88.4% of the 215 in England and Wales) being in membership in the current year. The trend over the last few years is as follows:

1985	174
1986	179
1987	181
1988	185
1989	190

The Government's White Paper on the NHS clearly envisages that an increasing number of Health Authorities will merge over the next few years. The White Paper has also raised questions about the future number of CHCs in Wales. These factors could impact on the number of CHCs able to join ACHCEW in the future and, as the bulk of the Association's income comes from subscriptions, on the resources available for the Association's work. Nevertheless, the continued level of support for ACHCEW from CHCs is welcome, particularly at a time when CHCs have many calls on their limited budgets.

Information Service

Member CHCs continue to make considerable use of ACHCEW's Information Service. The number of enquiries runs at the rate of about 100 per month. The service maintains a database of information on reports produced and surveys conducted by CHCs, together with information on other reports and publications whose contents may be of relevance to the work of CHCs. All CHC's are encouraged to forward reports and surveys to ACHCEW and the Association now holds some 1000 of these. This data source is of increasing interest to academics and other organisations. Each year a list of CHC reports and surveys received is produced and distributed to member CHCs and a range of other organisations.

Steps have been taken during the year to increase the number of other reports, books and publications received by the Association and a large number of these are reviewed or summarised in 'Community Health News'. Links are also being formed with a variety of other libraries and information systems, and a wider range of periodicals and journals are now being received in the office.

'Community Health News' has been published ten times during the course of the year. It continues to be produced by Judith Cook with considerable input from the ACHCEW information team. The same mixture continues of news and comment, the occasional feature, plus reports on the major activities of CHCs, publications received and conferences and meetings. During the year there has been some increased emphasis on items of interest culled from journals and on news stories that CHCs may have otherwise missed. The choice of which items to include and which to cover at great length is never easy, and we continue to rely on CHCs letting us know of their activities or drawing our attention to items for inclusion.

Increasingly, other organisations or academics, some from overseas, approach ACHCEW for information about the work of CHCs. The Association always tries to be as helpful as possible with these and has prepared a standard information package on CHCs and ACHCEW.

Health News Briefings

A number of 'Health News Briefings' have been published during the year. These are primarily for the information of member CHCs, but have also been circulated more widely as part of a deliberate exercise in raising the public profile of CHCs and of ACHCEW.

'The State of Non-Conventional Medicine' was published in November 1988. This argued that there is a strong case for the Government to intervene to ensure that non-conventional medicine is properly regulated with adequate safeguards for those receiving alternative treatment. The paper pointed out that interest in so-called alternative/complementary/natural medicine is increasing and that, at present, it is too easy for people to set themselves up as non-conventional therapists. Sound consumer protection is essential, so that the public can have confidence in the ability, competence and integrity of all those calling themselves practitioners. The paper argued that this can only be achieved through properly enforced standards of training, examination and qualification, which should be coupled with properly organised registration and regulation of those practising.

'Benzodiazepines — A suitable case for treatment?' was published in May 1989. This reviewed the use of Benzodiazepines as tranquillisers and as sleeping pills, and pointed out that despite severe warnings about their use in certain circumstances, about their side-effects and about the problems of withdrawal, they are still widely prescribed. The paper proposed a reduction in benzodiazepine prescribing by dealing with the underlying causes of anxiety and depression in a non-medical way. It also argued that better information should be provided to patients and to GPs and suggested ways in which health authorities and FPCs might respond to the problems outlined.

"Consultation and the rights of Community Health Councils" was issued to all Community Health Councils in December 1988. This

paper was prepared by West Birmingham CHC and offers a guide to existing procedures whereby health authorities should consult CHCs on their proposals. It points out that there is a need to consolidate previous formal and informal advice into a revised procedure which takes account of the relevant court rulings. This should emphasise the need for early consultation and the necessity for health authorities to be open and receptive to the views of those they are consulting.

Papers are also due for publication on the health problems associated with homelessness, on the first fifteen years of CHCs, and on quality assurance and quality control. Initial reactions to the NHS White Paper and the Association's detailed response were also circulated as Health News Briefings.

Other publications and publicity material

ACHCEW has produced a new general leaflet, introducing the role and work of CHCs. This followed much discussion by the Publicity Working Party and consultations with a variety of public relations advisers. The leaflet, "CHCs — Working for a Better Health Service", has been distributed to member CHCs and to a wide variety of other organisations. Posters to go with the leaflet are also in preparation.

The general leaflet on 'Patients Rights' jointly produced by ACHCEW and the National Consumer Council, has been updated and reprinted for circulation to CHCs. This summarises the rights and responsibilities of users of the NHS. Thanks to a specific grant from the Department of Health, the leaflet is being made available in Urdu, Bengali, Punjabi, Gujerati, Hindi, Cantonese, Vietnamese, Turkish and Greek. Arrangements to reprint a Welsh version of the leaflet are in hand, by cooperation between the Welsh Consumer Council and the Association of Welsh CHCs.

During the year, a paper was circulated to CHCs highlighting a number of successful publicity initiatives taken by CHCs and investigations are taking place to identify other support that might be given to CHCs in promoting their work and activities.

ACHCEW has also reviewed its "Directory of Community Health Councils" and this is now being updated on a regular basis.

Conferences

A special seminar was organised by ACHCEW in October 1988 to discuss NHS complaints procedures. The purpose of this was to identify the problems associated with the existing procedures and to suggest how a better system might operate. CHCs have long been concerned about the NHS complaints system and whether patients can have confidence that their grievances — both minor and major — will be dealt with in a professional, equitable, just and sympathetic manner. The conference looked at professional accountability, through the service committee procedures and via the General Medical Council, at hospital complaints, at complaints as a quality control measure, and at the role of the professional advice worker. A full report of the conference has been prepared and is due for publication in June 1989.

A Special General Meeting of the Association was also held in April 1989 to consider the Government's White Paper on the future of the National Health Service. This was attended by more than 250 representatives of 131 CHCs.

Responses to consultation documents and representations on behalf of CHCs.

A significant amount of staff time is devoted to considering consultation documents, issued by the Department of Health, other Government Departments, or other external agencies, and , where appropriate, submitting responses in line with the Association's policy. Mention has already been made of the NHS White Paper, but other consultations to which ACHCEW has responded over the last year have included:

- The development of services for people with physical and sensory disabilities (DoH)
- Alcohol misuse (DoH)
- Consent to Treatment (DoH)
- General dental services (DoH)
- General ophthalmic services (DoH)
- Original pack dispensing (DoH)
- Welfare of children in hospital (DoH)
- Revision of service committee and tribunal procedures (DoH)
- The informal complaints procedure (General Medical Council)
- The Health Education Authority Programme (HEA)
- Decision making and incapacity (Law Society)

Individual CHCs have also asked ACHCEW to make representations on their behalf or in respect of issues which concern them on a wide range of issues. Most such matters have been considered by the Standing Committee and pursued with the DoH or other bodies as appropriate. A particular theme, during the year, has been the operation of consultation procedures and these are now understood to be under review, following the publication of the NHS White Paper. Vigilance will be needed to ensure that CHCs' rights are not diluted as part of this process, but are instead enhanced to deal with the more complex structures and contractual processes envisaged in the White Paper.

If CHCs are to represent local users of services effectively they must remain as locally based as practical. ACHCEW has fully supported the Association of Welsh CHCs in its bid to resist the Welsh Office proposal to reduce the number of CHCs in Wales from 22 to 9 and has made representations accordingly.

External relations

A number of measures have been taken over the last year to increase the public profile of CHCs and of the Association. Regular contact is maintained with the specialist press, with health cor-

respondents on the national newspapers and with relevant programmes on radio and television. A range of news releases have been issued over the year both highlighting ACHCEW publications and activities and in response to Government announcements and other events. This has led to substantial coverage for the Association and its publications. There have also been an increasing number of requests for comment on other current health concerns.

Good links are maintained with other consumer bodies. During the year there have been discussions with officers of Health Council Associations in Scotland, Wales and Northern Ireland. There are frequent contacts with the National Consumer Council, the Consumers' Association, the Patients' Association and the College of Health. ACHCEW participated fully in the 1989 National Consumer Congress and is also taking part in the newly-established Patients' Forum. A number of joint projects have also taken place involving the Association and the NCC. Contact also continues with Health Rights, Hospital Alert, Action for Victims of Medical Accidents and a variety of other organisations.

There are good working relationships and regular meetings with the National Association of Health Authorities, the Institute of Health Services Management, the Society of Family Practitioner Committees, and the National Council for Voluntary Organisations. ACHCEW continues to participate in the Community Care Consortium and is also associated with the group, Community Care Now. There have also been a number of contacts and discussions with the Association of Directors of Social Services, the General Medical Services Committee, the British Medical Association, the British Dental Association, the Pharmaceutical Society, the Pharmaceutical Services Negotiating Committee and many other organisations. Finally, particular reference should be made to the close working links maintained at staff level with the Health Education Authority, with the National Community Health Resource, and with the various parts of the King's Fund.

Finally, there is a cordial and constructive relationship with officials from the Department of Health. There is regular contact between the Association and the policy division of the Department with responsibility for CHCs and there are increasing links with other parts of the Department. The Department has renewed the Association's grant for 1989/90 at the £50,000 level. This has remained unchanged for three years with no uplift for inflation and discussions have now begun on the level of funding to take effect from 1990 onwards.

Parliamentary Contacts

Initiatives have been taken to increase the Association's contacts with Members of Parliament. Accordingly, a considerable number of MPs from all political parties have been contacted regarding ACHCEW publications and regular briefings are being provided as appropriate to MPs on current health issues. Meetings have also taken place with individual MPs at their request.

Standing Committee and Working Groups

Since the AGM in 1988, the Standing Committee has met on four occasions. Meetings have focussed on current issues affecting the NHS, ACHCEW initiatives and publications, and on policy concerns raised by member CHCS.

The Honorary Officers of the Association have also met on a regular basis throughout the year but in addition have always been available to provide direction, support and advice. Individually their work has been substantial and has been much appreciated by the staff.

The Officers, together with members of the Standing Committee, have also represented the Association at a variety of meetings and conferences. This has been important in ensuring that the work of CHCs attains a high profile and has also meant that the views of users of services have become more widely recognised and understood.

The Director has also had a substantial degree of contact with regional groupings of CHCs. This has helped make sure that ACHCEW is better informed about the views of member CHCs but has also provided an opportunity for the Association to report back on its activities. Another major channel for this two-way flow of communication has been the individual members of the Standing Committee, who are appointed as regional representatives to enable this to happen more effectively.

A number of Committees and Working Groups, appointed by the Standing Committee, are in existence at any one time. Thus each year the Arrangements Committee plans the forthcoming Annual General Meeting/Conference. In 1988/89 it had a double load in that it also had responsibility for ensuring that the Special General Meeting on the NHS White Paper ran smoothly.

The 1987 ACHCEW AGM established a Panel of Inquiry to review the existing arrangements for the establishment and resourcing of CHCs and to investigate alternative structures. Having sought evidence from member CHCs and in the light of developments associated with the NHS review, the Panel's report, "Effective CHCs for the 1990s" is being put before the 1989 AGM.

The Working Party on CHCs and Black and Minority Ethnic People has produced two papers during the course of the year. The first of these was, "Appointment of CHC Members: increasing the number of Black and Minority Ethnic people appointed." and the second was "Networking with Black and Minority Ethnic Groups: Confirming the CHC's representative role." These dealt with ways of achieving a broader representation on CHCs and of building links with local groups within the black and minority ethnic communities.

The Complaints Working Party was responsible for getting the one day seminar on the NHS complaints procedures off the ground and is now considering ways of taking forward the issues raised at the seminar.

The Publicity Working Party has also met on a number of occasions and agreed the form of the publicity initiatives taken during the year.

Staffing arrangements

Ken Howse left the Association's staff having spent three years as ACHCEW's Research/Information Officer in August 1988. He has been replaced by Belinda Gumburd and Leigh Bryan has also joined the staff as Secretary/PA to the Director.

CHAIRMAN'S MESSAGE

Dear Colleagues,

My three years as your Chairman have gone by so quickly, but so much has happened during that time. I believe that CHCs are now working together better than ever before. What is more, there is a feeling of confidence within ACHCEW about our ability to act collectively as an Association.

If there has been a theme to my time as Chairman, then this has been it. The important lesson for all CHCs is that by working together and pooling our knowledge and resources we can benefit the users of the NHS in the communities we represent. I believe that there are now very few CHCs which still work in isolation. These few are not using all the channels available to them to represent their communities.

ACHCEW must continue to be a grass roots led organisation and this, of course, means work for member CHCs. However, being part of ACHCEW also saves duplication of work and reinventing the wheel, if CHCs make use of the ACHCEW information base and the knowledge and experience of the Association's staff. It has been necessary for the national office to seek information and views from individual CHCs. However, it is only by doing this on a regular basis that ACHCEW can speak and be seen to speak authoritatively on behalf of CHCs and the users of the NHS.

Work on publications, such as "Patients' Charter" and the "Public and the NHS", has been achieved by CHCs working together. It is the joint experience of CHCs that not only informs but gives authority to the views put in other ACHCEW publications. Your continued support for this process is most welcome.

This year the work of the Association has been dominated by our concerns for the future of the National Health Service, by the long wait for the Government's White Paper, and by lack of consultation on its main themes when the proposals finally emerged. This culminated in the Special General Meeting of the Association held on 10 April 1989 at the request of member CHCs. The overwhelming concern expressed then by CHCs, together with the detailed response prepared, meant that the Association was able to say clearly why the Government's proposals will not as a whole benefit patients and the users of the NHS.

What of the future? User representation within the NHS will become even more important and essential if the interests of users are to be protected. We must continue to press at all levels for CHCs to be involved fully in consultation. We must press for more training for CHC staff and members. We need more publicity to inform users of our existence and the work we do. We must continue to be ready to do more networking in our communities to ensure that we fully represent all users of the NHS. We must be prepared to be accountable for what we do on their behalf. Above all, we must have the resources to do it. There will be many challenges ahead, if all we do is to strive to achieve the seventeen points in our Patients' Charter.

We must continue to strive for a service free for all at the time of need. Our NHS is what all countries should have. It needs improving. It could be more efficient and compassionate and it would be if professionals, managers and Ministers listened more to the people who use the service.

I shall miss being your Chairman and in twelve months time will be forced to take a break from CHCs for the first time since 1976. Over that time being a CHC member has taken up many hours of my time, but the health of the nation and of every individual has to me always been a priority.

My thanks go to you the members for your support. I also wish to thank members of the ACHCEW Standing Committee over the last three years for their help and assistance. In particular, I want to thank my Vice-Chairman, Hwyel Wyn Jones, and my Treasurer, Ross Thomson, for being such towers of strength and for being there when needed. I am also very grateful to our Director, Toby Harris, with whom I have enjoyed working, to Chye Choo, the longest serving member of the ACHCEW staff, and to the rest of the staff team, who really are a team always ready to respond to the needs of member CHCs.

To you all, keep up the good work.

With best wishes,

Wyn Pockett, Chairman.

Association of Community Health Councils for England & Wales 1988/89

Chairman: Mrs Wyn Pockett (Hounslow & Spelthorne CHC: North West Thames Region)

Vice Chairman: Cllr. Hywel Wyn Jones (Ceredigion CHC: Wales)

Honorary Treasurer: Mr. W.R. Thomson (Stockport CHC: North West Region)

Members of the Standing Committee

Cllr. Mrs. M. Hall (Northern Region)
Mr. Gordon Mullis (Yorkshire Region)
Cllr. E. E. Jones (Trent Region)
Mr. H. Place (East Anglia Region)
Mr. George Wenham (North West Thames Region)
Ms. Doreen Scott (North East Thames Region)
Mr. S. R. J. Terry (South East Thames Region)
Rita Lewis (South West Thames Region)
Miss Heather Humby (Wessex Region)
Mr. Frank Harris (Oxford Region)
Mrs. K. Summerell (South West Region)
Mr. D. T. Hopkins (West Midlands Region)
Mr. H. Cunningham (Mersey Region)
Mr. H. Foden (North West Region)
Mr. Cliff Fenton (Wales)

Secretary Observers

Mrs. Judy Thomas	Northern, Yorkshire. Mersey, North West Regions
Mr. Dag Saunders	Trent, East Anglia Oxford, West Midlands Regions
Mr. Graham Girvan	North West, North East, South East, South West Thames Regions
Ann Covell	Wessex, South West Regions
Danny Davies	Wales
DHSS Observer	Mr. Philip Chinque
Society of CHC Secretaries Observer	Mrs. Joy Gunter

Staff

Toby Harris — Director
Chye Choo — Chief Administrative Officer
Hazel Fisher — Information Officer (Health Promotion)
Belinda Gumburd — Research/Information Officer
Suzanne Tyler — Development Officer
Leigh Bryan — Secretary/PA to the Director
Pippin Markandya — Secretary (p/t)
Rose Walter — Clerical Assistant (p/t)
Judith Cook — Newsletter Editor (p/t)

- There are 215 **Community Health Councils**(CHCs) in England and Wales. Their job is to keep under review the operation of the Health Service in their districts and to recommend improvements. They have to be consulted on any substantial development or variation in service.

  CHCs were set up in 1974, in response to evidence that NHS care was not sufficiently patient centred and to make a clear distinction between the management and public representation functions of the NHS. CHCs were given the role of representing the interests of patients and the community to managers of the health service.

  The budgets and staffing of CHCs is determined by Regional Health Authorities (by the Welsh Office in Wales) and there are variations in the levels of both throughout England and Wales.

  CHCs have been responsible for starting the process of opening up the NHS to the public and have kept the needs of vulnerable NHS users in the forefront of debates about resource allocation.

- The **Association of Community Health Councils for England and Wales** (ACHCEW) was set up in 1977 to provide a forum for member Community Health Councils, to provide information and advisory services to CHCs and to represent the user of health services at a national level. CHCs are not obliged to be members of ACHCEW but most are.

  CHCs pay an annual subscription to ACHCEW based on their own annual budget. Additional grants from the Department of Health, Health Education Authority and other bodies supplement ACHCEW's income.