



ASSOCIATION OF  
COMMUNITY HEALTH COUNCILS  
FOR ENGLAND & WALES



# Annual Report 1991/92



# Plus Ça Change

"Our approach stems from a profound belief that the needs of patients must be paramount. ...The closer decisions are taken to the local community and to those who work directly with patients, the more likely it is that patients' needs will be their prime objective. ... The NHS exists to serve patients."

**F**ine words. Their source? Not the manifestos of any of the political parties contesting the recent General Election, although all of them could have been. Nor do the words come from the White Paper 'Working for Patients' which launched the 1991 reorganisation of the health service, although again almost identical words can be found there.

In fact, they are taken from an earlier White Paper 'Patients First' issued more than 12 years ago in December 1979. The fact that the sentiments expressed could fit so neatly into so many disparate documents might be taken as proof of the broadly-based and deep-seated consensus about the role and importance of the National Health Service. The more cynical will argue that it represents the failure of the 1979 rhetoric about making the Service more responsive to the needs of its users.

Now we have the 'Patient's Charter' which promises that it means "a Service that ...always puts the patient first ... in ways responsive to people's views and needs." This is followed closely by an NHS Management Executive publication 'Local Voices'. This too nails its colours to the mast: "Making health services more responsive to the needs, views and preferences of local people is central to the new role of DHAs and FHSAs."

But then, more significantly, it warns: "To give people an effective voice in the shaping of health services locally will call for a radically different approach from that employed in the past."

Thus, there is explicit official recognition that the culture change necessary to make the NHS genuinely user-centred has yet to take place. Many managers and many clinicians have already made the leap, but many - as far as patient empowerment

is concerned - remain blinkered and slow-moving, like Jurassic dinosaurs awaiting extinction. Too many are still of the view that "If you want to know what my patients want, ask me - I know best what they need".

Such philosophies have long been outmoded. It is now widely recognised that involving those patients who wish it in the decisions affecting them, improves patient satisfaction and morale and this in itself is an important boost to recovery. Patient empowerment creates a partnership between the patient and the Service and this partnership will be essential for the future development of the NHS. Such a partnership will rebuild public confidence in a beleaguered Health Service. Such confidence will mean that patient-staff relations will improve and this in turn will boost morale within the Service. Above all a Service which remains high in public esteem is one that is less likely to be disrupted by further reorganisations and increased budgetary restrictions.

That is why the slow faltering steps that the NHS Management Executive is now taking towards strengthening patients' rights, enhancing the voice of service users in decision-making, and promoting patient empowerment are so important. For this to be effective, considerable changes in the culture of the NHS are necessary. 'Local Voices' at least seems to recognise this. However, institutional changes will also be essential.

First, genuine empowerment requires that those being empowered must be informed. Information is power and patients must have power over the information that affects them. This means an awful lot more than setting up a handful of regional telephone lines. It means that at every stage in a service user's encounter with the NHS all staff (whether medical, nursing or administrative) should share information with their patients on all aspects of their condition and care. Such information should be volunteered and should be reinforced by well-produced background material appropriate to the patient's needs. Service users should also have ready access to external information sources, but such a service must be independent of the service providers and should be

readily accessible to patients in person as well as by telephone.

Second, when things go wrong, service users should have ready access to independent advice and support, and there should be a user-friendly complaints system for them to pursue their concerns. The existing system for investigating patients' complaints is bureaucratic, cumbersome, long-winded and strongly biased in favour of the medical profession. The present arrangements need to be scrapped in favour of a new system, which focuses on the patient and enables the NHS to take a more positive attitude to criticism and take on board comments on the services provided.

Third, patients need their own independent representative structure to promote their interests in an increasingly market- and finance-driven environment. Such a structure should be an enabling one that encourages service users to put forward their views and facilitates community groups in feeding into the NHS.

In all of these three areas, Community Health Councils have a big role to play.

If the fine words of successive Government pronouncements are now to be turned into a genuine culture change throughout the NHS, then CHCs must be central to the process. Properly resourced and with their independence bolstered, CHCs can help make patients equal partners in the new NHS of the 1990s.



# Maternity Services

## *Progress Only Patchy*

1992 saw the publication of the most important report on maternity care in Britain for a decade: the House of Commons Select Committee on Health's *Maternity Services*. It therefore seems a good time to look at the opinions and experience of CHCs regarding this area of their work. 72 CHCs (36% of ACHCEW's member CHCs) completed a questionnaire on the maternity services available in their locality.

### Choice and Information

The Select Committee's report concludes that "the present structure of the maternity services frustrates, rather than facilitates" women who wish to exercise "greater choice in the type of maternity care they receive", and that "many women at present feel they are denied access to information in the antenatal period which would enable them to make truly informed choices about their care, their carer and their place of birth."

The survey of CHCs on the whole endorsed these findings. 57% of respondents did not feel that local women had available to them either the range of services, or the information, which could enable them to make a real choice about their maternity care.

"members of the CHC and the public have commented on the lack of emphasis placed on the right of women to choose their own type of care"

"much is said about choice but in practice this does not happen"

In one District virtually the only information available to pregnant women is provided by a CHC leaflet. Other CHCs also play an important role in information provision; for example, two CHCs have produced popular leaflets with their local branch of the National Childbirth Trust (one of which has been translated into four languages).

22% of responding CHCs were satisfied with the level of informed choice available to women in their area. In some Districts women had a good range of services available to them; and 11% of CHCs surveyed stated that significant improvement

was or had been taking place in local maternity services.

"there has been genuine effort over the past 12 months to disseminate information and extend choice"

"women who have clear preferences and possible contra-indications... wanting home births, get maternity services bending over backwards to help"

Several CHCs noted however that where choice existed, it was often limited to the "determined woman", to the "articulate minority...aware of the various options", and that it was "still not easy for 'ordinary' women to find out and to feel in control". The particular area of choice most commented upon by CHCs was the provision of home births (also the area of the Select Committee's report which attracted the most publicity). The other area of concern highlighted by the responding CHCs was the ability of the expectant mother to choose to be cared for by a woman doctor/consultant in her area (the difficulties in most cases arose from the local maternity unit employing male consultants only).

Main problems regarding choice specified by responding CHCs:

Home births difficult to obtain/actively discouraged 36%

Ability to choose to be cared for by woman doctor/consultant restricted/impossible 22%

The vast majority of CHCs surveyed felt that the contracting process had made no difference to the level of choice available to local women. A few stated that contracting had made it more difficult for women to exercise choice, while an equally small number claimed that this choice had been enlarged by contracting. Only about 8% of those responding knew of local hospitals applying set geographical limits regarding which women they would accept for delivery (such limits evidently call into question the ability of women to have complete choice regarding their delivery hospital, a choice promised in the Department of Health's 1990 publication **The NHS Reforms and You**).



## Planning and Consultation

The Select Committee on Health's report points to the Maternity Services Liaison Committees which operate in most health districts as potentially providing an important means of improving maternity care. The Committee concluded however that "at present, MSLCs are failing to provide women using the maternity services with a fully effective channel to influence the shape of provision for those services".

Attitudes expressed by CHCs with an MSLC in their district regarding its usefulness (the majority did not comment)

fairly to very satisfied with MSLC's effectiveness	29%
considered MSLC ineffective	13%
MSLC improving	7%

### Some complaints about local MSLCs

"decisions taken elsewhere"

"a PR exercise"

"lack of 'teeth' and lack of clarity about its role/to whom it is accountable"

96% of the CHCs responding to our survey stated that an MSLC existed in their district. Of these, only 16% did not have a CHC representative on the local committee. This is a small but worrying figure, especially since 45% of the CHCs not represented said that they would like to be, and had sometimes been actively denied representation. One CHC which was represented had had to fight for this for eighteen months. Another CHC stated however that instead of the MSLC, the CHC and women users "were involved in consumer liaison groups within the units...perhaps a more effective method of communication".

CHCs who belonged to their local MSLC were questioned regarding their satisfaction with the level of CHC involvement in the committee:

fairly to very satisfied	58%
dissatisfied	23%
did not say	19%

The majority were thus happy with their role on the MSLC, with some CHCs commenting that "we have plenty of influence on decision making", and that

"CHC views (are) taken very seriously". A significant number were however dissatisfied, often extremely so. The most common source of discontent was the strength of the medical professionals on the committee.

"tends to be dominated by consultants"

"not involved in MSLC decision making, considered to be professional"

26% of respondents with an MSLC in their area stated that CHC representation constituted the sole consumer input into the committee's work.

The findings of the survey add force to two important recommendations of the Select Committee on Health: that MSLCs should "establish systems to elicit and review comments from users of maternity services", and that the Government should strengthen the committees "by increasing the lay membership... and developing a mechanism to ensure that the committees are an integral part of the planning process".

Regarding the planning process, the survey asked CHCs about their involvement in the RHA reviews of and target-setting for maternity and neonatal services which the NHS Chief Executive declared in September 1990 to be a "matter of priority". 40% of responding CHCs stated that they had not been involved in the RHA review or that they had no knowledge of such a review taking place. Only 24% stated that the RHA had consulted local CHCs (however 14% said that the CHC had been involved in planning on a District level).

The survey of CHCs thus clearly demonstrates an unacceptable unevenness across the country in two key areas: the level of choice and information available to users of the maternity services; and the level of CHC and consumer involvement in the planning of these services.



# From Cradle to Grave?

## *Health Care for Elderly People*

Policy changes resulting in the reduction of long-stay hospital provision mean that elderly people can no longer expect to be admitted to hospital for continuing care. The policy developments mean that many elderly people, who once would have been admitted to hospital for long-term care, are now being cared for in their own homes, nursing homes or residential units. If the quality of life of elderly people is not to suffer as a result of the closure of long-stay hospitals, there is a great need for effective health services, particularly community health services.

### Community Health Services

In Britain, approximately 95% of people aged over 65 currently live in the community. With the implementation of the 'community care' part of the NHS and Community Care Act in 1993, it is likely that this number will increase, as will the reliance upon community health services.

CHCs were asked if they were aware of any problems in their District concerning the provision of community health services. Over four-fifths of respondents stated that they were aware of problems and of these 85% stated that the main problems concerned chiropody, incontinence services or both. Of the respondents 77% had received direct or indirect complaints about the community health services in their District. Poor chiropody and incontinence services were the focus of the majority of the complaints.

"Always concern about chiropody - only free to the elderly every six months. The elderly feel the service is required more often without paying."

"Incontinence materials and supply of commodities 'waiting list'!!!"

"Insufficient bath nurses - people have to wait sometimes 2-3 weeks."

When asked whether community health services were available upon request, or if there was a waiting time prior to assessment and actual provision, just over one-third of CHCs stated that there were delays - some of these being quite considerable:

"A year's wait or more for initial chiropody assessment is not unusual."

Of the remaining respondents some CHCs stated that the length of wait varied according to the service and some stated that services were made available as part of a discharge programme.

It is important that people have information about services in their area and that they are aware of how these services operate. For example, is referral by practitioners only, or can self-referrals be made. CHCs were therefore asked what information is available to elderly people/carers about community health services. Over three-quarters of CHCs stated that information about services was available. However availability ranged from 'Little - sporadic' to 'Good-through Leaflets/Roadshows/Exhibitions etc.' and 'Nurse Advisory support for elderly people and their carers.' Some of the information was only available upon request or verbally. Verbal information can be of use but written information gives the recipients time to read and digest the information and to ask questions if necessary. In some areas information was available only via agencies other than the health authority eg Age Concern and CHCs.

### Respite Care

The emphasis on community provision has resulted in elderly people being cared for by their relatives or friends. Although the carers should have access to health and local authority support, caring can be stressful and the stress of caring can have a detrimental effect not only on the carer but on the person being cared for. This being the case, many elderly people and their carers would welcome the opportunity to be able to have access to respite care.

CHCs were asked if respite care for elderly people was available in their District. Eighty nine percent of respondents stated that respite care was available. Although the question did not ask what level of care was available some CHCs did give an indication eg one CHC stated that there were only 6 beds available and another stated that there was only very limited respite care available. So although



71% of respondents said that there were no restrictions on the number of times that the service could be used, it is likely that in many instances, there would be restrictions resulting from the fact that demand outweighs supply.

"Not enough respite provision available to meet all needs, therefore, it is restricted but depends on individual circumstances as to availability."

"No crisis or on demand service."

Eleven per cent of respondents had received complaints about the lack of respite care provision in their District, but 65% of CHCs had not received any complaints about the service.

When asked about availability of information about respite care, common observations were that the service was not widely publicised or that only verbal information was available.

### Continuing Nursing Care

The debate about the funding and provision of continuing care for elderly people continues with calls for clear statements of health and local authority responsibilities. Whilst the debate continues, so too does the reduction of NHS long-stay beds.

CHCs were asked if there had been any reduction in the number of NHS long-stay beds for elderly people since December 1990. Seventy-two percent of respondents stated that there had been reductions. Of these 51% stated that there was alternative provision and 31% stated that their health authority encouraged the use of private nursing homes. The latter responses are evidence of the growing move towards elderly people and their relatives being expected to fund long-stay care in the private sector.

"No NHS alternative provision available. Patients are encouraged and assisted to find places in private nursing homes with the aid of 'Homefinder Service'."

Asked if they visited private nursing homes, 57% of respondents stated that they did. Of these 72% was

by agreement with the owners, or visiting rights had been written into the purchaser/provider contracts (14%). Some CHCs visited informally or at the request of home owners. Most CHCs found it useful to visit private homes. Of the CHCs who do not visit private homes some said that they would like to do so but could not because of resource limitations.

Clearly there are variations in health care for elderly people in different health authorities. It would, however, be encouraging if the following, an observation by a CHC, could be said of all health and local authorities:

"Both the Health Authority and the Local Authority would agree the services are not wholly ideal but we respect their determination and financial commitment to bring services up to a useful level."



# Discharge from Hospital

## *“Tries hard but could do better”*

Many CHCs have voiced concern over the years about problems that arise for patients when they are discharged from hospital. Typically, CHCs have confronted issues such as lack of communication between professionals and patients and their carers and, increasingly over recent years, a trend towards the earlier discharge of patients which has knock-on effects for carers at home and for community health services staff. This last issue has certainly in some cases been related to NHS financial restrictions and increased pressure on staff to use bed-spaces “more efficiently”. To some extent, however, there are also many simple practices that health authorities and NHS staff could adopt to avoid the situation of, for example, an elderly and frail person being sent home to an empty cold house with no food or support.

Partly in response to varying standards and recognition of the problems in February 1989 the Department of Health issued guidance to health authorities on the discharge of patients from hospital (Health Circular HC (89)5). This asked health authorities to ensure that before patients are discharged proper arrangements are made for their return home and for any continuing care that may be necessary. DHAs were to provide all wards, departments and all staff concerned with an up-to-date copy of discharge procedures.

ACHCEW carried out a national survey of Community Health Councils to find out if discharge policies were in place and if practices have improved as a result. CHCs were asked to consider discharge from all types of services, for example, acute care, continuing nursing or psychiatric care. 72 of the 198 member CHCs of ACHCEW responded to the questionnaire.

All CHCs bar one reported that local hospitals had developed discharge policies, were reviewing old policies or were about to finalise new ones.

### Discharge Policies in Place

Despite the evident activity there has been to implement agreed discharge procedures nearly all CHCs responding reported continued problems with discharge arrangements; 9 out of 10 CHCs reported at least one issue of concern, some reported several. The table below shows the

percentage of CHCs reporting particular problems with local discharge arrangements. It includes “double-counting” as many CHCs reported more than one area of concern:

### Problems with Discharge Arrangements

Problems reported	% of CHCs reporting problem
Support service not in place/ Failure to ensure support at home.	33%
Failures in communication between hospital staff, patients, carers, Social Services or GP.	36%
Patients discharged too early, at short notice, or at weekends or evenings.	35%
Pressure on elderly patients & relatives/carers to move into private nursing home	10%
NHS staff apparent disregard/ ignorance of discharge policy.	10%

Many of the problems shown in the table are those that comprehensive discharge procedures should eliminate. Of course, no arrangements will be perfect, but it is perhaps disappointing that so many CHCs report the “usual problems” associated with discharge from hospital. Over a third of CHCs responding mentioned either failures to ensure Social Services or community health services support was available to patients on returning home, failures in communication between professionals and patients or patients discharged too soon or at inappropriate times. Many mentioned more than one of these factors. Other serious concerns reported by several CHCs were cuts in Social Services and community health staff, and poor non-emergency ambulance services.

### Inappropriate Discharge

Many CHCs have warned for some time that the trend towards the faster turnover of inpatient beds is affecting the overall standard of patient care, reducing control, for example, over post-operative complications. In some cases early discharge is quite simply counter-productive by resulting in a further expensive inpatient admission. It is therefore a matter of great concern that more than one in three CHCs reported that some patients were discharged too early or an inappropriate time



for care to be organised in their own home. The growth of day surgery has changed the conventional wisdom as to the necessity of inpatient stays and in many ways it is more convenient to the patient and to be welcomed provided it is offered to suitably fit patients. However, the Medical Defence Union, wary of possible increases in litigation against doctors, has warned that day surgery has inherent risks and should not be extended willy-nilly. This is sound advice and CHCs more than anyone are casting a critical eye on the expansion of day surgery.

### Discharge from Long-Stay Care

It is a cause for disquiet that CHCs continue to report instances of pressure being put on elderly patients to move into private nursing homes from long-stay NHS care. This is an issue that ACHCEW has highlighted over a number of years and documented in the report "NHS Continuing Care of Elderly People" (1991). The apparent shedding of NHS responsibility for continuing nursing care for elderly people is having a considerable financial impact on those elderly patients, their relatives and carers who now have responsibility for all or part of the cost of private care.

It is also noticeable that a significant minority (10%) of CHCs suggested that NHS staff and GPs' disregard or ignorance of discharge policies contributed to problems that some patients face on returning home. 1 in 4 CHCs reported difficulty in actually obtaining copies of local discharge policies, which casts some doubt on whether they would be available to all relevant staff. A number of other CHCs suggested that increased professional awareness of problems connected with discharge arrangements would do much to improve the situation.

### Good Practice in Discharge Arrangements

Despite the problems that many CHCs reported, about half of those responding (35) cited aspects of local discharge arrangements that they felt worked particularly well. Many of these related to additional or specified members of staff with responsibility to ensure that Social Services, community health services and GPs were fully informed of patients' discharge and coordinated in order to provide an appropriate package of care

and support once patients leave hospital. Other examples were simple procedures designed to aid communication between professionals from the various agencies involved in aftercare. A number of examples are given below:

#### West Birmingham CHC

"There are 8 dedicated discharge home-care workers for Dudley Road Hospital who are responsible for patients 14 days after discharge."

#### Bolton CHC

"There is a multidisciplinary liaison team for follow-up care of the elderly, which often works well, although some people slip through the net".

#### Gloucester CHC

"All GPs' surgeries have a fax machine to receive their patients' discharge summaries, however, there is a lack of fax machines in hospital wards"(!)

#### North Bedfordshire

"A 'Minimal Care Unit' is available where elderly people can stay for up to six weeks following acute care."

#### Liverpool Eastern

"A Health Visitor visits Broadgreen Hospital Accident & Emergency Unit every morning to get a list of all discharges of patients over 75 years old and all such cases are followed up."

#### South Cumbria CHC

"Most elderly frail patients receive a pre-discharge visit for assessments by occupational therapists, social workers and physiotherapists. Assessments which take place after a person has returned home obviously delay support being made available."

### Conclusion

Clearly many initiatives have been developed to improve procedures and most CHCs can verify that local hospitals have developed discharge policies in accordance with HC(89)5.

CHCs have in most cases been heavily involved in drawing up such policies to ensure a smooth return home for all patients, informed of the situation and with some support services in their own home. However, hardly surprisingly, some common problems remain, for example, faster throughput of patients and poor communication between ward staff, GPs and community staff despite new or re-vamped policies. CHCs will continue to work to iron out these problems and, as always, help those individuals who encounter problems.



# CHCs ENSURING SERVICE

As in previous years, CHCs have undertaken in addition to their routine workload. Those out they demonstrate the diversity of CHCs' work.

## CHCS AND PROVIDERS - QUALITY ASSURANCE

**Blackburn, Hyndburn and Ribble Valley CHC** has been involved with the local Medical Quality Group in piloting a questionnaire to be freeposted to the CHC, providing ongoing patient feedback on their stay in hospital and highlighting the issues of immediate concern to be acted on as soon as they arise. After two serious incidents, **Hounslow and Spelthorne CHC** liaised with local MENCAP groups to discuss with providers the standards of care given in acute hospitals to people with learning disabilities. This resulted in standard-setting and improved information for professionals, clients and carers.

## ENCOURAGING CONSUMER PARTICIPATION

In order to learn the ideas and concerns of the "normally healthy", **Pontefract and District CHC** operate regular and successful coffee mornings in different parts of the district. The four CHCs in **Gwynedd** combined for a fortnight to have a presence in the foyer of the district hospital, raising public awareness of CHC work and ascertaining views on local health services and issues. **North Bedfordshire CHC** is developing a consumer panel of a few hundred health users to be regularly consulted by the CHC; it is currently attempting to increase working-class and minority ethnic representation on the panel. **Worcester CHC** is piloting small Focus Groups to tap consumers' views on their experience of NHS care; tried and tested in the commercial sector, this is an innovative and potentially rewarding method of increasing consumer participation in the public sector.

## CHCs AND COMMUNITY NETWORKS - LINKS WITH VOLUNTARY GROUPS

**Bolton CHC** worked with the local Council for Voluntary Service to bring together voluntary organisations, users and carers to discuss issues around community care. A successful Information Exchange Day was held; the CHC was particularly encouraged by the level of involvement of users of mental health services, and of a wide range of minority ethnic groups. **Chichester CHC** held a successful open-day for local voluntary organisations, also inviting members of the public to come and discuss their concerns. Local health organisations also took part, and a similar day is planned for later in the year.



# MEET PATIENTS' NEEDS

past year a wide variety of projects and initiatives and below represent only a few of these projects, but look at the multi-faceted nature of their role.

## CHCs AND PURCHASERS

**Haringey CHC** has been involved in determining its community's perception of local health needs, through priority-setting exercises conducted with groups of elderly people. The concerns highlighted were taken on board by the DHA, who have started work on a hospital respite scheme and are considering how best to adapt their transport contract to the needs identified by the CHC exercise. The CHC now plans a similar project regarding women's health needs.

## EMPOWERING USERS

**Bradford CHC** established a paid professional advocacy scheme, financed jointly by the local authority and the DHA, for elderly people and people with learning disabilities. **Merton and Sutton CHC** held a mental health day seminar, mostly attended by users whose confidence as self-advocates was greatly increased by the day.

## INFORMATION

**Wakefield CHC** produced a booklet on hysterectomy "for women by women, in non-medical terminology" which has been well received; a similar booklet on Hormone Replacement Therapy is planned. **Newham CHC** published a comprehensive guide on local services/groups for women, which earned the praise of Health Minister Virginia Bottomley. **Bristol CHC** is to publish a directory of local organisations dealing with the needs of homeless people.

## CHC PROJECTS - SPECIAL HEALTH NEEDS

**Cambridge and Basildon and Thurrock CHCs** investigated the health care of travellers. **Salford CHC**, supported by the DHA, conducted a survey employing in-depth interviews to assess the social care needs of people with AIDS /HIV; it also commenced a long-term project aimed at getting the issue of men's health 'on the agenda'. **Southend CHC**, having had an increased number both of complaints and enquiries regarding women's health issues, organised a highly successful Health Day for Women; topics covered included Hormone Replacement Therapy, AIDS/HIV, smoking and alcohol abuse and women's role as carers.



# The Work of ACHCEW 1991/2

The Association has two general objectives: firstly, to provide information and advisory services to CHCs, to assist CHCs in their work, to promote good practice amongst CHCs, and generally to promote their role and work; and secondly, to represent health service users at national level. Inevitably, the last year has been dominated by the huge changes that have been taking place within the National Health Service and the work of the Association has been geared to assessing the impact of those changes on patients, to supporting CHCs in feeding into and responding to the changes locally, and to ensuring that the role of CHCs is properly recognised at all levels within the NHS. The overall work of the Association is summarised in the sections which follow.

## Membership of the Association

The proportion of CHCs who are members of the Association has continued to increase. At 1 April 1992, there were 211 CHCs in England and Wales and 198 were members of ACHCEW. This represents 93.8%. The trend over the last few years has been as follows:

1986	82%
1987	85%
1988	86%
1989	88%
1990	92%
1991	93%
1992	94%

The actual number of CHCs in membership has fallen slightly but this reflects in part the number of mergers of CHCs that have taken place over the last year or so. A handful of CHCs have given notice of their withdrawal from ACHCEW (primarily for financial reasons) and a number of mergers are still pending.

Clearly, it is important that CHCs are funded by their establishing authority to an adequate level, so as to perform their duties effectively and so as to enable them to subscribe to ACHCEW and make use of the support services available. This is especially important from 1994 onward, when the subscription basis of the Association will change.

Following the 1991 AGM of the Association and the representations made to him during his visit to the AGM, Stephen Dorrell MP (then Parliamentary

Under Secretary of State for Health) wrote to RHA Chairmen in August 1991 on the subject of CHC mergers. This circular - ML(91)2 - made the following points:

- The Department of Health no longer requires RHAs to merge the relevant CHCs if their matching DHAs are merged.
- RHAs should not consider merging CHCs without first consulting the relevant CHCs and "other local community interests".
- RHAs must be satisfied that CHCs are organised to carry out their duty to represent the Health Service interests of the public in their own areas effectively.
- RHAs should consider whether maintaining the existing CHCs would help promote better accountability, local sensitivity and local responsiveness and so outweigh any advantages to be gained from merging.
- RHAs should take the CHCs' views fully into account before taking a final decision on a CHC merger.

ACHCEW's view on CHC mergers is clear. In cases where District Health Authorities merge, it should not automatically follow that the Community Health Councils involved should merge. The first priority of the establishing authority should be to ensure that the local communities involved are effectively represented. This will usually be best achieved by having more than one Community Health Council in the new District, each one covering a manageable local area or a defined community. Such an arrangement would permit more ready access to a CHC office and will allow there to be enough CHC members to cover the population and to have a wide range of local community links. The Community Health Councils that remained in such a District would need to establish effective liaison arrangements with each other, perhaps by means of a Joint Committee, so that their activities in making representations to the new DHA could be coordinated. CHCs should only be merged where it is clear that local communities would be more effectively represented by merged CHCs and where the CHCs concerned agree that this is appropriate.

## The Role of CHCs

A significant part of ACHCEW's work during the year has been to ensure that the proper role of CHCs in the new NHS structure was recognised by



health authorities. At first progress on this was patchy. In the absence of definitive guidance from the Department of Health, the involvement of CHCs seemed to depend on the personalities involved. If the General Manager or Chief Executive lacked confidence and was frightened of independent views from the CHC, the CHC was less likely to be given a proper opportunity to influence purchasing decisions. Whilst many CHCs were fully involved and were able to use their experience and skills to provide a user perspective on purchasing decisions, many were not.

ACHCEW accordingly made considerable efforts to persuade those within the Department of Health, the NHSME, the service itself and, of course, Ministers that more guidance was needed. January 1992 saw the publication of "Local Voices" by the NHSME. The ideas contained in this were extremely important. It stressed, for example, that purchasing authorities must take account of the local community's views not only in terms of needs assessment but at all the other key stages of the purchasing process. Thus the local community should be consulted and fully involved in identifying the health needs of the local population, in establishing priorities, in developing service specifications, and in monitoring services. That recognition and encouragement was extremely welcome.

While the "Local Voices" document was being finalised, other developments were also taking place. Stephen Dorrell MP, the then Parliamentary Under Secretary of State for Health, attended a meeting of the Standing Committee of ACHCEW. His message was to stress the importance of Community Health Councils, as the statutory representative of the patient and the voice of the local community, and the key role CHCs should have in respect of purchasing and in the context of the Patient's Charter.

The Standing Committee urged him to put this in writing. This he duly did, in a letter sent to all Health Authority Chairmen on 14 February 1992 - ML(92) 1- and this letter was followed up by a guidance note signed by Andrew Foster, as

Deputy Chief Executive of the NHSME - EL(92) 11. The key points in these two documents are as follows:

- the purchasing activities of health authorities must be rooted in the needs and wishes of local people.
- a good working relationship with local CHCs is important in this (and presumably health authorities should be expected to strive to achieve this).
- CHCs should focus increasingly on purchasing issues.
- there is a recognition of CHC involvement in individual casework.
- CHCs should have reasonable access to the information on which health authorities base their judgements, and also to the contracts placed by GP fund-holders.
- CHCs should have the opportunity to contribute to the process of:
  - local target setting (in the context of the Health of the Nation document).
  - monitoring performance against the targets set.
  - setting quality standards (as part of the purchasing/contractual process).
  - monitoring performance against standards.
  - assessing relative service priorities.
- health authorities should recognise the role given by Parliament to CHCs and should ensure that the opportunity exists for them to make a proper contribution to the purchasing function. (This means that CHCs should be properly resourced and adequate arrangements should be made for the development of CHC staff).

It is now clear that CHCs should be consulted fully by health authorities on their assessment of the health needs of the local population and on the local health targets to be set. It also means that health authorities should consult CHCs on their general purchasing plans. Thus, there should be proper local dialogue on the balance between hospital and community provision, on the balance and availability of services. Moreover, CHCs should be fully involved in discussions on the standard of service provision being set under the terms of the Patient's Charter and being required of provider units under the terms of service contracts.

Stephen Dorrell also emphasised the role of CHCs in contributing to the process of monitoring services. In practice, this means that CHCs should



be consulted both about purchasing authorities' plans to monitor services but also about the results of that monitoring and the conclusions to be drawn from them. This of course would itself be informed by CHCs' own independent monitoring and visiting activities.

These statements have been welcomed by the Association and provide a clear basis for the developing role of CHCs in the new environment within the NHS.

### **Health News Briefings**

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As usual a number of "Health News Briefings" have been published during the year. These have focussed on the changes within the NHS and have been primarily produced for the information of member CHCs. However, they have also been circulated more widely, as a contribution to debate and discussion on current health topics, and have attracted considerable press and media attention. The principal "Health News Briefings" issued during the year have been:

#### **GP Fund - holding: Profit or Loss for Patients**

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This paper was published in May 1991 and warned that the GP fund - holding scheme might damage the relationship between doctors and their patients. The worry is that patients will not be sure whether what their GP is doing is what is right for the patient or what suits the GP's budget. The paper concluded that strong arrangements for CHCs to monitor the activities of GP fund - holders are needed, given the concerns that exist that GP fund - holders are not properly accountable to the public, that their activities may destabilise the internal market within the NHS, that two - tier standards of service may develop and "expensive" patients may in effect be excluded from GPs' lists.

#### **From "Citizen's Charter" to "Patient's Charter"**

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Following the publication of the Prime Minister's Citizen's Charter in July 1991, the Association submitted detailed proposals as to what might be included in the Patient's Charter. Twenty pages of suggestions were produced and these proposals received the general support of fifteen national

organisations, including the National Association of Citizens' Advice Bureaux, the National Consumer Council, the Family Planning Association, and the National Association for the Welfare of Children in Hospital. Professional groups such as the Institute of Chiropodists, the College of Occupational Therapists and the College of Speech and Language Therapists also indicated that they broadly endorsed ACHCEW's proposals.

The paper put forward a detailed check - list of rights to be included in the Patient's Charter to cover:

- Information for patients
- Access to services
- Choice for patients
- Support for people at home or in hospital
- Consent to treatment
- Privacy, dignity and respect
- Rights for long-stay patients
- NHS complaints

In the event, the Patient's Charter that was finally published in October 1991, was something of a disappointment in that many of the detailed suggestions from the Association were ignored. Nevertheless, the Association has welcomed the Patient's Charter as being an important first step in strengthening the rights of patients within the NHS.

#### **Survey of CHC Relations with NHS Authorities**

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This paper was published in November 1991 and reported on a survey conducted earlier in the year of the extent to which health authorities at that time were involving CHCs in their work. The main finding was that health authorities were becoming more remote and secretive and less accountable to the public. Less than a third of DHAs were reported to be holding meetings in public on a monthly basis and only just over a quarter of FHSAs. Three-quarters of CHCs reported that their local health authorities were holding meetings in private at which items of importance were being discussed and key decisions taken, without the press or public present and without any input from a CHC representative.



## **Well Women Services: a progress report**

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This paper also published in November 1991 reviews the progress and development of well women centres and clinics. It found that many health authorities have been reluctant to fund well women centres and that it is being claimed that clinics being set up by GPs, in response to the cash incentives under their new contract, duplicate such services. However, the report showed that GPs' clinics generally provide only medical screening and fall a long way short of the comprehensive service called for by women, which would include counselling and time to discuss their problems. The report recommended that:

- Health authorities should provide the necessary funding and support for the development of accessible and comprehensive well women services.
- Well women services should be properly publicised, targeting women who are less likely to visit their GP.
- National guidelines (to be monitored by FHSAs) should be developed by the Department of Health, in keeping with ACHCEW's own guidelines, setting out the essential elements of a comprehensive GP well women service going beyond screening and including counselling and support for self-help groups.
- Training should be made available for GPs and practice nurses in counselling skills.

## **"The Health of the Nation": a response**

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In December 1991, the Association responded to the Government's Green Paper, "Health of the Nation", warning that the targets contained in it were not achievable without wide-ranging policies to tackle income inequality and associated ill-health. The response noted that all the latest evidence had demonstrated that the health gap between rich and poor had widened in the 1990s and suggested that the UK should follow the lead of Canada and New Zealand in banning cigarette advertising. It also stressed the importance of full consultation on the health targets that are set at local level and that CHCs and voluntary/self-help groups should be fully involved in this process.

## **CHCs and public health reports**

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This paper was published in January 1992 and looked critically at the extent to which DHAs were looking at the health needs of disadvantaged

groups, pointing out that all too often the statutory report on the health of the local population was being produced without listening to the public's views on their needs and the services that are already available. The report highlighted some examples of health authorities that had consulted local views and had been open to the views of service users.

## **NHS funding 1991/2: The impact on patient services**

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This paper was published in March 1992 and reported on the results of a national survey of CHCs on NHS funding. This indicated that many hospitals and units were under intensive financial pressure and that there had been some significant cut backs in local health services. Concern was also expressed by CHCs about the inappropriate early discharge of patients from hospital, often due to pressure on bed spaces. The survey also showed that the "rationing" of health services is increasingly being used as a method of controlling health spending by DHAs and that a significant number of DHAs had taken decisions (usually without consultation) not to purchase certain "non-essential" treatments.

## **Community Health News**

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"Community Health News" is the newsletter produced by the Association. It is edited for ACHCEW by Nicola Bennett-Jones and is intended to be a mixture of news and comment, plus reports on the major activities of CHCs, publications received, contents of medical journals and conferences and meetings. Although primarily for member CHCs, there are an increasing number of subscriptions from other organisations, the press and those interested. It has been published ten times during the course of the year.

## **Information Service**

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The Information Service maintains a data base 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 CHCs are encouraged to forward reports and surveys to ACHCEW and well over a thousand of these are now held by the Association. This data source is of



increasing interest to academics and other organisations. An annual listing of CHC reports and surveys is published and circulated widely to CHCs and others interested.

Much of the Information Team's time is spent on responding to requests for information and advice from member CHCs. Considerable use is made by member CHCs of this service and the number of enquiries runs at a rate of about 120 per month. Other organisations and academics, some from overseas, also approach ACHCEW for information, particularly about the role and work of CHCs and a standard information package is available.

### **Other Publications and Publicity Material**

ACHCEW's general leaflet "CHCs - Working for a Better Health Service" continues to be widely used by member CHCs to introduce the role and work of CHCs. Funds have recently been obtained from the Department of Health for this to be updated and translated into a variety of community languages. Three publicity posters are also produced to go with this leaflet, together with a poster-sized statement on equal opportunities for display by CHCs.

ACHCEW has also produced a leaflet, in conjunction with the National Consumer Council, on "Patients' Rights". This is available in English, Welsh, Urdu, Bengali, Punjabi, Gujarati, Hindi, Cantonese, Vietnamese, Turkish, Greek, Armenian, and Somali. The leaflet is widely used by CHCs, but also by many other advice organisations. There is a multi-lingual poster promoting this leaflet. Another leaflet, jointly produced with the National Consumer Council, entitled "Dentists: A Guide to Patients' Rights at the Dentist" is also available.

ACHCEW also produces a "Directory of Community Health Councils" and an annual bibliography of CHC publications.

### **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. Over the last year

these have included:

- Draft guidance on the Access to Health Records Act (DoH)
- Draft Code of Practice (Human Embryology and Fertilisation Authority)
- Integrating Primary and Secondary Health Care (DoH)
- The Health of the Nation (DoH)
- Mentally Incapacitated Adults and Decision-Making (Law Commission)
- Draft Code of Practice on the Provision of Mental Health Services (Commission for Racial Equality)
- Introduction of Specialist Titles and a Specialist List (General Dental Council)
- Orthodontic Review Group (DoH)
- Standards of Business Conduct for NHS Staff (NHSME)
- Draft Professional Standards (British Dietetic Association)
- FHSAs: Today's and Tomorrow's Priorities (NHSME)
- Unichem/Macarthy and Lloyds/Macarthy Merger Proposals (Monopolies and Mergers Commission)
- Contracting for Prison Health Services (Prison Medical Service)
- Draft Proposals for new Performance Review Procedures (General Medical Council)
- Arbitration for Medical Negligence in the NHS (DoH)
- The Association also gave written and oral evidence to the House of Commons Health Committee on the subject of Self-Governing Trusts.

In addition, both the Audit Commission and the National Audit Office routinely consult ACHCEW about their respective work programmes and individual studies concerning the NHS.

Individual CHCs have also asked ACHCEW to make representations on their behalf or in respect of issues which concern them. Many such matters have been considered by the Standing Committee and pursued with the DoH or other bodies as appropriate.

### **Seminars and Training**

A special day training seminar for CHC Chairs was organised to assist CHC Chairs to develop their skills and to exchange ideas and experiences.

Further one-day media skills courses are also being organised for CHC members and staff, following



positive feedback from the previous year's series.

Unfortunately, limited resources prevented more training events and seminars being held.

### **External Relations**

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The Association continues to try to create a high public profile for CHCs and for the concerns of patients. Regular contact is maintained with the specialist press, with health correspondents on the national newspapers and with relevant programmes on radio and television. A range of news releases has 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.

ACHCEW is part of the wider consumer movement and good links are maintained with other consumer bodies, in particular with our sister associations of Health Councils in Scotland and Wales. There is frequent contact and joint working with the National Consumer Council, the Patients' Association, the College of Health and the Consumers' Association.

ACHCEW and Action for Victims of Medical Accidents are working together on a major project on the case for a Health Service Inspectorate and a unified complaints system.

There are also good working relationships with a variety of organisations working in the health field. For example, meetings have been held with the General Medical Council, the Audit Commission, the National Audit Office, MENCAP, and the Tomlinson Inquiry. There are also good working links with the National Association of Health Authorities and Trusts, the Association of Directors of Social Services, the Royal Colleges, the Health Education Authority and the various parts of the King's Fund.

Finally, there is regular contact between the Association and the Department of Health and the National Health Service Management Executive. ACHCEW has been pleased to have constructive discussions on several occasions with Mr Stephen

Dorrell MP, Parliamentary Under Secretary of State for Health. Regular discussions take place with the policy division of the Department with responsibility for CHCs and there are increasing links with other parts of the Department.

### **Standing Committee and Working Groups**

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Since the AGM in 1991, 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 ACHCEW staff.

The Officers, together with members of the Standing Committee and Staff, 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 to 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 Standing Committee, whose members are appointed as regional representatives to enable this to happen more effectively. Close links have also been maintained throughout the year with the Society of CHC Staff.



# From the Chair

## Dear Colleagues

Eighteen years ago the concept of independent, unpaid, voluntary, lay member, consumer representation in the NHS, became a reality. This year we celebrate the "Coming of Age" of CHCs. It is a time to briefly reflect on our development to maturity, as independent representatives of the public in the NHS. We have come a long way, in often very difficult circumstances, not least those of recent years. We have a unique expertise in consumer perspectives of health care, due to the close relationships that we have with our local communities. They value the independent help and support that CHCs provide in what to many, is a very confusing world of health care.

It is still too early to properly assess how the NHS reforms are achieving the high aims of improved services to patients stated in the 1989 White Papers. CHCs are monitoring their local services and changes resulting from the reforms. We have been assessing where CHCs are, and should be, in the reformed NHS, and we wish to be involved in any such discussions with the Department and the NHS management.

Last year I referred to our concerns about the effects of the reforms on the role and function of CHCs. Our concern was again relayed to Ministers this year, and they have responded with their view of the position of CHCs in the NHS, in Management and Executive letters. I welcomed the unprecedented visit of Stephen Dorrell, Parliamentary Under Secretary of State for Health, to our December Standing Committee meeting to discuss with us our concerns about some attitudes to CHCs by Health Authorities, Trusts and Fund-holding GPs in the NHS, and the effects of the reforms on our work for which we are inadequately resourced. There is still more clarification needed as a result of the changes initiated by the requirements of the Patient's Charter. We have yet to see how the new information services in the NHS link with the work of CHCs.

ACHCEW was involved in discussions with Department of Health officials and Ministers on the content of the Patient's Charter, our views were based on our own Patient's Charter, produced in 1986. The final Charter includes some of the points that we had made, but has a long way to go to match our own Charter rights and standards. The NHS Charter will provide CHCs with a base for service monitoring locally.

Continuing the work of previous years, we made a strong case for increased funding from the Department. This year, it appears that the value of ACHCEW has been acknowledged, after five years of making a case for our grant to be at least increased



annually in line with inflation, and we have received a welcome increase in grant from the Department. Our grant will change to a subscription base from 1994, and the Officers are considering the implications of this change. We hope that this will reduce the time spent discussing finance with the Department and Ministers, during the year, and that time can be better spent on the many issues that inevitably arise affecting the people whom we serve.

I have welcomed invitations to visit Regional Associations and the Welsh Association, which are very useful and rewarding contacts with staff and members during the year. I have also visited the Association of Scottish Health Councils who have now re-formed their Association after substantial reorganisation and reduced Council numbers, this year. I hope that all of these visits will continue.

I have been pleased to represent ACHCEW with or without other Officers as appropriate, at conferences and at meetings with Ministers, professionals and voluntary organisations.

Finally, I say goodbye to all the colleagues and friends that I have made during my time as a CHC member and since 1986, when I first became involved in ACHCEW, as my terms of service as a CHC member end. I would like to thank everyone who I have worked with, especially our small but committed staff, including those who have left us this year. Special thanks to Toby our Director, without whose talents, ACHCEW would be poorer. My thanks to my fellow officers, Eleanor my Vice Chair and Ross our Hon. Treasurer, whose advice and support have been invaluable. I thank all the members and observers of Standing Committee who have helped with ideas and support throughout the year.

Keep up the good work

Yours Sincerely

**Rita Lewis**

Chair



# Association of Community Health Councils for England and Wales 1991/92

**Chair:** Mrs Rita Lewis (South West Thames Region)  
**Vice Chair:** Ms Eleanor Young (Northern Region)  
**Honorary Treasurer:** Mr. Ross Thomson (North West Region)

## Members of the Standing Committee

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Mrs J Elliot (Northern Region)  
Cllr JB Colebrook (Yorkshire Region)  
Mr John Laurent (Trent Region)  
Mrs Carole Myer (East Anglia Region)  
Mr Colin Barry (North West Thames Region)  
Mrs Maureen Howard (North East Thames Region)  
Mr Glyn Williams (South East Thames Region)  
Mr Arthur Harman (South West Thames Region)  
Dr Heather Wood (Wessex Region)  
Mrs Mary Judge (Oxford Region)  
Mr Allan Storey (South West Region)  
Mrs Margaret Hayes (West Midlands Region)  
Mr Frank Hardwick (Mersey Region)  
Ms Pat Leahy (North West Region)  
Mr Cliff Fenton (Wales)  
Mr M Hughes (Wales)

## Secretary/Chief Officer Observers

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Mr John Godward (Northern, Yorkshire)  
Ms Cath Arnold (Mersey, North West)  
Ms Jackie Gladden (Trent, East Anglia)  
Mr Tom Richardson (Oxford, West Midlands)  
Mr Richard Edwards (North West, North East Thames)  
Mr Graham Girvan (South East, South West Thames)  
Mrs Jacqueline Salter (Wessex, South West)  
Mr Mansel Davey (Wales)

### DoH Observer:

Mr. Alastair Finney

### Society of CHC Staff Observer:

Mr Paddy Conway

## Staff

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Toby Harris - Director  
Chye Choo - Chief Administrative Officer  
Richard Pawson - Information Officer (Health Policy)  
Carole Auchterlonie; Clare Collins (from January 1992) - Research/  
Information Officer  
Lorna Ryan; Angeline Burke (from December 1991) - Development  
Officer  
Anne Hamilton - Secretary to the Director (p/t)  
Estelle Kiss - Administrative Assistant (p/t)  
Rose Walter - Clerical Assistant (p/t)  
Nicola Bennett-Jones - Newsletter Editor (p/t)

There are 211 **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 community to managers of the health service.

The budgets and staffing of CHCs are 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 and other bodies supplement ACHCEW's income.