ASSOCIATION of COMMUNITY HEALTH COUNCILS for ENGLAND and WALES

annual report 1993/4

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ACHCEW
30 Drayton Park
London N5 1PB
Tel: 071 609 8405
Fax: 071 700 1152

CHCs – *on the crest of a wave?*

Over the last four years there has been a huge turn around in the attitudes of both Government Ministers and the NHS Management Executive towards Community Health Councils. In 1990, leaked documents suggested that the Department of Health was considering such a major restriction on the role of CHCs that it was difficult to see how they would be able to function effectively at all.

Since then, the climate has changed. The NHSME published *'Local Voices'*, the then Parliamentary Under Secretary of State wrote to health authority chairmen emphasising the key input that CHCs should make into purchasing decisions, and the publication of the Citizen's Charter and the Patient's Charter ushered in a new era of interest in patient empowerment.

In the last few months, the NHSME has issued new guidance to health authorities and to NHS Trusts which emphasises again the key role that CHCs have in ensuring that the health service is responsive to the needs of its users. At the same time, many CHCs have seen an increase in their resources - both in staffing and in budgeting terms.

In this context, CHCs might have hoped for a period of stability in which to consolidate their position and work on improving further their own performances and standards. However, yet again the spectre of NHS reorganisation looms.

It is, of course, a truism that the NHS is reorganised on average every three years. The major changes of April 1991 with the introduction of the internal market and the purchaser/provider split has now been followed in April 1994 by the reduction in the number of Regional Health Authorities from 14 to 8. Moreover, further legislation is likely in the next session of Parliament which will bring about the abolition of RHAs and legitimise the mergers of DHAs and FHSAs.

In practice, these changes are already taking place de facto in advance of legislation. This means that not only are CHCs having to relate to a very rapidly changing NHS environment, but that their own position is again under review. This arises because of the role of RHAs as the establishing authorities for CHCs in England. If RHAs are to be abolished in April 1996 and if in the intervening period their staffing is set to reduce dramatically, new mechanisms to establish and resource CHCs are urgently needed.

Whatever changes take place must be designed to strengthen CHCs in their role as the advocate of the users of the NHS and must foster their independence from the health authority structure. CHCs have often described in the past the conflicts of interest that have arisen between RHAs in their role in respect of CHCs and RHAs in their wider remit. Moreover, having CHCs established by RHAs and their staff identified as RHA employees, did little to make CHCs appear independent to members of the public seeking independent advice and support.

The opportunity now exists for CHCs to be made fully independent of both purchasers and providers in the NHS market. If the rhetoric of the Citizen's Charter and Patient's Charter means anything, it is an opportunity that must not be missed.

Real patient empowerment means that patients should be encouraged to put forward their views, even if these views may be inconvenient or may fail to fit in with the prevailing orthodoxy. It also means that those views should be listened to, responded to and acted upon. It means creating a partnership between those who provide or purchase services and those who use them.

Properly resourced CHCs, that are not only independent but are seen to be independent of the purchasers and the providers, are an essential part of a process that can enable patients to be empowered. An NHS that is itself healthy, needs its patients to be empowered and therefore it needs the strong independent voice of CHCs.

WHY ARE WE WAITING?

Despite the Patient's Charter, NHS emergency services themselves need urgent attention, according to our survey of CHCs. One hundred and three CHCs replied - exactly half of the total in England and Wales.

CASUALTY DEPARTMENTS

Complaints, concerns

Four out of five CHCs dealt with complaints about their local Casualty department last year - six complaints on average.

A third of the CHCs dealt with complaints about the time patients were kept waiting in Casualty. One CHC refers to delays of up to 12 hours; another to a patient with a cut leg waiting for four hours; a third to elderly people being left for over five hours. CHCs receive complaints about patients being left on trolleys for long periods: up to 55 hours, according to one CHC; over 24 hours, according to another.

There were also many complaints about misdiagnosis and some about poor discharge decisions and about the attitude of staff.

COMPLAINTS DEALT WITH BY CHCs

CHC one

"1. Admitted to A&E, severe stomach pain. Left waiting 3 hrs, decided to go home. Weeks later had to have op.
2. Child had staples inserted in wound, no local anaesthetic."

CHC two

"1. Complainant was not examined thoroughly which necessitated subsequent visits.
2. Complainant attended on 3 occasions, told not miscarrying, then eventually had miscarriage.
3. Length of wait and complainant felt examination should have been more thorough.
4. Treatment in Department by medical/nursing staff.
5. Food for diabetics not available - but has since been put right."

CHC three

"Failure to admit for observation.
Staff attitude - rudeness.
Discharge of vulnerable patients who have been admitted via emergency services. No attempt to contact relatives of vulnerable patients."

Three-quarters of CHCs report their own concern about the state of affairs. Again, this often relates to delays in people being helped but CHCs are also concerned about the skill levels of the NHS staff available in Casualty departments.

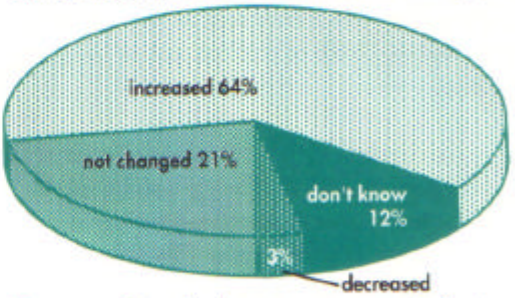
Waiting...

The Patient's Charter promised that Health Authorities would start publishing local standards for waiting times in Casualty "from 1 April 1992". So it is surprising that even in early 1994, 31 per cent of CHCs said that their Health Authority had not set out Local Charter Standards. Not all those that were set look very impressive: standard maximum waits for non-urgent cases of two or three hours are common and one CHC even reports a maximum of four hours.

Part of the problem is that the workload of Casualty departments continues to rise: two-thirds of CHCs report an increase over the last year whereas just three per cent report lower numbers. Many CHCs cannot explain this increase or refer to the national trend.Others point to improved facilities at the Casualty department which have attracted patients and 14 CHCs mention closures elsewhere. Some point to particular causes of accidents - for example, gun-related crime, traffic accidents... and the opening of an ice rink.

WORKLOAD

In the last year, has the workload of the casualty ...



However, Casualty departments are striving to meet the national Patient's Charter standard that patients coming in will be seen "immediately" and their need for treatment assessed. 17 per cent of CHCs report that their Casualty department understands this to mean that patients should be assessed straight away while another 69 per cent of CHCs report that the standard is understood to require assessment within five minutes. Four-fifths of CHCs report that the assessment will be made by a specific "triage nurse" while a further one in ten respondents say an "other nurse" will assess.

Staff

We also asked about the availability of other specialist staff. Over half the CHCs say that staff are always or usually available who have been trained in bereavement counselling but it is worrying that three out of ten say these staff are only available sometimes or not at all. Over a third of CHCs say staff are always or usually available who can speak the first languages of the main ethnic minorities in the district; nearly half say this is sometimes or never the case. Only a quarter of CHCs report that nurse practitioners - performing tasks otherwise left to doctors - are always or usually available and over a third say nurse practitioners are never present in Casualty.

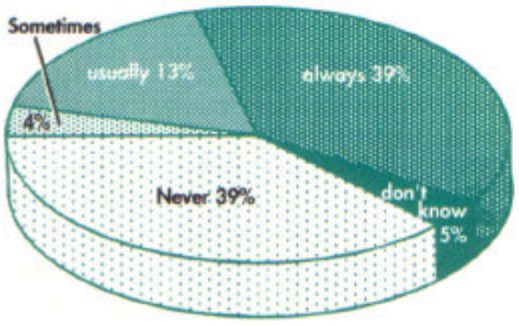
On the other hand, great progress has been made in recent years on the appointment of full-time A&E consultants - just five per cent of CHCs say their Casualty department does not have a consultant and a third report more than one (although even that does not guarantee that a consultant will be available around the clock). Also, four-fifths of CHCs say the department has a 'crash' team for cardiac arrests available 24 hours a day.

Facilities

Two out of every five CHCs have to report that their Casualty department does not have dedicated beds continually available. Only one in ten CHCs says that the number of dedicated beds is always sufficient. Half the respondents say patients can normally be X-rayed promptly and another third say this is always the case. Half the CHCs report that CT scanners are available (a third say not). Two-thirds of CHCs say their Casualty department include more than two consulting rooms where patients can be seen in private. Nearly all report more than two consulting cubicles.

BEDS

Does the Dept. have dedicated beds available 24hrs?



EMERGENCY AMBULANCE SERVICE

Generally, CHCs and the people they help have fewer complaints about the operation of the emergency ambulance service.

Half the CHCs report they did not deal with any complaints about the emergency ambulance service last year and those who did dealt with less than three complaints on average. A third report their own concern about aspects of the service.

The main problem area is the time it can take ambulances to reach the site of an emergency. One in five CHCs report that their local ambulance service has been failing to meet the national standards. These state that the ambulance should reach the patient within 8 minutes for at least 50 per cent of all emergency calls; and within 14 or 19 minutes in urban and rural areas respectively for at least 95 per cent of calls.

The closure of ambulance stations is causing concern. It can mean that ambulances have further to travel and that ambulance crews are less likely to know the best way to get to a specific address. One in five CHCs report that a reduction in the number of ambulance stations since 1990 has led to longer waits for some local people. Other CHCs report that ambulance stations have been closed without this leading to longer waits. 34 Community Health Councils - 40 per cent of those answering this part of our questionnaire - say that ambulance stations in their area have either closed or are now at risk of closure.

CONCLUSION

In the nature of things, patients and CHCs are bound to be particularly worried about the speed of emergency services. The Government is trying to meet these concerns through the laying down of Patient's Charter standards. However, the survey shows that these efforts are being hampered by other trends - the continuing increase in attendances at Casualty departments and the closure of both Casualty departments and ambulance stations.

DOCTOR, DOCTOR...

It is important that GPs and patients establish good relations if care and treatment are to be effective. Our survey shows clearly that a number of obstacles can prevent the building of such relations. A total of 96 CHCs, almost half of those in England and Wales, responded to the survey.

THE PATIENT/GP RELATIONSHIP

Changing GP

It can be in the interests of the patient and the GP if a patient decides to change GP, and the Primary Care Charter states that patients have a right to *'change doctor easily and quickly'*. However, almost three-quarters of CHCs said that patients experience problems either frequently or sometimes when wishing to change GP.

Removals from GP lists

Under the Terms of Service *'A doctor may have any person removed from his list'*. On the whole, any such removals from GP lists reflect the breakdown of the patient/GP relationship. CHCs were asked how many patients, in 1993, were removed from the lists of GPs in their district. In parts of Manchester more than 1,700 patients were removed from GP lists against their wishes. It was specifically stated that this figure excludes, for example, patients who were removed by reason of death, people who had moved to another area and those who changed doctor voluntarily. Overall, responses to this question show that somewhere in the region of 30,000 patients were removed. Even though it is not clear how many of *these* include voluntary removals (for example change of address), these are not inconsiderable numbers.

CHCs, as part of their statutory role of monitoring health services, would like to be able to analyse the figures for removals so that any trends could be identified. However, two factors prevent them from doing so. The first is that 92% do not, on a regular basis, receive information about removals from their FHSA, and the second is that GPs, since 1990, are not obliged to state their reasons for removals.

The fact that in 1993 over three-quarters of CHCs received complaints from patients about being removed from GP lists illustrates the extent of the problem and suggests that if the problems are to be solved there is a need for information to be collected and analysed. This Association has in the past argued that it would be in the interests of both patients and GPs if reasons for removals were given. Patients would also be expected to give their reasons for changing GP.

Of the CHCs who gave details about the type of complaints they received the main areas of concern were that few patients are given a reason for being removed; there appear to be many instances where people are removed because they complain about a GP; and in some cases people are removed from lists because they have problems associated with a mental illness.

More than half of CHCs reported that patients who had been removed from a list subsequently experienced problems in finding another GP. Again the people who had difficulty in finding another GP seemed to fall into specific groups. These included people with a mental illness; so-called 'difficult' patients; and elderly people. One CHC noted that *'Some GPs' perception of patients who have been removed from lists is that they must be troublemakers'* whilst another noted that difficulty *'applies particularly to older people with chronic conditions'*. In some areas 'difficult' patients often need the assistance of the FHSA to find a GP and frequently end up being passed from one GP to another. Difficulties with finding a GP can be exacerbated in rural areas where choice is already severely limited. One CHC knew of a particular family who were disadvantaged because they had been allocated a GP 8 miles away from their home.

Home visits

Many doctors feel that patients request home visits inappropriately and would like to see an end to their commitment to 24 hour cover. This, coupled with the fact that between 1983 and 1993 the number of night visits made by GPs more than doubled[1] (resulting in increased costs to the NHS), has led to discussions between the Dep–

partment of Health and the General Medical Services Committee to look at how the present arrangements can be changed.

With the current levels of dissatisfaction in mind CHCs were asked if they were aware of any problems with GPs refusing to or being reluctant to make 'legitimate' home visits. Although it is difficult, in this context, to establish the precise meaning of 'legitimate' more than half of the respondents said that they were aware of problems. One CHC said that the complaints were too numerous to list, and another said that approximately 80% of complaints to the CHC were about refusals to make home visits. A number of the responses indicated that a failure to make home visits can have serious, even fatal consequences and has been the subject of formal complaints: *'GP gave telephone advice re. stronger painkillers for young man with severe headache later admitted with meningitis. Medical Service Committee hearing found him in breach of contract'.*

Out of hours services

GPs employ a number of methods of providing 24-hour cover for their patients. CHCs were asked whether arrangements in their districts were satisfactory. They were more or less evenly divided with some praising arrangements and some expressing concern. *'Deputising service is generally staffed by GP principals...who do a good job in covering for one another'.* One CHC referred to *'Concerns over the use of deputising service...Concern includes GP not knowing patient, no access to records, lack of information...'.* Fewer than one in six CHCs have been involved with the FHSA in setting the criteria for the use of deputising services.

Availability/Access

77% of CHCs stated that patients are usually able to see a woman GP if they choose. Taken at face value this response is encouraging but it should be noted that there are still a considerable number of practices who do not have a woman GP. In 1991 only 27% of GPs in England were women[2]. Obviously this will curtail patients' choice.

CHCs were asked whether they consider physical access to surgeries – particularly for people with disabilities and people with pushchairs – to be good, average or poor. The majority of CHCs considered access to be average with 14% stating that access is generally poor.

Changes to the GP contract encouraged practices to set up and run health promotion clinics. It has been reported that these clinics tend to be concentrated in more affluent areas. This, however, was not the general experience of CHCs, although 18% of respondents confirmed such a trend.

RELATIONS BETWEEN CHCs AND GPs

Even though CHCs do not have a statutory role in relation to GPs they were asked a series of questions about relationships between themselves and GPs in their district.

CHCs are keen to develop relationships with GPs and in some instances they have done so successfully -*'Two separate practices used CHC survey and assistance to gain views of patients on quality of service received'.* For others, unfortunately, this is not the case. One CHC stated *'Because of our involvement with Service Committee hearings some GPs are reluctant to develop relationships with the CHC'.*

Over half of CHCs have arrangements to visit surgeries in their district. However, these arrangements vary from joint visits with their FHSA to visits by invitation only. In one district a fundholding practice objected to the CHC visiting with the FHSA so the CHC is now no longer able to visit.

Although it was encouraging to learn that 68% of respondents said that GPs displayed information about CHCs in their surgeries only one in three CHCs are involved with patient satisfaction initiatives run by GPs.

CONCLUSION

Perhaps the main conclusion to be drawn from this survey is that there is much to be gained by improving the dialogue between patients and GPs and between GPs and CHCs.

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1 Hansard (House of Commons), 2 November 1993.
2 Health & Personal Social Statics for England (HMSO). 1992 Edition.

WITH RESPECT ...?

CHCs look at the standards of privacy and dignity afforded to patients, compared to those which are promised.

Patients are told that they can expect that their privacy, dignity and cultural beliefs will be respected at all times when receiving NHS care and treatment. The results of this survey, based on the views of around half the CHCs in England and Wales, show how seriously these issues are being taken.

According to past monitoring visits, more than three quarters of the CHCs responding felt that the overall standards in their major general hospital were satisfactory, and one third believed that suitable measures were being taken to ensure that privacy is maintained at **all times** in the hospital.

However, these initially encouraging findings are marred by all-too-frequent tales of where a patient's right to personal dignity seems to be left at the hospital doors: *"The X-Ray Dept is a corridor between the main entrance, and the A&E and outpatients departments. Patients have to sit here in nightclothes to wait for X-Rays to be carried out"*

MEETING PATIENTS' NEEDS

Although information about privacy and dignity whilst in hospital was made available to 74% of patients as part of the initial admissions procedure, in less than a third of cases was this available in languages other than English. CHCs were in no doubt that patients who had special requirements (such as those with particular religious or cultural beliefs) were encouraged to make these known on admission but, as a high proportion of these will not speak English as their first language, it cannot be certain that the message is getting across to those for whom it is intended.

MEALS

In almost every hospital, meals were available where necessary to suit special dietary requirements. This nearly always includes the provision of vegetarian meals (although one CHC commented that 'vegetarian' can mean in some cases existing meals minus meat/fish!) but patients who do not read English are unlikely to have access to a menu in any other language or in pictorial form (only 23% and 11% of hospitals, respectively, provided this service). Religious preparations such as Halal and Kosher food were most common, being available in over three quarters of cases.

HOSPITAL FACILITIES

The structural limitations and layout of old hospital buildings were frequently cited as the greatest difficulties in achieving an acceptable level of privacy - particularly where curtains are used to partition cubicles in A&E and outpatient departments. Several CHCs pointed out that clinics are rarely held in purpose-built areas and older buildings are notoriously difficult and/or expensive to adapt. On wards, problems can be exacerbated by the close proximity of beds - sometimes 6 or 8 in a single bay. *"We have tried to promote the idea of ward surgeries rather than ward rounds. The problem is staff assume if patients want privacy they will ask for it. We believe privacy should be offered not requested."*

This is not to say that these problems cannot be largely overcome through staff familiarity with and sensitivity to their environment, eg doors should be closed and curtains fully drawn, conversations about certain topics avoided in semi-public areas. This latter point applies particularly to reception areas which, by their nature, are the most difficult places to ensure privacy is maintained.

Private rooms are made freely available in 69% of hospitals to enable patients to have confidential discussions either with relatives/friends or staff. These rooms are of course essential not only for social reasons but also for counselling purposes. In some cases, although an increasing number of nursing staff are qualified counsellors, their efforts are hampered by the lack of 'quiet rooms' available. (See Fig. 1)

A QUESTION OF CHOICE

The question of the appropriateness of mixed sex wards continues to be hotly debated throughout the health service although it seems that patients are often given no choice in the matter. A similar situation exists for children who may be plac-

ed on adult wards in two thirds of the hospitals quoted in the survey. Although this seems to be a more common occurence with older children and adolescents, in some areas - such as intensive care wards -it can apply to children of all ages. (See Fig.2)

CHCs report an even greater problem faced by patients wishing to see a doctor of the same sex: this seems to be a luxury granted to less than one in ten, which is surprising even when compared to the ratio of male to female consultants (approximately 6:1).

CHCs are unaware of any patients who have no access to a hospital chaplain if required, but it was felt that non-Christian faiths were often not catered for. In some cases information packs explaining more about the spiritual and cultural needs of different patients had been developed in conjunction with the CHC and these were available on each ward. In Waltham Forest last year the country's first 'co-ordinator for non-Christian faiths' was appointed by the local Trust... could this be the shape of things to come?

DEVELOPING STANDARDS

Although most hospitals provide some sort of staff training looking at privacy and dignity issues, this is often not directed to those who could most benefit from it: *"A consultant organises induction courses for new medical staff which includes showing respect to patients and ensuring dignity and privacy. Unfortunately there are no similar courses for 'die hard' consultants and this is recognised as a problem".*

Where in-hospital monitoring of standards is carried out this is usually part of a wider patient satisfaction survey, although careful examination of complaints and returns on charter standards are other methods used respectively by providers and purchasers. Although relatively few (38%) have been involved in the development of privacy/dignity standards, most CHCs monitor these standards as part of their routine visiting programme. Salient points are then brought to the attention of staff and management on a regular basis.

LONG-TERM CARE

It is perhaps in the nature of long-term care that difficulties of privacy and dignity are different to those experienced in general hospital care. Problems are sometimes inherent more in the day-to-day routine which is followed or in staff attitudes, than they are in physical restraints of the building. (See Fig. 3)

Fig.1 PRIVACY IN HOSPITAL

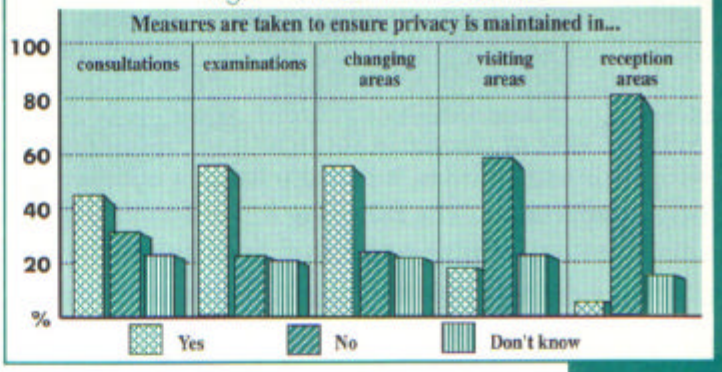


Fig.2 PATIENT CHOICE

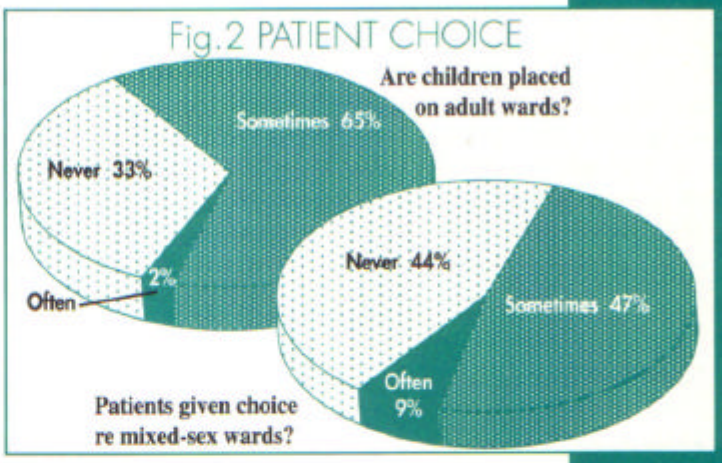
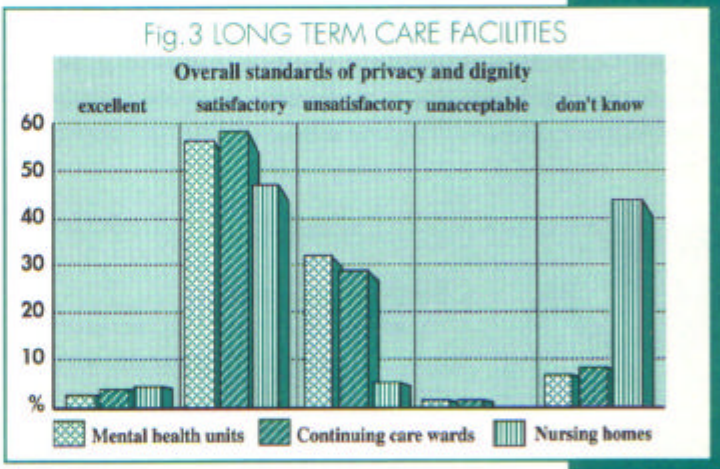


Fig.3 LONG TERM CARE FACILITIES



Advocacy services are still only just beginning to be introduced for some residents of mental health units; around 60% now have access to them (this is twice the figure which CHCs reported would have access to advocacy services if they were on continuing care wards). A little over half of these residents could expect a lockable facility for their personal belongings and about two thirds had access to a 'quiet area' at all times.

"Several years ago we had to insist on the doors to toilet cubicles being put back on - little upsets happen from time-to-time, that's why the CHC visit."

MAKING

Another year of change in the health service has not only kept CHCs busy with their usual duties, it has also led to a number of innovative projects being undertaken. The following direct quotes from CHCs give an idea of the sort of initiatives with which they have involved over the last 12 months.

CASTING A WIDE NET

Wigan & Leigh

"...last year I was contacted by two couples whose children had suffered an adverse reaction to the MMR vaccine. A quick press release led to over 30 members of the public contacting the CHC. It was then agreed to organise a public meeting with a panel to look at a number of issues...Publicity reached the national media and [we] received a high number of phone calls/letters...from all over the UK. The public meeting was attended by a solicitor who had dealt with vaccine damaged children, the Specialist in Community Medicine, a local MP and a parent of a child who had reacted to the MMR. Over 130 people attended the meeting which really focused on three issues: (1) The secrecy surrounding the manufacture of drugs and the lobbying system employed by the pharmaceutical industry. (2) The issue of legal aid to fight compensation cases. (3) The need to set up a support group."

North East Essex

"North East Essex have employed a [p/t] Liaison Worker for one year to assist a community group looking at care in the community. This group...was formed following a town council meeting when interested parties were invited to discuss community care issues. The aim is to look at the provision of services from the view of the community. The chief problem established by the working party is not the lack of services, but the lack of information about what services exist and how to obtain them. They are compiling a list for publication and have supported the local surgery's application for GP Care Advisor, to provide advice at the surgery level."

TURNING THE

South Buckinghamshi

"A GP practice commis one 60 patients random improvements. Outcom need for] privacy to dis achieving small but pra

Brighton

"A working group surv put in a comprehensive need for more access t

Anglesey/Ynys Mon

"The four CHCs in Gw local strategy for healt questionnaire...and a g being considered for de which had drawn up th qualitative data was co and Local Authorities."

Riverside

"Riverside has a very a as challenging authori we try to work construc

FLOATING IDEAS

Southport & Formby

"Southport & Formby CHC initiated and funded a joint survey of the health & social care needs of Formb aged 65 and over, in partnership with the Health Studies Department & the Social Sciences Department of University College...It comprised 4 phases: 1) Fieldwork; 2) Postal Questionnaire; 3) Focus Groups; 4) Se tured interviews and case studies. Quarter of a population of 30,000 was targeted and we achieved a respo than 72 per cent making it a very authoritative study...The findings & recommendations, based on discussi local people & professional health & social care workers in both the statutory & voluntary sectors are bei working document by Sefton Health Authorities and Sefton Social Services who intend to use them when p purchasing for 94/95 & beyond. A very successful...piece of research that will be used!!"

Oxfordshire

"CHC has been commissioned jointly by DHA/FHSA/SS to study views of users & carers on care manage assessment processes & outcomes following implementation of **Caring for People.** *Long-term study...with RHA for project worker, expenses etc...The work arises from concern that current monitoring arrangemen primarily on internal systems, not on the impact of those systems on services to people."*

Scunthorpe

"Scunthorpe CHC was approached by the two local purchasers to comment on their joint report **Barriers Screening Amongst Women who have Never Had a Smear.** *This original report was compiled from the r survey of 143 local women. To make a reasoned judgement, the CHC decided to take the findings & recon out into the community to gather even more views & to target those groups of women who failed to respon original purchaser survey... The CHC used a variety of methods to obtain feedback from the public, inclu uting 650 leaflets and 500 posters (in 4 languages) to individuals & organisations..& using the local medi response received complemented the original findings & recommendations while adding other useful idea cerns which the purchasers of cervical smears in the area could use for the benefit of the local p*

G WAVES

TIDE

e

sioned the CHC to undertake a survey of their patients' views of the services provided. CHC members undertook to interview one-to-ly selected - across [a wide] age & sex range. Then a general discussion took place with patients contributing and suggesting e: the surgery was able to move a partition which irritated everyone, one receptionist was clearly identified as being unpleasant, [the uss ailments at reception [was] addressed. This was a good exercise as patients actually felt they had been able to play a part in ctical changes for their community."

yed counselling available around pregnancy/birth by talking to parents and voluntary organisations. The information gained was report and has proved instrumental in creating a part-time counselling post in the Special Care Baby Unit and in acknowledging the counselling services."

nedd (Aberconwy, Arfon/Dwyfor, Meirionnydd and Anglesey/Ynys Mon) worked jointly to gather the public's views on the Gwynedd . A survey was carried out involving over 50 CHC members and staff and 619 interviews conducted by means of a id system to measure agreement and disagreement with a number of issues. The public's view of 11 of the most expensive services velopment by the Purchasing Authorities plus another 6 topics, were tested. Overall, the public agreed with the views of the panels options. These panels represented health professionals, CHCs, voluntary groups and service users. In addition, a great deal of lected...These will be used to further inform and influence quality and service delivery with both Purchasers and Providers in Health

tive Race & Health Working Group...We have been developing a visiting protocol for health & race visits to NHS premises. As well ies about eg ethnic monitoring, advice to Trusts, encouraging complaints from people from black and ethnic minority communities, tively advising various willing bods (& unwilling bods)."

y residents Edgehill ni-struc- se of more ons with g used as a lanning

nent & £20k from ts focus

o Cervical sults of a mendations l to the ling distrib- . The good & con- opulation."

CHARTING THE WAY

Hillingdon CHC

"One-Stop Health Shop: This proposal...is aimed to open in July '94. The shop will be in Hayes High Street and a CHC 'outreach' worker and 2 HA staff will be based there. The 'outreach' person will be able to speak at least one Asian language...as this area has a high proportion of Hindus and ethnic minority population. The scheme is funded by Hillingdon Health Agency and Social Services will provide a wide range of information to the public on health, housing, education and social services issues. It will host seasonal and topical health promotion campaigns and also provide a base for local voluntary organisations to hold surgeries. The CHC staff will also offer assistance with complaints at this shop. It will be opened at regular publicised hours and it is intended that it will be physically welcoming...encouraging people to drop-in as part of their day-to-day activities."

Pontefract & District

"CHC needed to move to better, more accessible premises. We took the opportunity to contract with the DHA at Wakefield to provide health information in Pontefract and develop local voices for the DHA to listen to. Through negotiation we obtained resources from the DHA to get us good town centre premises, 3 extra staff and a further amount of general overheads.. . We opened in June 1993 under the title Pontefract & District Community Health Council, ' The Health Information & Advice Centre'."

South East Staffordshire

"In conjunction with PREMIER HEALTH Trust, the establishment of a "Saturday Service" - a young person's health service covering all aspects of sexual health - held at CHC office; medic and nurse staffed. CHC issues condoms on weekdays."

The WORK of ACHCEW

THE ROLE AND POSITION OF CHCs

Much of 1993 was spent waiting for the promised NHSME guidance on the work of CHCs. There was no formal opportunity for CHCs or for ACHCEW to comment on the draft guidance which was frustrating for CHCs who were aware that the draft was circulating widely within the NHS.

Finally, however, the guidance was issued as EL(94)4 on 25 January 1994 under the title *"The Operation of Community Health Councils"*. It has been broadly welcomed by CHCs, even though it does not clarify all the issues which CHCs would have liked to have seen addressed.

The guidance sets out clearly a number of expectations of purchasers and providers(in particular NHS Trusts) in relation to CHCs. It also clarifies the role of RHAs as the establishing authorities for CHCs in England. It recognises virtually for the first time the role of CHCs in complaints work and also acknowledges that CHCs are finding themselves involved in community care issues which interact with local authority social services.

The guidance makes clear that CHCs should be involved in the following key phases of the purchasing process:

- *needs assessment and priority setting within purchasing plans;*
- *strategy underlying decisions on the placing of contracts;*
- *the development of quality standards within contracts;*
- *monitoring services in coordination with health authorities;*
- *matching the services planned to the cultural, religious and other aspects of the health needs of the community.*

In addition, CHCs should be involved in the development of standards and goals set under the Patient's Charter and in monitoring Patient's Charter activity.

The guidance also spells out that NHS Trusts should:

- *recognise the statutory role of CHCs in representing the interests of the public;*
- *agree with CHCs arrangements for liaison, access and monitoring;*
- *consult CHCs on their Strategic Directions or Summary Business Plans;*
- *invite CHCs to give advice or support when Trusts are planning how to establish patients' views;*
- *involve CHCs in their arrangements for monitoring complaints.*

At the same time, the guidance is explicit about the role of RHAs in their capacity as the establishing authority for CHCs. It says that RHAs should:

- *properly resource CHCs to carry out their work (this includes the provision of accessible accommodation, and appropriate staffing and equipment);*
- *ensure that CHCs are able adequately to reflect the views of the communities they serve;*
- *ensure that CHC chairs and members are properly supported (and this should include flexible training opportunities);*
- *ensure that CHC staff have access to appropriate training courses;*
- *consult and involve CHCs as independent local providers of information and advice to patients and the public;*
- *ensure that relevant databases and other information are made available to CHCs to support them in their information and advice role.*

There is now also an expectation that regions should require CHCs to develop and publish their own annual plans and to discuss the progress and resourcing of these with individual CHCs.

This clarification of the RHA role is, of course, helpful, but has been overshadowed by the Secretary of State's publication of her proposals in

ASSOCIATION of COMMUNITY HEALTH COUNCILS for ENGLAND and WALES

1993/4

There are 206 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 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 centered 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 of 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.

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