Annual Report

Association of CHCs for England & Wales

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The State of the NHS

During the last year, the **resourcing problems** of the NHS that had been simmering steadily for a number of years finally boiled over. In the latter part of 1987 the vast majority of health authorities reported that they were facing budget deficits in the financial year 1987/8 and crisis measures would have to be taken to reduce costs. Those crisis measures led to service developments being postponed and entire units or hospital wards being closed or shut down at weekends. Other patient services, such as chiropody, community dental services and family planning clinics, were reduced. Non-urgent operations were postponed, staff appointments delayed and over-time banned.

The financial prospects for the current year are not much better. Notwithstanding the welcome increase in nurses' pay, the allocation for the financial year 1988/9 may only just cover inflation let alone the extra money required for AIDS patients, to reduce waiting lists, and other priorities. Nothing is available to deal with the underlying problem of shortage of cash.

CHCs report that the underfunding by the Government of pay awards and inflation have, over the year, taken their toll. Even though volume expenditure (after adjusting cash spending for the increase in price of goods and services used by the NHS) rose by 4.8% over the last seven years, this is a long way short of the 2% per annum growth, recognised by such diverse bodies as the British Medical Association, the National Association of Health Authorities, the Royal College of Nursing and the Institute of Health Service Management as being necessary to cope with demographic pressures and technological advances. The cumulative shortfall amounts to between £1.9 billion and £3.2 billion, depending on whether so-called "efficiency savings" are taken into account.

The Government's response to this has been to establish a Ministerial level review of the NHS and its finances. The report is awaited with interest and concern, as a wide range of alternative systems of funding the NHS are reportedly being considered.

As far as ACHCEW is concerned the debate about insurance schemes, vouchers, hotel charges or internal markets is largely irrelevant. Indeed, the debate has merely served to put up a smokescreen to obscure the real questions about the level of resources needed to run the NHS. The simple lesson is that you cannot go on year after year under-resourcing a service and at the same time expect to get more out of it.

Major radical reforms in the NHS are likely to be extremely disruptive and the last thing the NHS needs after being reorganised every few years for the last couple of decades is yet another sequence of major changes. Moreover, many of the alternatives posed would have other disadvantages. They would create an increasingly two-tier service with treatment available on the basis of ability to pay rather than need.

One of the biggest issues over the last year has been the implementation of care in the community policies. Much of the year was, of course, spent waiting for the publication of the report from Sir Roy Griffiths. In the event, this was made available in the most low-key fashion possible the day after the budget and the implied message was that the Government was less than keen on his key recommendations.

The Government cannot of course just forget about the issues. Back in December 1986, the Audit Commission pointed out that "the option that is not tenable is to do nothing. The result will be a continued waste of scarce resources and worse still, care and support that is either lacking entirely, or inappropriate to the needs of some of the most disadvantaged members of society." That was a year and a half ago and the problems are getting worse all the time.

The Government's proposals on primary care finally emerged in November 1987 — again after a long gestation period. It is still too early to see what effect the proposals will have, as the only major ones to be implemented to date relate to the increases in dental charges and the introduction of charges for optical tests. These were greeted with widespread dismay by CHCs, as there is already evidence that the charges act as a disincentive for many people in seeking treatment.

All in all the year has not been an easy one for the National Health Service and those who use it. Nor are we likely to be reassured if we turn our attention from organisational and funding issues to the basic state of the nation's health. There are still major inequalities in health status: for example, men in social class 5 have a mortality rate twice that of men in social class 1 for the age group 15-64. The risk of lung cancer is more than twice as great for manual workers as for non-manual workers. Heart disease and cerebro-vascular disease are respectively 40% and 65% more common in the manual categories. The evidence is that these inequalities have actually widened since the 1970s.

There are also major health inequalities for people from black and minority ethnic communities. For example, the maternal death rate per live birth is nearly two-thirds higher for women born in the new Commonwealth and Pakistan than for other women.

At the same time there is increasing concern about the general health of the population compared with overseas. On a European league table, England and Wales has the third highest mortality rate for circulatory diseases, heart disease and cancer. A third of the population still smokes, leading to 100,000 early deaths a year. Alcohol consumption and associated problems are on a rising trend.

The Charter of the World Health Organisation declares: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." The UK clearly still has some way to go and there is a major task for CHCs in ensuring that such issues are addressed. ACHCEW's "Patients Charter" is very relevant to this process and the statement of rights which it contains remains an agenda for future work and development.

The public's worries and complaints: what CHCs have heard in 87/88

CHCs represent the interests and views of the users of the health service in their districts. It is the purpose of this section of the annual report to summarise some of the concerns, queries and complaints that CHCs hear from the users of the NHS, either individually or collectively. We do not intend by this to suggest that CHCs spend all their time channelling public grievances to the relevant authorities. It is nevertheless important to know what kinds of problem arise and where. We therefore asked our member CHCs to give details of problems raised by users over the last year. These might be formal complaints or simply queries arising out of a need for information.

Generally speaking, most of CHCs' contacts with the public are dealt with by passing on information, rather than by 'taking up' a complaint. For example, one Northern CHC recorded 2,039 contacts with the public in 1987. 306 of these were complaints, the most common problem being the ambulance service. A further 269 were continuing complaints from the previous year. The rest (1,464) were requests for information of various sorts. Even these, though, can be very revealing. Over 10% of this CHC's enquiries concerned alternative medicine.

Our own questionnaire was a simple one and it was not our intention to elicit the kind of information that would enable us to make a methodologically sound estimate of the relative frequency of the various problems experienced by users. Rather we were seeking illustrations and examples from which we could put together a 'snapshot' view of issues raised, not just by the CHCs themselves, but by the communities whose interests the CHCs represent. The quotations come from the CHCs themselves.

Waiting lists

Just over one-fifth of CHCs responding to the questionnaire mentioned the handling of enquiries and complaints from the public on the length of waiting lists as a prominent concern. There is, of course, no formal procedure for complaining about the waiting time for hospital treatment. People may just wish to register their dissatisfaction. More typically, they want to know if an operation can be done more quickly elsewhere.

> *"Waiting lists are a continual problem ... it is difficult to reassure someone who is waiting for a long period, knowing that very little can be done. The normal advice is always given — return to GP, contact hospital, seek other districts with shorter waiting times. But how can someone be convinced that the NHS is working if he has to wait for one year or more?"*

And again ...

> *"Queries about waiting lists ... GPs should have more information about waiting lists in the DHA and surrounding areas ... More information should be made available about individual consultant's lists, so that we can advise patients better."*

In all these cases, the number of queries and complaints had increased over the previous year. Although such enquiries cut across all specialities, that most frequently mentioned by CHCs is orthopaedics — in particular, hip replacements.

Community Health Services

It is the view of some CHCs that community health services have been under more pressure over the last year or so than the acute sector. Indeed it is clear to most of them that the more the acute sector overspends, the more the community budget is "raided" to make good the shortfall. It would seem furthermore that problems over the levels of community health services are much more likely to be brought to the CHC by individuals or groups of users than problems over the levels of acute hospital services.

Problems arising out of the earlier discharge of elderly people from acute care are a clear illustration of the connection between the two sectors of care. To a certain extent this is a question of organisation and timing.

> *"Precipitate discharge arrangements with insufficient allowance given for home circumstances. Ambulance leaving patient alone in cold house, with little or no food immediately available."*
>
> *"The CHC has received a number of complaints about inadequate arrangements for discharge of elderly people into the community ... The CHC has asked the Health Authority for sight of its hospital discharge procedure for the elderly, but has not yet been successful."*
>
> *"We would like all support services to be geared up ready to spring into action on the day of discharge."*

Sometimes though, improved organisation without more resources is just not enough.

> *"The Health Authority has improved its procedures, but it is difficult to design a fool-proof system. Social Services do not have sufficient resources."*
>
> *"Although efforts are made to provide community services once a patient has returned home, Social Service Departments are so stretched that this care, if given, is of a limited nature."*

The most frequently mentioned issue in the community health services was chiropody, in particular, waiting times for treatment. As with waiting lists for in-patient treatment, the problem is brought to the CHC's attention by people who are not receiving the sort of service they expect, in this case, the elderly or their relatives.

> *"The waiting time for chiropody appointments in this district is a scandal — except for very urgent cases referred by a GP."*
>
> *"Two year waiting list for non-urgent chiropody."*
>
> *"There is a desperate shortage of chiropodists and there are long waiting lists for treatment. Only patients in certain priority categories will receive domiciliary visits ... The quality of life of an elderly person is largely dependent upon maintaining their mobility."*

Booking systems can cause problems.

> *"Difficulty in making appointments with introduction of*

a centralised 'phone booking system — can't make date of next visit at time of treatment; 'phone lines always engaged."

One CHC told us that it had received 24 complaints about chiropody in the last twelve months.

All kinds of community health services have presented the users with problems.

"Closure of a family planning clinic has resulted in a lot of public reaction in support of services ... "

"The CHC has campaigned for a local (modest) well women service with a broad medical/social application and has considerable support. Our plans have been rejected by the DHA because of lack of money. We still have frequent requests for information about local well women services and complaints about the lack of them."

Sometimes the issues are brought to the CHC, not by individuals, but by groups. This might happen when a service for children with special needs is withdrawn or reduced.

"The problem is the level of physiotherapy provision in the district. Parents of children with special needs formed a committee and are gathering detailed information — trying to establish the gap between what is provided and what is needed ... The CHC is represented on the committee and will be advising them every step of the way."

Perhaps in cases such as these, where the need is clearly defined and circumscribed, the CHC is more likely to achieve a success than with the problems of the acute sector.

"The main speech therapy clinic had to close its waiting list to clear the backlog because of lack of staff. Difficulty was recruitment. Letters were received from very anxious mothers and CHC was unable to offer much hope. However pressure on DHA produced two part-time posts, which were eventually filled."

Sometimes, however, even a unit that is supposed to be "fully staffed" falls short.

"The local service is failing to see children quickly and also failing (recently) to provide any outpatient service for stroke victims. One complaint was about the cost of arranging private speech therapy sessions — could this money be recovered?"

Community care

This is a major source of difficulties for CHCs. Sometimes they are raised by individual users of the service; at least as often it seems to be groups of parents or relatives that band together to have their concerns heard. The problems dealt with by CHCs tend to fall into two categories: the lack of support services for priority groups in the community; and inadequate consultation and planning for the transition from hospital-based care to community care.

Often the lack of support services is seen as mainly an organisational problem.

"For over two years this CHC has been involved in trying to get a Crossroad Attendant Scheme established — so far with no success. The need for this carer support has been acknowledged — at least by the health authority. Social Services however will not cooperate, although they cannot provide the service themselves. Social Services appear to resent any 'interference' in what they consider to be their area of responsibility."

"Lack of respite care for those in need of nursing care, particularly children ... NHS, Social Services Department, & Crossroads all shift responsibility from one to another."

"Specific issues dealt with recently include: involvement of parents of severely handicapped children in proposals to change respite/rota care services; and the question of how consultants talk to patients and relatives etc."

The problem however is not always amenable to an organisational solution.

"Lack of formal support for informal carers. At present only two respite care beds for physically handicapped — and a further two beds for mentally handicapped children."

Domiciliary services of all kinds needs to be improved.

"Problem arises from the withdrawal of incontinence supplies to some users in the community; and administrative problems with the assessment procedures to establish need. Service was changed before assessment was carried out; also lack of information to the users which led to confusion and distress as a result of 'rumours' being circulated. New supplies turned out to be unsuitable in some cases. Shortage of district nurses meant delays in assessment procedures. Overall impression — lack of planning/foresight."

"A particular issue raised has been the lack of services available to stroke patients, including speech therapy and O.T."

"Gaps in the community mental health service leaving carers trying to cope but not knowing where to turn while G.P. and consultant etc. say it's not their responsibility. Community psychiatric nurses offer some support but become caught up in the buck passing."

"I am becoming increasingly aware of mentally ill pa-

We asked CHCs who are members of ACHCEW to give us up to 6 examples of problems commonly brought to them by members of the public in 1987. 97 CHCs responded and we received 353 completed questionnaires.

Community Health Services	**137**
Hospital and Related Services	**107**
Family Practitioner Services	**78**
Miscellaneous Issues	**31**
Resources for Community Services	**78**
inc. support for priority groups ...	**44**
chiropody ...	**16**
Resources in the Acute Sector	**31**
inc. waiting lists ...	**21**
Quality of hospital care	**55**
Quality of GP care	**32**
Organisation and planning of community care	**25**
Hospital transport	**21**
Dental Services	**21**
Discharge arrangements	**13**
GP lists	**15**
FPC Service Committee Procedures	**10**

The remaining issues included amongst others: requests for information on alternative medicine and health education, access to abortion, medical accidents, child abuse and hospital security.

tients transferred from hospital accommodation without the necessary back up and care — particularly from social workers."

"Worried relatives no longer able to support elderly person and statutory services struggling to cover."

In the case of care in the community, it is common for CHCs to take the initiative as well as reacting to users.

"We are trying to establish and maintain links with organised groups, e.g. mentally handicapped and mentally ill, to find out where areas of difficulty exist — particularly on the local authority side. Ongoing problem not easily resolved with present pressures facing both Health Authority and Local Authority."

Sometimes, particularly in the case of relatives who are looking after someone at home, a crucial problem is the lack of information.

"We have organised a number of public meetings with the Council for Voluntary Service for informal carers, as we have become increasingly aware of the lack of information and facilities — where to obtain sitting services, help with laundry, respite care ... We have placed pressure on the health authority to produce information leaflets."

The CHC may act because users' views are not being adequately represented.

"Community care for elderly people and mentally handicapped people was being planned and put into practice with no 'non-officer' monitoring. At the CHC's insistence, such schemes now have monitoring arrangements 'built-in' — with CHC representation, especially for the mentally handicapped."

"The DHA wanted to close a 50-bed Mental Illness hospital as part of its general strategy, which covers next ten years. We insisted on separate consultation, which was at first refused. We referred the matter to the Welsh Office and whilst waiting for a response the DHA did a re-think and acquiesced."

Private residential care & nursing homes

This issue is, of course, closely connected to that of care in the community and many CHCs are having to deal more frequently than before with queries and problems concerning non-NHS residential care, particularly for the elderly.

"The health authority only concerns itself with the level of nursing care and the provision of basic amenities; GPs are responsible only for the patient's medical care; but there is no-one to complain to about a patient's general well-being. A patient has to rely on a visiting relative if he/she is too frail to complain on his/her own behalf. CHC has received many complaints regarding the standard of care in nursing homes and considers urgent action necessary."

The importance of the CHC's unofficial role in respect of nursing homes is illustrated by the following case.

"A woman was denied visits by her common-law husband in a Southport nursing home ... Her assets and possessions were taken by her daughter of a former marriage through a Court of Protection order and her house and car were sold without her knowledge ... Sefton Social Services Department, the Citizens' Advice Bureau and three firms of solicitors all gave up or said they couldn't help."

In the end, it was the CHC secretary who 'took up the cudgels' on the woman's behalf and sorted out the problem.

As well as this, there is a need for information on the choice of care.

"Relatives with very little background knowledge or information ... often turn to us in despair as a final resort."

Hospital transport

One-fifth of CHCs reported problems with hospital transport. Organisational failings are often at the bottom of this.

"Recurring problem unfortunately — wrong collection times, wrong delivery times sometimes resulting in loss of consultation. Usually the reason given is 'computer error', although fault has been admitted on at least one occasion."

"Teething problems following a major reorganisation. Patients arrive too early for appointments or left to wait for long periods (e.g. 2hrs) after appointment."

"Service inefficiently managed. Elderly people waiting over an hour for an ambulance to arrive, spending sometimes 90 minutes in the ambulance both ways, arriving late for treatment."

It would be surprising if the disappearance of a service did not give rise to complaints.

"Abolition of free ambulance car service as cost saving. Replaced by fee paying voluntary care service."

"Health authority stopped all transport to outpatient clinics except to some priority groups."

Resources are also likely to be behind this kind of complaint.

"A patient was referred to the Accident & Emergency Department of the District General Hospital and ambulance transport was provided at the request of the GP. The patient had suspected fractured ribs, which was subsequently confirmed at the hospital, but return ambulance transport was refused by the doctor, leaving the patient to walk one mile to the bus station in the rain."

Sometimes, though, it may be just the insensitivity of official procedures that is at issue.

"A 74 year old man, terminally ill, required an ambulance for transport to hospital. His wife was told that she could not travel with him as escorts would take up space. She was expected to arrange transport for herself."

Professional manners and attitudes

Two-fifths of CHCs reported issues relating to the attitudes and manners of professional staff — all groups of professionals came in for criticism but the chief offenders seem to be GPs, dentists and nursing staff.

"The most common aspect of complaints received by this CHC is the attitude of both professionals and their staff, including receptionists and administrators. We accept that it is difficult to include "rudeness" in contracts but we would like to see the DHSS and FPCs putting more emphasis on caring attitudes, less brusque approach and the offering of more information."

GPs, for example, are criticised for the way in which they speak to and treat their patients. Complainants feel that GPs are often rude and make no real effort to communicate, rather they simply dispense prescriptions. Often there is an apparent lack of care or real interest in the patients problem.

"Many of the complaints which this CHC refers to the FPC are over GPs attitudes and these are particularly difficult to resolve. In one case the widow of a man who had died from Alzheimers disease felt that the GP had lacked understanding and sympathy. GPs should be reminded more often that they are providing a service to people who are entitled to be treated with understanding, tact and consideration".

Out-of-hours calls and home visits are recurring problems.

"Complaints from a range of age groups about GPs refusing to respond to out of hours calls for urgent treatment. On two instances it was not the patients own doctor but an "on call" doctor giving cover."

"GPs often fail to respond to home visits requested by elderly patients."

Although hospital in-patients acknowledge the burden of work on nursing staff, they do not accept that this is a reason for neglecting common courtesy and the personal needs of patients. Problems to do with nursing care, discourtesy and inconsiderateness particularly affect elderly patients, who tend to need more personal care and attention. Many cases are actually taken to CHCs by the relatives of elderly patients concerned about the quality of nursing care. Some CHCs made the point that the elderly themselves are often reluctant to make official complaints as it might adversely affect the kind of treatment they receive from staff.

Relatives, as well as patients, expect courtesy.

"Instances where trained nurses refuse to give their names to next of kin over the telephone or put the 'phone down on enquirers can not be allowed to continue."

Another all too common problem arising from the insensitivity of the professional is the unwillingness of dentists to persevere in making adjustments to badly fitting dentures. Once again this is a problem particularly affecting the elderly.

"Some dentists charge patients for every re-lining or adjustment to dentures, making it very expensive for patients whose false teeth are uncomfortable."

Information and communication

"The provision of information to patients and between departments often falls down — a very high percentage of complaints dealt with by this CHC have a strong element of poor communication. Improving communication should be an integral part of pre and post qualification training."

A large number of CHCs echoed the comments above. From the users' point of view it is, of course, the provision of information to them that is paramount.

"Lack of information and communication between medical staff and patient — covering diagnosis and prognosis leading to unrealistic expectations. Also a lack of information whilst patients are being treated leaves them feeling ignored. Patients often find it difficult to obtain information once a formal complaint has been made. We would like to see an understanding by DHA and medical staff that many complaints can be resolved merely with an explanation of what has happened or should have happened. There is a need for medical and nursing staff to communicate directly and plainly with the patient about the illness, care and treatment."

A sad example of a breakdown in communication was given to us by one CHC.

"The lady had been told all through pregnancy that a normal delivery was expected — but the child was delivered stillborn. She came to the CHC because subsequent explanations did not seem to tie in at all with what she had been earlier told. We arranged a meeting with the consultant and this helped the woman to understand what had gone wrong".

Indeed maternity care appears to be a common source of dissatisfaction.

"Women frequently complain that they are not informed sufficiently of their right to choose where to have their baby — hospital or home. Neither are they made aware of the domino scheme. (Mothers stay in hospital for a very short time after the birth of their child but are given full backup support in the community.) Once in hospital there is little information or discussion about the various facilities and services available during childbirth".

Other examples of the clogged channels of communication in the NHS include patients requesting and being denied access to their medical records, "semi-literate" letters to patients and irritatingly elusive consultants. Many GPs and hospitals do not have any formal procedures for providing interpreters for patients from ethnic minority communities.

"Where the patient does not speak English or does not fully understand British medical practices there is a total failure to communicate. HAs should employ an adequate number of interpreters and advocates and work towards the training and employment of ethnic minority staff at all levels".

Lack of information about dental services is another frequent source of difficulties. 15% of CHCs reported receiving regular complaints about charges for dental treatment. The public need to be better informed about rights to and costs of NHS dental treatment, especially since percentage charges were introduced. We received many comments along the lines of the following.

"We receive a steady stream of enquiries about how to get refunds when unnecessary payment has been made — in some cases receptionists have known patients to be in receipt of social security payments and have not advised them of their rights."

Other CHCs reported patients experiencing difficulty in finding dentists willing to undertake work such as crowns, dentures and bridges except on a private basis. Practitioners also seem reluctant to refer patients to other dentists who are willing to under-

take such work on the NHS. CHCs say they would like to see dentists being given the responsibility for discussing and agreeing charges with patients before commencing treatment. They also say that more information on rights to and the scale of NHS treatment should be made readily available in dentists surgeries.

People want more information on the range of health services available to them. Some CHCs reported an increase in requests for information about GP services. Few GPs as yet have produced practice leaflets and the public therefore find it difficult to choose between them.

The GPs' role as the "gate-keeper" to specialist care can cause problems.

> *"Difficulties arise if the GP is unable or unwilling to listen to what patients are saying. This at its worst causes major problems to go untreated and may sometimes lead to serious illness. Some patients have come to the CHC seeking to bypass the GP but this is rarely possible."*
>
> *"Complaints received about GPs reluctance to refer a case to a consultant, or referral to a consultant which the patient feels is not right for them."*
>
> *"Referrals for a second opinion — patients are not clear about the situation with regard to referrals for consultant opinions. Most patients assume that they have the right to a second opinion and are not happy when told they can request but not demand referral. They are also unaware that the GP has to agree to a private referral."*

In all, 37 CHCs raised issues relating to poor communication and inadequate information.

We asked CHCs who are members of ACHCEW to list in order of priority the 3 issues which had dominated their work in 1987. 97 CHCs responded:

Acute sector funding	**36 said it was their no 1 priority** **60 listed it as a priority.**
Shortages of all staff	**11 said it was their no 1 priority** **33 listed it as a priority**
Community Mental Health	**7 said it was their no 1 priority** **48 listed it as a priority**

Other issues included in CHCs top 3 were:

Development of Primary Care	22
Cervical Cytology	18
Discharge Arrangements	17
Private Residential Care	14
Choices in Maternity Care	11
Waiting times in OPDs	9
Child Health	8

Delivery and organisation of care

The organisation of a hospital department is a complex undertaking. In an outpatients' department, for instance, appointments must be scheduled so as to make the most efficient use of available staff and equipment. Too often this appears to be done with no regard to the convenience or commitments of patients. 28 of the 97 CHCs which responded to our questionnaire reported that they received fairly frequent complaints from health service users about the way in which care is organised. CHCs told us of complaints about long waiting times at out-patients departments due to badly organised booking procedures, cancelled appointments because contultants arrive late or fail to turn up at all and misplaced and inaccurate medical records. All of which leads to delay and frustration for the patient.

> *"Postponement of admission to hospital for surgery has caused major inconvenience to patients and their families who in some cases have postponed holidays, arranged time off work, made arrangements for the care of children etc. Patients often receive no explanation or apology for why the delay has occurred".*

Or similarly ...

> *"A woman waited 3 hours at out-patients and was then told that the consultant was away and her notes were missing. On her second visit she waited 4 hours and her notes were still missing. The CHC has helped her write a letter of complaint to the hospital and has discussed problems of missing notes with the UGM on several occasions as the system has been causing complaints for about two years."*

It is not only the convenience and patience of users which is ignored; insensitivity to non-medical needs and personal feelings can be shown in all sorts of ways.

> *"A lady admitted to an acute medical ward complained that she was not warned that the ward was for mixed sexes, nor was she offered the choice of moving to an all-female ward. She was particularly distressed as the toilet and washing facilities did not afford total privacy and men sometimes wandered around the ward in a state of semi-undress".*

At other times clinical procedures may be organised in what seems an officious and rigid manner.

> *"We have a steady stream of complaints about the current policy of not allowing partners to accompany pregnant women at the time they undergo ultra-sound scans".*

Or ...

> *"Parents frequently complain that they are refused access to children on the ENT ward, on the day of operation by one particular consultant".*

GPs are criticised for failing to make their services accessible to some of the most disadvantaged groups in society, such as not providing wheelchair access for the disabled, failing to use interpreters or language cards for people whose first language is not English and ignoring other groups such as the homeless.

> ***"Problems have been brought to us by voluntary groups working for the homeless rather than by individual consumers. Homeless people have difficulty in registering with GPs and often miss out on follow-up care after discharge from hospital. The children of homeless families frequently miss out on regular health checks etc".***

CHCs covering large rural areas reported that people in small hamlets and outlying villages often complain that the primary care services seem to ignore their needs and particularly the transport problems of people needing to see a GP. A CHC in Wales told us that:

"Doctors are reluctant to establish branch surgeries, forcing patients to travel into towns from outlying areas."

For 16% of CHCs the largest source of complaints and queries seems to be the GPs' list. Just as everyone has a right to choose and change their GP, GPs are under no obligation to accept an individual into their practice unless specifically requested to do so by the FPC. Patients who try to change GPs and those who are "struck off" their GP's list for being "troublesome", sometimes experience considerable difficulty in finding another GP to accept them. A large number of CHCs reported that GPs in their locality seem to operate an informal policy of not accepting their colleagues ex-patients.

"A number of patients who have made a complaint against their GP and have subsequently been removed from that GPs list, have found other GPs in this area refuse to take them on. This applies to whole families struck off because of one member's argument with a doctor."

"A group of patients defined by the FPC as "difficult" are put on the merry-go-round of GPs, assigned first to one and then another. They become steadily more distressed and unable to cope and may miss out on regular medical checks which pick up illnesses at an early stage, because they never built up a proper relationship with a GP."

"Patients wishing to change from one GP to another in the same locality often experience difficulty, even when the reason for wishing to move does not amount to a full blown complaint — other GPs in this area seem to have an "arrangement" not to take colleagues ex-patients."

Dealing with users complaints

Making a formal complaint is often a difficult and irksome business. CHCs, in their role of 'patients' friend, are well placed to hear about the problems of pursuing a complaint.

"At the Service Committee Hearings of the FPC many complainants feel unfairly disadvantaged when faced by the Service Committee Chair, FPC Administrator, 3 GPs and 3 lay people all of whom can ask questions."

"A number of clients have refused to press their complaints because they were unnerved by the thought of the FPC Service Committee Hearing and having to represent themselves against professionals."

We were also told that patients feel that complaints generally take too long to resolve and the procedures are often inflexible and impersonal.

"There are long delays by both the Health Authority and FPC in handling complaints. It can sometimes take over a year from the first letter to completion of enquiry and at the end the decision is not always acceptable to the complainant."

Special Health Authorities can present special problems.

"Users come to us because complaints are badly handled by the Special Health Authority. It often takes up to 4 months for the SHA to reply to complainants' letters. Users complain of defensive and aggressive attitudes of managers during face-to-face meetings and a lack of information from the hospital on what is going on."

Nor are FPCs always as helpful as they might be.

"Letters from the FPC to complainants are often impersonal and unsympathetic. Users come to the CHC because the FPC does not adequately explain the complaints procedure."

Conclusion

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 the CHC. Sometimes these can be readily categorised as 'resource-dependent'. There simply is not enough of a particular service to go round. As far as the acute hospital sector is concerned, waiting lists are perhaps the clearest index of the problem. For many non-urgent operations, they are too long and the people waiting are unhappy about it. For the community health services, the problems seem, if anything, more pressing and more urgent. Certainly, problems that were related to the actual level of provision of community health services were mentioned by CHCs more often those in the acute sector.

By no means all the problems affecting the users of the NHS depend on the quantity of services being provided. Nor does the 'solution' always lie in the expenditure of additional resources. The quality of care, either in respect of its organisation or the manner of its delivery by the professional, accounted for most of the worries and concerns taken by individual members of the public to CHCs. More often than not, these originate in a lack of sensitivity to their needs and wishes. Such insensitivity may be displayed by individuals, such as curt or unsympathetic doctors, or by the way that some part of the service is organised, so that it lacks flexibility to meet the circumstances of the individual user. Communication, between professionals and users, and between different parts of the organisation, is often poor. Users need to be encouraged to ask questions of the professionals; and the professionals need to be encouraged to regard patients and their carers as participants in the management of care.

The number of people who bring their worries or complaints to a CHC represents a very small proportion of the total number of people who use the service. This should not be taken as grounds for complacency, however. There is still plenty of room for improvement in the quality of care, its organisation and the manner of its delivery.

The work of ACHCEW 1987/8

The Association is now on a much stronger and firmer footing than it has been for a number of years and this has been reflected in the range of activities in which the Association has been involved. Throughout, the objective has been to represent the interests of the consumer of health services at a national level, to promote the work of CHCs, and to provide a wide range of information and support services to the individual CHCs.

Membership of the Association

The number of CHCs who are members of the Association has continued to increase slightly. In 1987 there were 181 member CHCs (out of 216 CHCs in total in England and Wales). At the time of writing 160 members have paid for 1988. 2 have withdrawn from membership, having given on year's notice of their intention to do so as required by the Constitution, but these are more than balanced by the 6 CHCs who have rejoined the Association. This gives the prospect of 185 CHCs — 86% of the total — 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

Information service

Member CHCs continue to make considerable use of ACHCEW's information service. Indeed, now that the service is fully staffed and more accessible by telephone, the number of enquiries is running at around 80 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. As in previous years, a listing of CHC reports has been produced and circulated to member CHCs. Improved links with other organisations that have libraries or information systems have been established and a wider range of other organisations' publications are now being received.

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. There have been a number of minor changes in format, but essentially 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. The choice of which items to include and which to cover at greater length is never easy, and as ever we do depend on CHCs letting us have information about their activities and publications.

A new initiative in 1988 has been the preparation of regular supplements reviewing current videos which might be of interest to CHCs in their work. This followed the publication of a Health New Briefing on video aids for CHCs and reviews have covered videos on AIDS, women's health, community care and health promotion.

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.

Cook-Chill: A Cause for Concern was published in November 1987. This looked at some of the issues surrounding the introduction of cook-chill catering in NHS hospital kitchens and warned that cook-chill systems could lead to a catering disaster and that it might just be a matter of time before a major food poisoning outbreak occurs, unless strict safety standards are enforced. The fear remains that under pressure to keep costs down, cook-chill systems will be installed on the cheap and there is evidence that some health authorities are planning to do this without adequate reheating facilities on hospital wards or will not have sufficient money to ensure that there are enough staff

Ante-natal Care: Still waiting for Action was published in December 1987. This summarised the findings of surveys conducted by a number of CHCs on the ante-natal care available in their areas. It found that the same problems were still being reported by women as were identified in a Ministry of Health report in 1961. These included long waiting times in clinics (the 'block booking' system is still widely used), inadequate facilities in hospitals, and poor provision of information to women. The paper makes a number of specific proposals for improvements, many of which could be achieved at little cost by changes in administrative and managerial procedures.

Mid-Year Budget Cuts: Health Authorities in Crisis was published in January 1988. This reported on a survey of CHCs conducted by ACHCEW, assessing the budget shortfall for District Health Authorities in 1987/8, the reasons for DHAs' financial problems, and the short-term measures being taken to bridge the budgetary gaps.

The Impact of General Management on the NHS: The Views of CHCs was published in March 1988. This summarised the views of some 69 CHCs who had submitted comments on the way in which the introduction of General Managers had affected consultation with CHCs and altered the role of health authority members, and on whether or not it had had a discernible effect on service quality and efficiency.

AIDS and HIV Infection is being published in June 1988. It summarises the facts about the spread of AIDS and HIV infection and looks at some of the policy issues that this poses for health authorities and other agencies. In particular, it focusses on the role of screening for HIV infection, issues of confidentiality, and the need for a wide range of counselling and support services for those with AIDS or who are HIV positive. It also suggests a checklist of issues that CHCs might wish to pursue locally.

ACHCEW evidence *Financing the NHS: The Consumer View* (mentioned earlier) was also circulated as a Health News Briefing in May 1988.

Annual Report

Other publications

ACHCEW has produced *Good Practice for CHCs*, written for the Association by Christine Hogg. This is intended as a handbook drawing attention to the many initiatives taken by CHCs to fulfil their role on behalf of the users of services.

During the year the Association has collaborated with other organisations in the production of other reports, booklets and leaflets.

In December 1987, for example, ACHCEW together with the National Consumer Council, published *Care in the Community* a report based on a survey of CHCs and district health authorities on the local development of care in the community policies. This drew attention to widespread criticisms by CHCs of aspects of existing community services for mentally handicapped and mentally ill people and to the unacceptable variation in levels of provision in different parts of the country. The report argued for better consultation by health authorities with CHCs and with those using the services and stressed the need for clear guidelines from the DHSS on the minimum standards of service to be provided.

ACHCEW has also worked with the NCC in the production and distribution of a leaflet *Dentists: A guide to patients' rights*. The NCC is also funding the publication by ACHCEW of translations of the general leaflet on *Patients' Rights* into Punjabi, Hindi, Gujerati, Bengali and Vietnamese.

The Institute of Health Service Management and ACHCEW have jointly produced a pamphlet on the organisation of hospital accident and emergency departments. This was drawn up in the light of CHC concerns about local A & E services and is intended to provide guidelines for A & E staff and managers on how to improve services for all those patients who arrive unannounced and unscheduled, in varying states of anxiety, all of whom hope to be seen, diagnosed and treated in a short space of time.

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

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 DHSS, 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 review of NHS funding but other consultations to which ACHCEW has responded over the last year have included:

- Performance Indicators (DHSS)
- Patient information on medicine (Association of the British Pharmaceutical Industry)
- Proposed changes to Food Hygiene (General) Regulations 1970 (DHSS)
- Procedures for Investigating Complaints against Doctors (General Medical Council)
- Oral Hearings of Service Committee Appeals (DHSS)
- The Sharing of FPC registration data with DHAs (DHSS)
- Discharge of Patients from Hospital (DHSS)

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 DHSS or other bodies as appropriate.

Parliamentary matters

Andrew Faulds MP was successful in the ballot for Private Members Bills and reintroduced the Community Health Councils (Access to Information) Bill in the House of Commons. This measure will require CHCs to open meetings to the press and public, except for items dealing with tightly defined confidential matters. The Bill will also require that CHC papers for such meetings should be open for inspection, along with the names and addresses of CHC members. The Government has been neutral in respect of the Bill and the Bill had at the time of writing completed its House of Commons stages.

The Association was also interested in another Private Members measure: Archie Kirkwood's Access to Medical Reports Bill. This would allow people to see a report which their GP proposed to send, or had sent, to an insurance company or employer. They would have a right to correct errors, attach their own statement about disputed matters, or, after seeing a draft report, withdraw consent for it to be supplied. ACHCEW has worked closely with the Campaign for Freedom of Information and other organisations in supporting the Bill and the Bill is expected to become law this Session.

External relations

Considerable efforts have been made over the year to increase the public profile of CHCs and of the Association. A wide range of contacts has been established in the press and with the broadcasting media. This has led to substantial coverage for the Association's news releases and publications and to an increasing number of requests for comment on other current health concerns.

Good links are maintained with other consumer bodies and with those organisations active in the health field. Frequent contacts are maintained with the National Consumer Council, Consumers' Association, Patients' Association, College of Health and Health Concern. There are good working relationships and regular meetings with the National Association of Health Authorities, the National Council for Voluntary Organisations, the Health Education Authority and the Institute of Health Services Management. There is also regular contact with the Society of Family Practitioner Committees, Action for Victims of Medical Accidents, the British Medical Association, the British Dental Association, the Pharmaceutical Society, the Association of Directors of Social Services and many other organisations.

Finally, there is a cordial and constructive relationship with officials from the Department of Health and Social Security with regular contact between the Association and Malcolm Harris and his team in the policy division with responsibility for CHCs. The Department has renewed the Association's grant for 1988/9 at the 1987/8 level of £50,000. This degree of support is, of course, most welcome.

Standing Committee

Since the AGM in 1987, the Standing Committee has met on four occasions. Meetings are now less dominated by financial and ad-

ministrative matters and it has been possible to devote more time to following up policy concerns raised by member CHCs and to discussing the implications for the user of health services of current developments.

The 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 Association's viewpoint is heard and understood by other organisations, but is also crucial in ensuring that the work of CHCs attains a high profile. Standing Committee members also act as a major channel of communication between the Association and regional groups of CHCs. Communication is, of course, a two process, as not only does the Association need to report back on its activities to Members and Secretaries in the regions but also needs to be informed of the views and work of individual CHCs.

Office accommodation

After a long search and after a difficult period in temporary accommodation, the Association is in permanent office premises at 30 Drayton Park in North London. Inevitably, the office move was fairly disruptive, but there is no doubt that the benefits of having good quality comfortable accommodation is now being felt.

Staffing arrangements

Two new members of staff joined the Association in July 1987: Hazel Fisher as Information Officer (Health Promotion), whose post is partly funded on a three year basis by the Health Education Authority; and Suzanne Tyler as Development Officer.

Annual Report

Chairman's message

Dear Colleagues,

As you see from the Annual Report and the work of the past year it has been a busy one for ACHCEW. In last year's report I was pleased to say we had achieved the core staffing needed for the national office. We now have permanent office accommodation to work in. Having now achieved what was recommended by the ACHCEW's Committee of Enquiry following our financial problems in 1983 it is important that CHCs continue to work together. It is the only way fully to represent the views of the users of the National Health Service. It is a good sign that membership of ACHCEW continues to increase; more are joining than leaving. We can only hope that those who did not will eventually recognise that the work we are doing cannot be duplicated by individual CHCs and that one day we will have 100% membership. The financial situation in the NHS and the impact of shortage of money on patient services is of major concern to us all.

The survey of members views last autumn of what is happening in their health districts and therefore to the NHS as a whole surely should demonstrate to those in doubt the need to work together and speak with a national voice.

As I write we are anxiously awaiting the result of the Ministerial review of the NHS. To enable a prompt response from ACHCEW membership views will be needed as soon as possible.

We are aware in the national office of the pressure that constant "seeking-of-information" puts on already overworked CHC staff and try to keep it to a minimum. It is nevertheless important that you do respond with information to keep ACHCEW up to date with your views.

It is remarkable how much CHCs are doing despite poor staffing levels. I am concerned that the knowledge, ability and diversity of work that most CHC staff are undertaking goes unrecognised in so many instances when regrading of posts and the increase of staff are considered by RHAs and the DHSS. To enable ACHCEW to work efficiently and effectively we are proposing a framework of objectives and tasks. Each year's work programme will be formulated in connection with the decisions taken at the AGM. We, that is, the Officers, the Standing Committee and the staff believe this to be the best way of working and keeping the membership informed of what we are doing.

My thanks are due to the staff who have worked extremely hard during this year. There is a good team spirit at the national office and it is a pleasure to work there. To my fellow Officers, to the members of the Standing Committee and member CHCs my special thanks for your support.

Best Wishes.
Wyn Pockett
Chairman

Association of Community Health Councils for England & Wales 1987/88

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

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

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

Members of the Standing Committee

Mr. S. Kitching (Northern Region)
Mr. Gordon Mullis (Yorkshire Region)
Mr. H. Ferry (Trent Region)
Mr. H. Place (East Anglia Region)
Mr. George Wenham (North West Thames Region)
Mrs. Mavis Garner (North East Thames Region)
Mr. S.R. J. Terry (South East Thames Region)
Rita Lewis (South West Thames Region)
Mr. Peter Cotton (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)
Mrs. Joan Reynolds (Wales Region)

Secretary Observers

Mr. Ian Webb	Northern, Yorkshire.
Mr Michael Quinton	Mersey, North West Regions
Mr. John Stevens	Trent, East Anglia
Mr. Dag Saunders (from May 1988)	Oxford, West Midlands Regions
Maggie Mansell	North West, North East,
Mr. Graham Girvan (from Dec. 1987)	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)
Ken Howse — Research/Information Officer
Suzanne Tyler — Development Officer
Secretary/PA to the Director — vacant
Secretary (p/t) — Pippin Markandya
Clerical Assistant (p/t) — Rose Walter
Newsletter Editor (p/t) — Judith Cook

- There are 216 **Community Health Councils** 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 by health authorities on any substantial development or variation in service.

- **The Association of Community Health Councils for England and Wales** (ACHCEW) was set up in 1977 to represent the consumer of health services at national level and to provide a forum for member CHCs. ACHCEW is mainly funded by subscriptions from individual CHCs but it also receives grants from the DHSS and a number of other bodies.