# CHC NEWS

**A newsletter for community health council members and staff**

## Hungry in hospital

There has been a great deal of reaction to the publication of ACHCEW's report, *Hungry in Hospital*, which concluded that there is a real problem of some patients not eating enough food during their hospital stay. The report said that in some hospitals no one is taking responsibility for ensuring that patients are eating or investigating why some patients are not eating and drinking.

The initial response from the Department of Health was not particularly helpful. A spokesman said: "Any suggestion that patients are being starved to death in NHS hospitals is an insult to the thousands of nurses, doctors and hospital staff who provide first class care. ... The NHS complaints system enables patients to highlight shortcomings."

However, ACHCEW has received numerous phone calls, the overwhelming majority of them supporting the report's conclusions. Many have phoned to give their own examples of people not being given enough help with eating while in hospital.

A number of newspaper articles appeared on the topic after the report was published and the director of the Relative's Association wrote to *The Times* to back up ACHCEW's claims. When interviewed, representatives of the Royal College of Nursing shared ACHCEW's concerns about some patients not being given sufficient help to eat.

All of this puts pressure on the Government to respond to ACHCEW's calls for action, which included a recommendation that the Department of Health, with the involvement of professional and patients' groups, should ensure that the roles and responsibilities of staff at meal times are clearly defined.

## For your diary

The NHS is celebrating its 50th birthday next year – on 5 July. It seems a long way off, but as with all events that need organisation, it will be on us sooner than we think. A national steering group is co-ordinating national events and support local initiatives.

NHS staff are being asked to think of events which they can stage locally which will act both as a celebration and at the same time contribute to the purpose of the NHS.

The steering group can provide resource materials – including fact sheets, ideas for events, a history of the NHS, artwork for the anniversary logo and other background materials. For copies, contact NHS 50, Communications Unit, NHS Executive, Quarry House, Quarry Hill, Leeds, LS2 7UE.

To get on to the 50th Anniversary mailing list, phone 0113 2546035.

*ISSUE 8, MARCH 1997*

## In this issue:



ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES
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# Mental health services

## Patient's Charter

The NHS Executive has produced a booklet with a mix of new, improved and existing Charter rights and standards for mental health services. As usual, the booklet describes the distinction between "rights" and "expectations", although it notes that the Mental Health Act may be used to override certain "rights". For example, you may have no right to refuse treatment.

The booklet is accompanied by an Executive Letter. The first new standard the letter mentions is related to "explanation on diagnosis". You might have expected the Charter to contain something like "You have a right to be given a clear diagnosis". But, no, what you actually find is "You can *expect to be able to ask* for an explanation of your diagnosis in plain language ..." [our italics]. Well thank you. Many of the new standards are more useful than this, but they all have the status of expectations: the only "new" Charter rights were already rights under the Mental Health Act.

Copies of the Charter and the accompanying Executive Letter (EL(97)1) have been sent to CHCs.

## London service in crisis

London's mental health services are near to collapse, and in a much worse situation than other parts of the country. This is the finding of a report from the King's Fund (*London's Mental Health*, £15). The report found that rates for psychosis in inner London are double those for other inner cities. As a result, there are more acts of violence, more compulsory detentions and higher rates of admission in London. Another result is that patients who are not psychotic or have not been compulsorily detailed are less likely to get an acute bed than in other parts of the country. The average wait for admission to a secure unit is 24 hours.

A report in *The Independent* gives a picture of just what these pressures mean for a team of 20 mental health workers battling to provide care to a caseload of 1700. It takes only a little calculation to realise how thinly the service must be spread.

*Independent, 22 January*

## Electro-convulsive therapy

The mental health services Patient's Charter points out that people can be treated compulsorily under the Mental Health Act. One of the treatments given can be electro-convulsive therapy (ECT). The issue of ECT tends to polarise opinion. But even those who support ECT recognise that improvements are needed to services. A recent audit of ECT clinics in England and Wales suggests 70% of clinics fail to meet the standards recommended by the RCP in 1995. Of 53 clinics surveyed, 16 were rated as good by the RCP criteria, 26 as deficient in some areas of practice and 11 as poor.

*RCP report of its Winter Meeting, Guardian, 21 January*

**Some facts on ECT** (compiled by *The Guardian*)

- About 2000 people a year receive ECT under the Mental Health Act.
- About 100,000 treatments are given every year to 20,000 people in the UK.
- Two-thirds of people given ECT are women.
- Over half the people given ECT compulsorily are women aged over 50.
- Contrasting treatment rates:
  - in Oxford 126 per 100,000 people
  - in Cardiff 420 per 100,000 people.

## Joint working for emergency services

The ambulance and fire services in North Derbyshire are considering joint working as a way of overcoming financial pressures. The chief executives of Derbyshire County Council and the Derbyshire Ambulance Service Trust have raised the possibility of merging control facilities and sharing stations, saying that closer co-operation could bring major benefits to patients. However, it is also understood that the ambulance service is considering reducing its number of ambulance stations from 15 to five, which could be relocated to fire stations. Officially, both services are talking of co-operation rather than mergers – soon after a controversy was stirred up over reports of a merger plan between the two services in London.

*Health Service Journal, 6 February*

## Rude awakenings

Ten patients in a teaching hospital in Bristol were woken up one night in January and told to go home – between 10 p.m. on a Sunday and 1 a.m. on Monday! Some were collected by friends and relatives, but others had to go home alone by taxi.

One woman, who had been admitted on the Sunday with chronic asthma, bronchitis and fluid on the lung had been told she would remain in hospital until the middle of the week. She said that the nurses were very upset about having to send her home the same night. A hospital spokesman said that the crisis had been caused by a large number of Accident & Emergency admissions, but that only begs the question of why hospitals should be running so close to full capacity.

*Daily Telegraph, 9 January*

## Fundholding: not always a bed of roses

Fundholders who have overspent their budgets in the south east of England are asking for treatment of their patients to be delayed, according to *The Times*. Documents obtained by the newspaper from a London hospital show that 191 fundholding GPs covering 350,000 patients have asked for help in dealing with their financial problems. One practice has asked the hospital not to admit any patients until the new financial year. Another has asked that **no routine cases should be admitted until they had been on the waiting list for 11 months**: this would achieve waiting list targets while at the same time put off payment for as long as possible.

The National Association of Fundholding Practices found two years ago that a quarter of fundholding practices had overspent or made no savings. The association said that the problem has become worse as budgets have tightened.

*Times, 21 January*

## Kent leads the way on home care privatisation

Kent County Council is set to privatise its home care services for elderly and disabled people in an attempt to save money. The council has been advised by the analysts Laing & Buisson that it could buy 30% more care if it privatised home help and other domiciliary services. The saving could be made mainly because staff would be paid less.

The move to privatise services will almost certainly be followed more widely if the Conservative Party wins the forthcoming general election. Government ministers would like local authorities to become mainly purchasing departments, providing only a few specialist services directly.

Kent is also considering raising home care services by up to 400%. This, too, reflects a more general trend. Only 7% of local authorities still provide free care, compared to 17% two years ago, according to a survey reported in the *Labour Research* magazine. Almost two-thirds of local authorities have a minimum charge even for people on benefits. The highest minimum charge is £5 an hour in Bury. There are also systems for maximum charges, with enormous variations. The highest maximum charge is £320 a week in Surrey (but 60% of users in the county receive free care).

Government funding for local authorities is based on the assumption that councils will recoup 10% of the cost of home care services. If they do not do so, they must find the money elsewhere in their budgets.

*Times, 7 January; Guardian, 20 January*

## Mixed sex wards to go

Health authorities and NHS trusts have been told that they must scrap mixed sex wards, with exceptions for A&E and intensive care. Single sex bays within mixed wards are to be allowed. Health authorities have been told to put a programme of work in place which will:

- ensure good standards of privacy and dignity for hospital patients
- achieve the Patient's Charter standard for segregated washing and toilet facilities
- provide safe facilities for patients in hospital who are mentally ill which safeguard their privacy and dignity.

Health authorities and trusts are to agree targets for delivering the required changes, and are to inform regional offices of their intentions by 28 February 1997. The Executive Letter setting out the requirements (EL(97)3) has been has been copied to CHCs.


## How does your manifesto propose to ...?

In the run up to the General Election, two organisations have produced leaflets on the policies which affect public health. Though different in style, the two leaflets identify many of the same issues. One, from the Faculty of Public Health Medicine, invites readers to ask politicians a series of questions on what measures their party manifestos propose in relation to public health. The other leaflet, from the Public Health Alliance and *Health Matters* magazine, sets out factors which produce inequalities in health and asks political parties to formulate policies which will reduce these inequalities.

# USER INVOLVEMENT

**Community Service Users as Consultants and Trainers**
*Department of Health*

**Encouraging User Involvement in Commissioning**
A resource for commissioners
*Department of Health*

**Consultation Counts**
Guidelines for service purchasers and users and carers
*Department of Health*

**Working Together**
A guide and strategy for involving local people in planning health and social services for adults and their carers
*Produced by Salford CHC with NHS and social services agencies in Salford*

**Consumer Involvement in the Audit Activities of the Royal Colleges and other Professional Bodies**
*College of Health*

We have received a batch of booklets on user involvement. In their different ways, they all discuss the aims of involvement, highlight good practice, identify barriers and present the inevitable checklists. Since their messages overlap – and no-one would want to read all five – we hope that these brief descriptions will help you to decide which ones are relevant to you.

➤ ***Community Service Users as Consultants and Trainers*** results from the work of the National User Involvement Project (NUIP) which was run by disabled people, people with learning difficulties and mental health system survivors. It provides detailed advice on user involvement in purchasing, though the lessons could also be applied to service provision. It contains a host of practical advice on topics ranging from meeting local organisations to acceptable levels of consultancy fees.

➤ ***Encouraging User Involvement in Commissioning*** is also based on projects set up by the NUIP. The first section advises commissioners on the issues which they should clarify before embarking on a user involvement initiative. The second section identifies the advantages and disadvantages of various methods of user involvement and the third section provides a series of checklists.

➤ The National User and Carer Group was formed to provide feedback and information to the Department of Health on the implementation of community care legislation. ***Consultation Counts*** is based on the group's experiences of consultation. A section for service providers deals with what users and carers have said about consultation, about when and how to consult and about who should be consulted. A section aimed at users and carers discusses how to become involved, involvement as an individual and as a group, and running a consultation process.

➤ In Salford a strategy has been developed with the aim of involving users, carers and local people in the planning and provision of services. A Joint Development Group is being set up to make sure that involvement happens and works. Over half its membership will be drawn from users, carers and local people – other members will come from various health and social care agencies, including the CHC. ***Working Together*** sets out the context of the strategy and guidelines for involvement. One of its main aims is to be a clear statement about what is involved in a true partnership in joint planning.

➤ ***Consumer Involvement in Audit Activities*** is rather different from the other documents in that it presents findings from a survey of consumer involvement with 21 royal colleges and professional bodies. As a result, it gets down to the nitty-gritty of consumer involvement in practice, and particularly of the workings of patient liaison groups (for example systems for selection, recruitment and representation). A key theme to emerge was that patient liaison groups must not become mere talking shops: it is not enough to have a few committed individuals within professional bodies – those bodies must also overcome organisational obstacles that prevent the groups from influencing practice.

Contrasting views on patient liaison groups ...

"I do not feel a part of the college, but an isolated group."

"I can tell you with certainty that our comments are passed on to outside bodies and taken into account internally."

## Problems with independent review

**Working Hard to Please**
NHS Trust Federation; phone: 0171 240 7997
**Are You Being Heard?** Society of CHC Staff

The Society of CHC Staff and the NHS Trust Federation have both carried out six-month reviews of the complaints procedures. Many of their findings overlap, although some of their interpretations differ.

Both found that the **Local Resolution** stage in most trusts was working fairly well. The Society of CHC staff noted an improved attitude among trust staff towards complainants. However CHCs were very unhappy about the Local Resolution stage with GPs. Many complainants were put off from making a complaint once they heard that they had to return to the practice involved in the complaint. A major concern was the inability of health authorities effectively to monitor complaints about family health services. These comments conflict sharply with the views of GPs reported in the *Doctor* magazine (see below).

Both the Society of CHC staff and the NHS Trust Federation noted problems with **Independent Review.** Among trusts with direct experience of this stage only 29% were satisfied with it, many citing problems with costs, the time demands on convenors, time limits and inadequacy of training. CHCs noted a wide variation in how this stage is handled between trusts. They also noted specific problems with access to reviews, obtaining assessors, reimbursement of expenses for complainants and access of lay panel members to a complainant's medical records.

Both found that some complainants did not perceive the review panel as being independent. CHCs expressed concern about the influence of trust or health authority staff over convenors, while the Trust Federation notes that many convenors felt a conflict of interest. The Trust Federation suggests two options to overcome this problem:

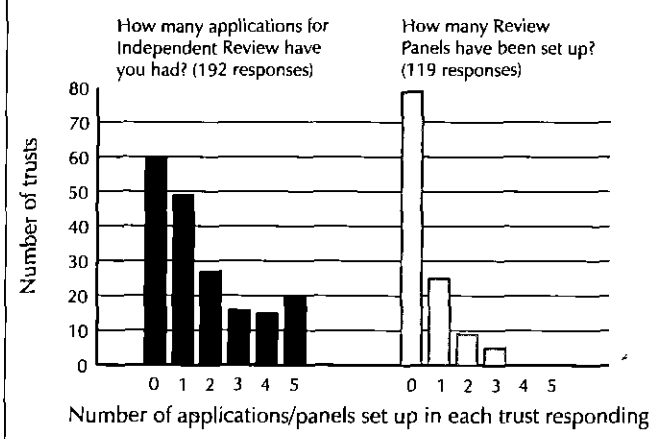
- make it clear that independent investigation happens only when the NHS Ombudsman investigates; or
- give the role of convenor to a third, independent panel member and not a trust board director.

## New Ombudsman

Michael Buckley became the new NHS Ombudsman in January, when Sir William Reid retired from the post.

**Independent Review Panels at NHS Trusts**

*Source: "Working Hard to Please" NHS Trust Federation, November 1996*




## Complainants' experiences in Leeds

Leeds CHC sent a questionnaire to all 92 people who had enquired about a complaint in the first five months of the new procedures and who had left contact details.

- Responses were received from 44.
- Eleven had not gone on to make a complaint, most of them because they "did not think it would do any good".
- While 14 were satisfied with the outcome of their complaint, 15 were not.
- Eleven people who were dissatisfied did not go on further: four of them said that they hadn't been told that they could.
- Four of the five requests for an Independent Review have already been accepted.
- Several respondents praised the CHC, although three who did not pursue a complaint said that they had needed more help and support.

## GP perceptions

The Local Medical Committees in Buckinghamshire and Berkshire are to set up training for lay and medical complaints assessors who are involved in running the Independent Review stage of the complaints procedure. The secretary to the two committees, Dr Eric Rose, said that training was needed because official guidance is too flexible. It seems that GPs have been unhappy when a complaint has been upheld because a medical assessor has said that a GP should have carried out some particular task, even when most GPs would not have done so either.

According to the *Doctor* magazine, the new NHS Ombudsman has said that GPs are running practice-based procedures effectively, but that lay convenors on review panels have been making arbitrary decisions.

*Doctor 6 February*

## How to work with your doctor

The Patients' Liaison Group of the Royal College of General Practitioners has produced five leaflets on using primary health care services:

- How the family doctor service works
- You and your GP during the day
- You and your GP at night and weekends
- Coping with minor ailments
- Getting the most from your pharmacist

Although the leaflets ask patients not to make unnecessary demands on primary services, the tone is not dismissive of patients' worries. The leaflet on out-of-hours care, for example, lists signs which may indicate that emergency care is needed and a checklist of signs to help parents decide how ill a baby is. It emphasises, particularly in the case of babies, that people should ring for advice if they are worried. The leaflets explain how the system works, outline patients' rights and suggest things that patients may do for themselves.

Available free from the NHS Health Literature Line: 0800 555 777.

## Breaking Bad News

> "His words were 'Prepare yourself for the worst, I think it's a tumour' ... It was only when I went to see my mum that I said 'Does that mean it's cancer?'"

This report from the King's Fund describes a project which developed guidelines on how patients should be told that they have cancer: the "bad news" interview is a crucial part of patients' experience of cancer. Although many senior doctors are sceptical about courses in communications skills – "You can either do it or you can't" – the report concludes that consultants should insist that junior medical staff should take such training and that basic guidelines for planning and organising the "bad news" interview can help.

The project involved patients and doctors in drawing up guidelines which can be audited – for example on providing individualised written information at the end of an interview. (The guidelines are available separately from the King's Fund.) The report discusses the pros and cons of setting up a joint working group. There were clear advantages, though the authors conclude that the use of a professional facilitator was vital to enable the patient representatives overcome the "comfortable camaraderie" of the professionals.

Available from BEBC; phone: 0800 262 260; £6.95

## Finding out about NHS continuing care

Faced with discharge from hospital, patients with long-term care needs, and their families, need information on local eligibility criteria for NHS care, on discharge procedures, on local authority provision and on independent review procedures. Researchers from the National Consumer Council had considerable difficulties in getting the information they needed in some areas, despite the fact that they knew what they were asking for, were persistent and were not seeking information at a time of family crisis.

This useful publication surveys the information available in 15 health authority areas in England. It found examples of good practice as well as examples of inaccuracy, incompleteness and lack of clarity. CHCs should find the "good practice guidelines" for various documents helpful in monitoring local information provision: these cover core health authority policy documents; short policy documents for informing the public; information about hospital discharge and information about review procedures.

The publication also calls on the NHS Executive to set out criteria for judging how well health authority investment in continuing care matches local needs, to monitor the accuracy of information provided and to ensure that GP fundholders are held fully accountable for their role in continuing care.

Available from NCC Publications, 20 Grosvenor Gardens, London SW1W 0DH; £12.

## HEALTH RESOURCE CENTRE

The Department of Health has allocated £600,000 over three years for a new Health Resource Centre to be run by the Help for Health Trust. Money for patient information must, of course, be welcome, but equally CHCs can only wonder what they could have achieved with such a grant.

The purpose of the Resource Centre is to:

- provide an advice service for the NHS and patient groups seeking or producing patient information;
- maintain and update a database of good quality information about health services, service delivery, and treatment choices and outcomes;
- develop, disseminate and encourage good practice and guidance about the production of patient information;
- support the production and dissemination of relevant good quality patient information;
- build links with and between producers of patient information.

# AROUND THE CHCs

## CHC demands enquiry

Cornwall CHC has threatened to use its statutory powers to conduct an investigation into Treliske Hospital in Truro if the hospital does not hold its own inquiry into a series of mistakes. Treliske Hospital is the one where, over a period of just two years, a hypodermic needle was left inside a baby after it broke off during tests, a nurse performed part of an appendix operation for which she had received no formal training, and a 76 year old man suffered burns when fluid ignited on an operating table. The CHC has said that a review is needed, if only to enhance public confidence. The hospital has repeatedly refused to hold its own inquiry. The CHC Chief Officer, Geoff Poxon, is to meet the hospital's Chief Executive and Chairman over the issue.

## Persuading health authorities to consult

Brent CHC, working together with three other CHCs, has successfully challenged plans to transfer three mental health units from Horton in Surrey to Park Royal in Brent.

The decision had originally been made by the three health authorities involved, without any consultation with users or the local community. The health authorities have now backed down from their original plans and favour a new option of siting the units in St Bernard's in Ealing. However, the CHCs still believe that at least one of the units should be sited in central London, so as to be nearer to users' homes. The four CHCs persuaded the health authorities to set up an independent review into whether the three units need to be transferred to one site. As a result of the review, Kensington, Chelsea & Westminster Health Authority has agreed to look at whether one of the units should move to a central London hospital.

## Mobilising local interest

Brent CHC has had great success in opening up its meetings to the public. The CHC had found that when it advertised CHC meetings in the usual way, members of the public were understandably fed up at having to sit through an hour of the routine business before more interesting topics were discussed. Although the whole of the CHC Business Meeting remains open to all, the CHC now advertises only the "juicy bit" at the end. After completing the routine business, there is a short break and a livelier debate follows at the advertised time. The CHC sends its newsletter drawing attention to the meetings to about 400 voluntary organisations.

The success of this approach was demonstrated when over 100 people attended a meeting in January to listen to a panel of national experts in providing community support to young black men in distress – an issue which is to form a major part of the CHC's work in the coming year. The meeting heard of the need to show cultural understanding and use talking treatments for mental distress rather than relying solely on diagnoses of schizophrenia and treatment by restraint. The panel linked the over-representation of young black men in secure accommodation with stereotyping, racism and poverty. Such was the interest in the discussion that the meeting carried on for two hours beyond the pre-arranged programme.

## Let us have your reactions

The *Health Service Journal* has recently been publishing letters about CHCs in reaction to the ***Insight*** report. One from a former CHC member (6 February) is particularly outspoken. With a low opinion of the "intellectual standards" within CHCs, Paul Craig believes they simply could not manage to work with health authorities on strategic planning issues. And he regards the suggestion that CHCs should be involved in the decision-making of GP commissioning groups as "fatuous". We are sure that some readers of this newsletter would want to react to these comments – or more generally to the proposals in the ***Insight*** report. Please write and tell us what you think, for publication in *CHC News*.

## Could your CHC help stop children smoking?

*From the Tobacco Control Alliance*

This country is facing a teenage smoking crisis. Today more children smoke than ever before: one in four 11-15 year olds can be called a regular smoker.

*Cashing in on Children Smoking* is a blueprint for action supported by over 60 national organisations. It advocates the use of the £108 million generated by illegal sales of tobacco to children on initiatives to tackle teenage smoking. The measures proposed include a ban on tobacco advertising and sponsorship, stamping out illegal sales to children and the establishment of a foundation to provide community-based support for people who want to give up smoking.

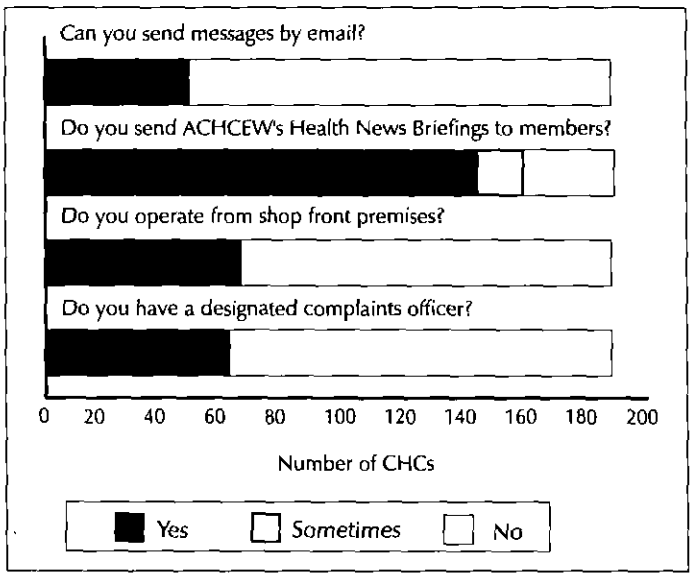
Helping isn't difficult:

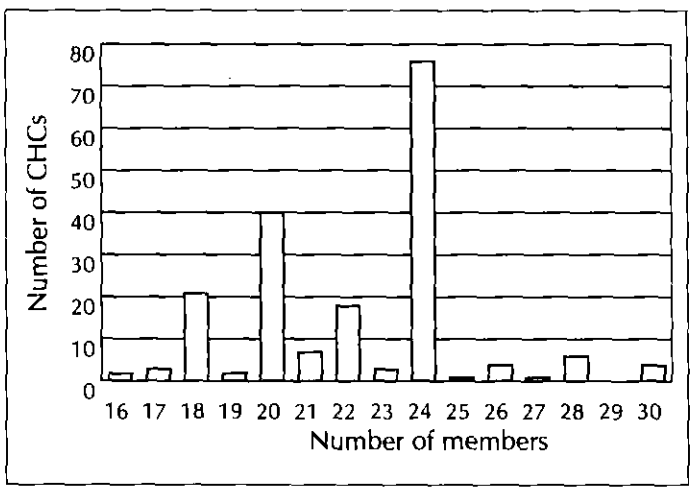
- Write to your local MP and ask for his/her views on current strategies to tackle teenage smoking.
- Put the issue on the agenda of your next CHC meeting. Invite local providers and purchasers to tell you what they are doing to tackle teenage smoking.

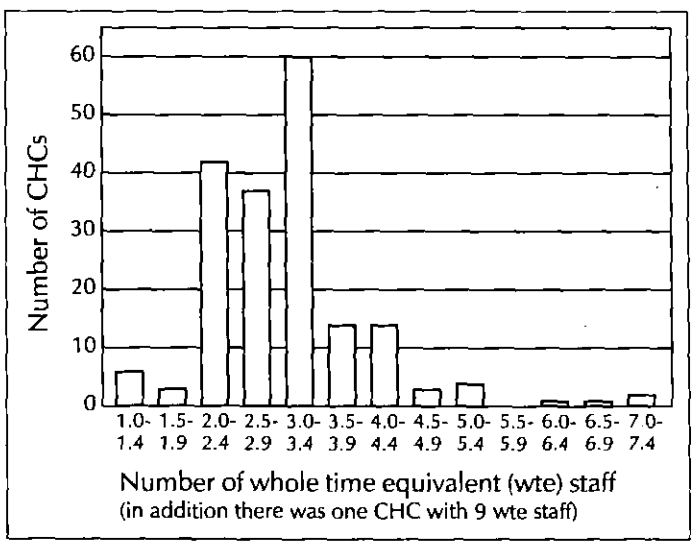
For further information about the campaign, please contact Jane Cooper, Devon House, 12-15 Dartmouth Street, London SW1H 9BL

## How does your CHC compare?

Last year ACHCEW conducted a survey of member CHCs. We received responses from 189 CHCs – 92% of ACHCEW membership. The graphs below illustrate some of the findings.




## *Out of hours services*

Doctors at two GP practices in South Devon come out rather well from a survey on out of hours care conducted by Torbay & District CHC. Of 295 respondents, 66 had asked for at least one out of hours visit during the last two years. Four had received advice over the phone (one found this unsatisfactory) and two had been asked to go to an out of hours service (neither was satisfied with this). Most patients were visited by their own doctor or by a doctor from their usual surgery. Patients were asked to tick check boxes on the attitude of the doctor. The positive categories ("polite", "reassuring", "concerned", "informative") received a total of 127 ticks, compared to just seven for "impatient" and "dismissive" and none for "rude". Over half of the visits were made within 30 minutes of the patient's call.

Asked about possible improvements to the service, many patients said that none were needed. However, a number suggested that the visiting doctor should have access to the patient's medical records. There were also calls for evening and weekend surgeries.

## *Sexual health and young people*

The publication of this report is timely given the fuss that broke out in February over sex education. The NHS Centre for Reviews and Dissemination has recommended that children should learn more about contraceptives and that they should receive some sex education in primary school. There were instant objections from some politicians. Lady Olga Maitland declared that young girls need to be protected, and health ministers tried to distance themselves from the recommendations.

The gap between the politicians and researchers is reflected in the gap between parents and health professionals which emerges in the Southport & Formby CHC report. Whereas professionals felt that some sex education should start with 9-10 year olds, parents thought that sex education should start at 13. They felt that young people were "bombarded with too much information about sex" and that sex should be talked about in the context of loving relationships. If the barriers to talking about sex were not so great, all involved might recognise their common ground. Young people criticised sex education for being too biological, and not dealing enough with relationships – much the same criticism as that from the parents. A way forward may be possible: both parents and young people thought that parents should be more involved in school sex education programmes.

The report also covers: knowledge of and attitudes towards services; information/advice on sexual health and contraception; and sexuality and relationships.