CHC NEWS

A newsletter for community health council members and staff

NHS funding

Extra cash this year

The government has announced an extra £300m for the NHS across the UK, of which £30m is to be found from efficiency savings with the rest coming from the Ministry of Defence and the Department of Trade and Industry.

The health secretary, Frank Dobson, has insisted that the money should not be seen as a short-term cash injection, but is about modernising the NHS for the long-term. The government wants it to be spent on:

- helping hospitals to provide better cover for periods of high demand
- reducing delays in discharge by improving after care services
- reducing the need for hospital admission by improving primary and community services.

Guardian 15 October, DoH Press Release 14 October

Health authorities in the red

Before the above announcement, the BMA had been warning with increasing urgency about the financial crisis facing health authorities. The *BMA News Review conducted a survey of all 120 health authorities in the* UK. Of the 84 which responded, 17 English HAs already have deficits totalling just over £45m. A further seven English and Welsh HAs expect to be in deficit by the end of 1997/98, while 16 English HAs are expecting to cut services in order to balance the 1997/98 books. Proposals for cut-backs include halting or delaying elective surgery, closing wards or units, deferring new developments and cutting GP fundholder budgets. In some cases the cutbacks have already begun. For example, Merton, Sutton & Wandsworth Health Authority, which has a deficit of £9.6m, has stopped all elective surgery at St Helier Hospital, leading to the closure of a 30 bed surgical ward.

Both the BMA and the NHS Confederation estimate that the NHS needs £1bn of extra funding a year to maintain its services. What it is getting is £300m this year and a promise of £1.2bn for next year.

BMA News Review September

Flying a kite

There was a flurry in the media when it was reported that the BMA was considering charges on patients or more private health insurance. In fact the Association's view is that the financial needs of the NHS are best met through public funding. It seems that the BMA wanted to attract attention to the financial crisis in the NHS and to get across to government ministers that "that they have painted themselves into a ludicrously tight corner" by saying that they would not raise income tax. The press reports came a week before the release of a BMA report *Options for Funding Health Care,* which outlines possible sources of revenue in addition to general taxation. These included charges to visit a GP (ranging from £2.50 to £10), hotel charges for hospitals (£40 to £80), increasing uptake of private insurance, and social insurance. The report details problems associated with each option. Approving the document, the BMA reiterated its commitment to funding the NHS solely from general taxation and called for an urgent £500 cash injection. This was before the announcement of the extra £300m on 14 October.

Guardian 3 October, BMA News Review October, BMJ 11 October

In this issue:

ISSUE 15, NOVEMBER 1997

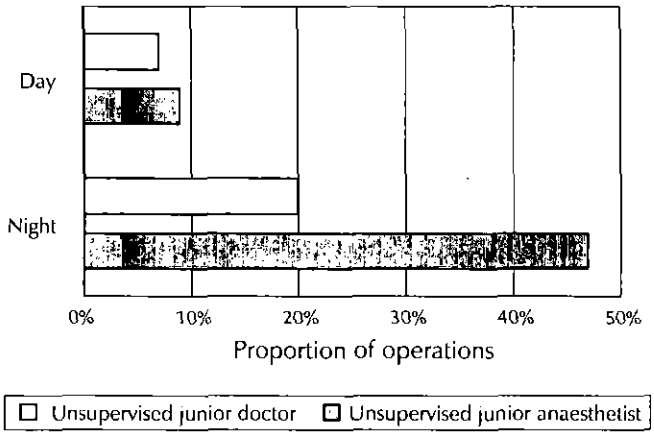
ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES
Earlsmead House, 30 Drayton Park, London N5 1PB. Phone: 0171 609 8405 Fax: 0171 700 1152

Unsupervised junior doctors

A fifth of operations which take place at night are carried out by unsupervised junior doctors according to a survey carried out by the National Confidential Enquiry into Perioperative Deaths – and even more junior anaesthetists are unsupervised (see graph). The survey into about 52,000 operations at 355 NHS hospitals found that 6% of operations take place between 6.30 p.m. and midnight and 1% take place between midnight and 8.00 a.m. Although most of these are classed as emergency operations, the survey team concludes that some of these "emergency operations" could in fact have been carried out during the daytime had facilities been available.

Unsupervised staff at NHS operations

Source: Guardian 1 October 1997



Review of the Patient's Charter

The health secretary, Frank Dobson, has appointed Greg Dyke, former head of London Weekend Television and now chief executive of Pearson TV, to oversee the drawing up of a new Patient's Charter. The new charter, which is to be in place by July 1998 to mark the 50th anniversary of the NHS, is to place more emphasis on the quality of NHS care rather than easily measured administrative details. Frank Dobson has also stressed the responsibilities of patients, claiming that the expectations created by the present Patient's Charter have been partially responsible for an increase in violence against staff.

ACHCEW has welcomed the announcement that the Patient's Charter is to be reviewed and would like it to incorporate the points set out in ACHCEW's Patients' Agenda. It has also called for patient representatives to be included on the panel which will draw up the new Patient's Charter and for full consultation on any proposals and changes.

ACHCEW, Daily Telegraph/Guardian 9 October

Charter for the Third Age

The *Observer* newpaper has set up a campaign *Dignity on the Ward* to work for improved care of elderly people in hospital. It started the campaign after it was contacted by charities and relatives' groups which wanted to comment on a report in the paper that an 88 year old woman had been forced to go without a drink for 10 days in Bath Royal United Hospital after suffering a stroke. The *Observer* has since compiled a dossier of complaints on the ill treatment of elderly people on hospital wards. It has published a 10-point charter aimed at restoring respect for elderly people in hospital.

For more information, contact Dignity on the Ward, The Observer, 119 Farringdon Road, London EC1R 3ER.

Life and death decisions

The Royal College of Paediatrics and Child Health has issued guidance to doctors on coming to decisions about whether to withdraw treatment from children who are expected to die without such treatment. The guidelines stress that decisions should be made jointly by doctors, nurses, parents and, where possible, by the child. The guidelines, which took almost three years to draw up and involved extensive consultation, are not legally enforceable.

Five situations are identified in which it might be appropriate to let children die:

- where a child is certified as brain dead
- where a child is in a permanent vegetative state
- where there is "no chance" – treatment would delay death but not ease suffering from a very severe disease
- where there is "no purpose" – survival is possible, but with such a degree of physical or mental impairment that it is unreasonable to expect the child to bear it
- in an "unbearable situation" – in which the child or the family feels that in the face of a progressive and irreversible illness, the child cannot bear further treatment.

Anti-euthanasia and anti-abortion groups have claimed that the guidelines promote euthanasia, the national chairman of Life saying "It appears there is nasty fascism lurking in the document". A member of the committee which drew up the report has responded that whereas pro-life groups put an absolute value on life, this has never been a principle of medical ethics – "Doctors do not struggle to prolong life against the interests of the patient".

Sunday Telegraph 21 September, Guardian/Independent 25 September

NEWS

Taking whistle-blowers seriously

Two different cases have recently raised much the same questions about how the NHS responds to concerns raised about clinical standards.

Two surgeons and the former chief executive (also a doctor) of the United Bristol Healthcare NHS Trust are facing a GMC disciplinary hearing. It is alleged that they continued to carry out (or allow) heart surgery on children despite warnings from other doctors that the death rate was higher than it should be and even after a report commissioned by the Department of Health recommended that the unit suspend such operations.

The other case concerns cervical cytology at the Kent & Canterbury Hospital. Again, worries had been raised over a period of years, and again both clinicians and managers failed to act. Some 1800 women were wrongly told that their smears were clear, and 5 have since died. The enquiry report criticises staff at all levels. A copy has been sent to the GMC for consideration of the actions of doctors. In response to the report's recommendations, the health minister Baroness Jay has said that the goverment "will take very seriously" calls for managers to be made professionally accountable in a way similar to clinicians.

Independent 10 October, Radio 4 news 20 October

COMPLAINTS

The reality doesn't match the rhetoric

Thirty-four CHCs helped in this *Which?* survey (September 1997) by sending a questionnaire to 1469 patients who had approached them about making a complaint. 40 questionnaires were distributed by other means. 542 people responded, of whom 491 had actually made a complaint.

Satisfaction

- About 300 respondents were dissatisfied with the outcome of their complaint.
- Under a quarter of those who went to a **complaints manager** were satisfied with the investigation. However...
- 80% of those who went to a **lay conciliator** were satisfied with how their complaint was handled by the conciliator.
- Those who were told what action had been taken following a complaint were more likely to be satisfied.

Information and explanations

- Over half (of 300 who answered the question) weren't told either that they could contact a CHC for help or that they could direct their complaint to a complaints manager.
- Of those dissatisfied with the outcome, over half were not told that they could request an independent review.
- Over 70% received a written response outlining the outcome of the complaint, but ...
- Only 30% got an explanation of what had gone wrong, and ...
- Only 20% knew what practical steps had been taken to prevent the same thing happening again.

CHCs

- A majority said that they would have found it more difficult to complain without the CHC.

***Which?* says ...**
"We would like to see CHCs given more power in providing help with NHS grievances."

NHS Complaints Procedures: the first year, National Consumer Council

£8, phone: 0171 730 3469

This report is based on meetings and conversations with staff from CHCs and voluntary organisations, complaints managers and conveners, panel chairs and practitioners and their representatives. It notes some hopeful signs of how the system is working, for example the perception that staff in NHS trusts are putting more effort than before into resolving complaints. However, there are problem areas, which will be familiar to CHCs. There is room here to mention only two of these problems and the associated recommendations.

Researchers were told by CHCs and others that many patients feel unable to take up a complaint with the practice at the local resolution stage, and some fear a come-back, such as being struck of the GP's list.

- **Recommendation:** The DoH and practices should clarify and publicise complainants' right of access to health authority complaints managers where they feel they are unable to use the usual procedures for local resolution.

It was found that although some GP practices are trying to get the system right, they did not have sufficient skills and were making quite serious mistakes in complaints handling.

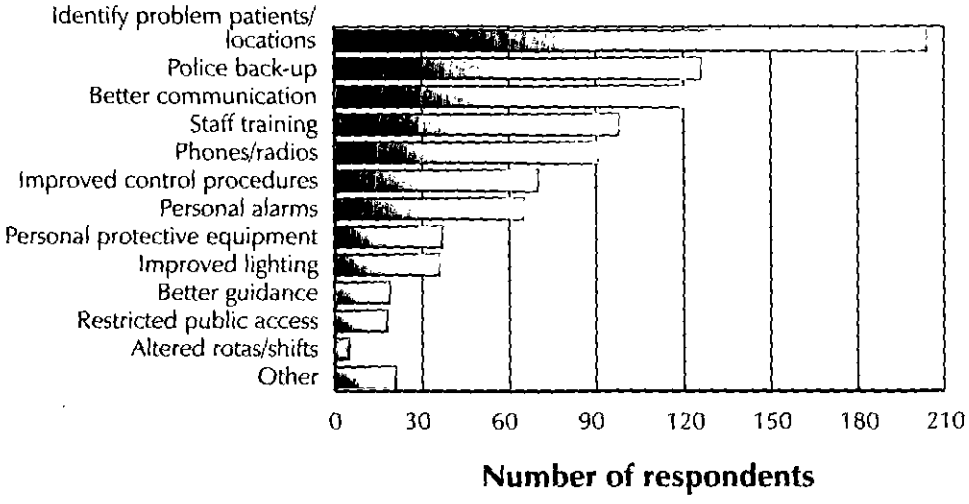
- **Recommendation:** The DoH should work with family practitioners, health authorities and health consumer organisations to identify ways of monitoring the procedures and outcomes of local resolution among family practitioners.

Violence against ambulance staff

Earlier this year, Westcountry Ambulance Services Trust surveyed its staff's experience of violence at work. It found that half of the ambulance staff responding had been physically assaulted in the past three years (10% needed medical assistance) and 58% seriously threatened. Yet managers had asked fewer than 10% about the causes of the incident or how to prevent a recurrence. The graph on the right shows the suggestions staff chose from a list of preventive measures which they thought would protect them from violence in the future.

Measures that would protect staff and their colleagues from future violence (Total number of respondents = 311)

Source: Health Service Journal, 4 September 1997



Framing the Debate: The Impact of Crime on Public Health

Public Health Alliance, £12.50, phone: 0121 643 7628

There is a great deal of public debate on crime and a great deal of public debate on health provision – but there is remarkably little debate about the links between crime, the fear of crime and public health. Compartmentalised administrative structures do little to help in drawing the links.

This carefully researched report used a variety of methods to "examine the soup". It presents findings from a postal questionnaire, interviews, focus groups and a questionnaire used in GP waiting rooms. The findings on the direct health impact of crime, the impact of the fear of crime and the adjustments people have made to their lives in response to crime make interesting, if depressing, reading. The heightened effects among people from ethnic minority groups and among women are particularly striking. However, the effects did not, contrary to popular belief, appear to vary much with age.

Through the report, the Public Health Alliance aims to promote an informed discussion on these issues with a view to practical action. However, it has identified a lack of reliable data on which to base a debate. Among its recommendations are calls for substantive research on the public health, social and financial costs of crime.

COMPLEMENTARY MEDICINE

In the 1997 ACHCEW conference a motion on developing alternative and complementary therapy within the NHS was remitted to Standing Committee for further consideration. Standing Committee has identified three key issues in relation to such therapies: evaluation, regulation and availability.

An article in October's *Health Which?* on the safety of complementary medicine focuses on risks, regulation and evaluation. Although a high proportion of people who use complementary medicine are satisfied, there are various risks: allergic reactions, poisonous herbs, injury, infection and psychological damage. There are, of course, risks associated with conventional medicine, but in the case of complementary therapies the law sets no minimum levels of training and there is no official reporting system for side-effects.

Health Which? recommends that therapists' professional bodies should:

- set minimum training standards
- have a code of practice
- have a complaints handling procedure
- have a disciplinary procedure
- insist that members have professional indemnity insurance.

Subscribers to *Health Which?* can get a free factsheet detailing what therapists must do to join each major professional body from freephone 0800 252100.

Improving communication between doctors and patients

Royal College of Physicians of London
Phone: 0171 935 1175

This report was prompted by an awareness that communication between doctors and patients is often far from perfect. It outlines reasons for this, both on the side of the doctor and of the patient.

Many of the recommendations are concerned with the teaching of communication skills: although training has improved since 1981, when only 30% of medical schools taught communication skills, many schools still do not teach the subject throughout the clinical course. The report refers to evidence that the teaching of communication skills has a significant and long-lasting effect on how well doctors communicate and advises on the content and running of such courses.

There is a brief consideration of how doctors should handle complaints, which, among other things, advises doctors to be sympathetic and to give full explanations. It warns them not to allow their hackles to rise and not to assume that a complainant is motivated by malice.

Dr who?

> "The chances of getting information about where to get your car booked in for specialist repair are considerably greater than those of finding the right specialist for your body."

GPs and patients are repeatedly told that people with certain conditions, such as breast cancer, should be treated by specialist surgeons. Yet information about individual surgeons is jealously guarded. An article by Marianne Rigge, director of the College of Health, details her experiences of trying to get hold of information on consultants: names, training, qualifications, special interests and waiting times. This is, after all, information which the *Code of Practice on Openness in the NHS* says should be made available on request. In reality, it is hard to come by. When Ms Rigge asked for the information, from half the trusts she contacted she received no information at all. From the others she received anything from a sheet of A4 to a glossy brochure aimed at fundholding GPs.

Ms Rigge has found that patients who want to know about a surgeon are expected to wait until a consultation and then ask the surgeon how many operations of the type in question s/he does a year and what the complication rate is. In a make-believe world perhaps!

GPs don't necessarily fare much better than patients – one explained that he had to address some referral letters to "Dear Dr" since he cannot get information about the consultants who work in a nearby teaching hospital. To another GP, this wasn't a problem because "one gets to know one's consultant colleagues on the golf course and that sort of thing".

CHCs in Wales can at least get information on waiting times by individual consultants in Wales on the Internet (http://www.open.gov.uk/hmis/waitime.htm). The information on waits for outpatient appointments, time on waiting lists for inpatient and day case treatment and total waits from referral to treatment is incomplete, but it is a step in the right direction.

Health Service Journal 11 September

Examples of lay involvement in research and development

Sandy Oliver and Phyll Buchanan, EPI Centre, Social Science Research Unit, London University Institute of Education, phone: 0171 612 6393

In April 1996 the NHS Central R&D Committee set up a Standing Advisory Group on Consumer Involvement. The Group set up a project to describe lay involvement in health care research, both within the NHS R&D programme and beyond, and to collate the expectations and experiences of lay people and others who were involved in setting research priorities and commissioning research. The researchers found 107 examples of lay involvement at various stages of the research process and across a range of health topics.

This substantial report describes: how the project was carried out; findings about where, how and why lay people are involved; and their perceptions. It draws lessons from areas where lay involvement has been an underlying principle, outlines steps towards lay involvement and recommends ways of enhancing an understanding of lay/professional partnerships.

Research: What's in it for me?

A conference in the new year will draw on this review of lay involvement and on the experiences of others.

- Date: 28 January 1998.
- Place: Kensington Town Hall.

The conference organisers are currently calling for papers and posters for:

- 5 minute presentations
- longer contributions for workshops (3 per 90-minute workshop)
- exhibition stands

For further information contact Sue Weston on phone: 01865 226 917; fax: 01865 880 946.

The voices of older people in Greenwich: their views on the health service

Greenwich CHC

Greenwich CHC held discussions with 42 older people in five groups. The discussions were unstructured, but all covered certain themes: views on continuing care in hospital compared to continuing care in the community; participants' views about themselves; their fears about health care; their need for NHS services; and information and communication. Each subsection of the report summarises the views of the participants and presents the CHC view.

If you had three wishes ...

Towards the end of their discussions, four of the groups were asked to make three wishes for things that could be done to improve the health service specifically to meet the needs of older people. (A group of older Asian women did not do this since they spoke two languages and could not discuss the wishes between the two subgroups.) The following wishes were each identified by two groups:

- Better hospital discharge arrangements (better information about discharge and community care).
- Better response by GPs to home visit requests – this seems to be related to a need to see a health professional quickly when in an anxious situation.
- Shorter waits for treatment – participants were particularly worried that their condition might deteriorate while they waited.
- More resources for the NHS – to improve the pay of staff (but to spend less on managers) and to spend more on patients.
- Better nursing care – standards were felt to be declining. Helping older people in hospital with their meals was a key issue.

Health Watch in Caerphilly

Caerphilly CHC has recently set up a Health Watch project in which local people will have a direct say in the development of local health services. The project involves a network of nine health watch groups which cover the whole county borough. The initiative is being supported by Gwent Health Authority, which is seconding staff to help in the extra work. Launching the initiative, the Welsh secretary, Ron Davies, praised the work of CHCs in representing the public perspective. Colin Hobbs, the CHC chief officer, said that health consumer groups throughout Wales were monitoring the progress of the Caerphilly Health Watch, with a view to starting similar groups.

Child and adolescent mental health services monitoring report

North Thames Regional Group of CHCs

In June 1996 members and staff from various North Thames CHCs formed a mental health services monitoring group. The group immediately decided to monitor the co-ordinated planning of child and adolescent mental health services and to develop monitoring tools.

The group conducted two surveys: one to find out where health authorities were placing adolescent psychiatry contracts and the other to assess the progress local authorities and health authorities were making in developing Children's Services Plans.

The first survey revealed that some districts had inadequate local facilities and that many ECRs were being made. The second survey revealed a very varied picture. Different age definitions were used for "child" and "adolescent". Few HAs had defined child and adolescent mental health problems. Some had set up needs assessment projects, while others were relying on existing literature or a stock-take of local services. Only four HAs said that they had had systematic success in involving users and three had invited CHC participation on their joint working groups.

Guidelines on monitoring providers

The group found that CHC monitoring of tier 4 (highly specialised) units which provide services for young people from a number of health authority areas was sporadic. There was little co-ordination between CHCs or comparison of methods or results. This report includes guidelines on CHC monitoring of tier 4 units.

Monitoring purchasers

The report recommends that CHCs should ensure that proposals in the local Children's Services Plan are being implemented. It sets out areas which CHCs could concentrate on and key questions.

Surgeon's daughter in operation

In August the daughter of a surgeon at Mayday Hospital, Croydon, took part in an operation without the patient's consent. A complaint followed, and Croydon CHC helped to ensure that the patient's concerns were taken seriously, so that the complaint was resolved speedily and satisfactorily. The hospital has suspended work experience until clear guidelines have been developed. The CHC commented that, although the patient suffered no harm and was in no danger, patient consent must be taken seriously. It should be possible to offer young people work experience without neglecting the rights of patients.

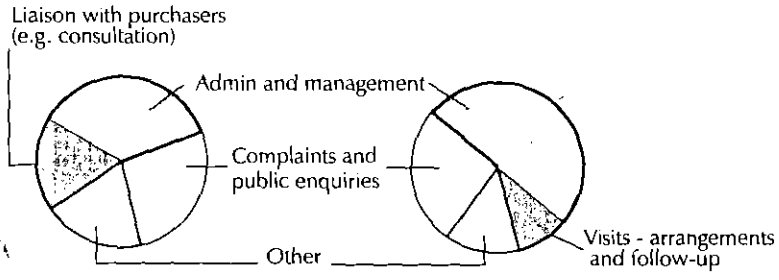
CHCs Making a Difference

ACHCEW has recently produced a substantial Health News Briefing which makes a strong case for the efficiency and effectiveness of the CHC contribution to the NHS. *CHCs Making a Difference* provides a wealth of examples of how CHCs have achieved improvements, both small and large, across the whole range of NHS services. We are grateful to CHCs which sent details of their work for inclusion in the report.

An overview gives a breakdown of CHC activities, many of which do not result in specific and identifiable positive changes. This does not mean, however, that they do not play a useful part. Helping complainants, routine visits and meetings with NHS staff and the very existence of CHCs all help to keep the NHS on its toes. The graphs show the average time spent by CHC staff on various activities:

Time spent on CHC tasks by chief officers and other staff

Source: Christine Hogg, Staffing and Resources for CHCs, ACHCEW 1995, cited in CHCs Making a Difference



Chief officers' time

Time of other staff (excluding project staff)

CHCs receive less than 0.1% of the NHS budget – the average English CHC's budget is £116,000, while the average in Wales is £56,000, just 31p and 38p per head of population respectively. The briefing compares these small budgets with the huge sums spent by the NHS on assessing services when they use outside consultants. One health authority, for example, paid £25,000 for a report on public perceptions of *Changing Childbirth*. That CHCs achieve so much on so small a budget is in large part due to the contribution of the 5000 unpaid members. ("Non-execs" on NHS boards received £5000 a year for a similar time commitment.)

The briefing concludes that CHC can justly be proud of what they have achieved. But with power shifting from health authorities and with increasing complaints work, CHCs need both extra powers and the resources that will enable them to meet new challenges.

Copies of *CHCs Making a Difference* have been sent to CHC offices.

Hospital Acquired Infections

ACHCEW has also distributed a short Health News Briefing on *Hospital Acquired Infection*. It was prompted by concerns raised by Bassetlaw CHC which had looked into the issue in partnership with local NHS providers. Members were concerned by the extent of the problem and the lack of readily available information on the issue. At any one time, about 10% of acute hospital inpatients in the UK are suffering from an infection acquired since they were admitted. Apart from the suffering caused by these infections, it is estimated that they are the primary cause of 5000 deaths each year and a contributory factor in a further 15,000.

ACHCEW wants to collate information on infection control procedures which are in place on hospitals around the country and has asked CHCs if they could provide information by 28 November. The briefing includes questions which CHCs might like to consider.

The briefing gives a list of "useful reading". It was too late to catch a publication which hit the headlines in September – *Hospital Acquired Infection* from the Office of Health Economics. This report outlines what is known about such infections and discusses the principles, management and cost-effectiveness of infection control. (£7.50 from the OHE, phone 0171 930 9203.)

ACHCEW Work Programme

ACHCEW's Standing Committee has approved the Association's Work Programme for 1997/98. CHCs have made it clear through the recent questionnaire on ACHCEW's work and through AGM resolutions that they want ACHCEW to do more press/promotional work on their behalf. ACHCEW therefore intends to give this aspect of its work a higher priority in the coming year. It is also proposed that ACHCEW should make a bid to the NHS Executive for a project to raise the profile of CHCs and to give CHCs more national identity.

A copy of the work programme will be circulated to CHCs.

News From ACHCEW

Nationwide Casualty Watch

In ACHCEW's recent questionnaire to CHCs about its work, CHCs were enthusiastic about carrying out joint projects on topics of widespread interest. ACHCEW's Standing Committee has decided that a nationwide "casualty watch" would be a suitable candidate for the first such project.

At present Southwark CHC co-ordinates a casualty watch involving 37 CHCs. A day and time is chosen on which CHC members visit their local casualty departments to collect information about the patients waiting in the department. The information is collected with the help of hospital staff and takes up to 30 minutes to record. The results are faxed to the co-ordinating centre and analysed. They provide a snapshot of the numbers of patients waiting and enable comparisons between areas.

ACHCEW has written to CHC offices, asking if they would be interested in taking part. It is proposed that, if there is sufficient interest, the national casualty watch will take place on:

Monday 26 January 1998.

Results will be input by ACHCEW staff and released to the media on the same night.

To sort out logistical problems, it is also proposed that there will be a "rehearsal" on:

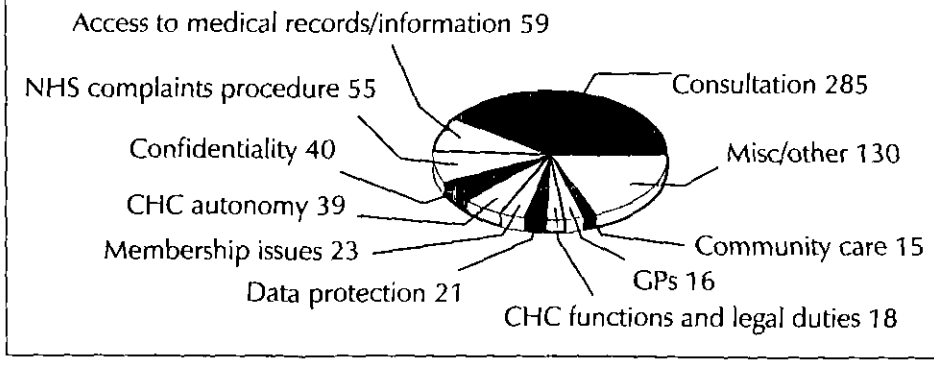
Monday 24 November 1997.

ACHCEW Legal Services

ACHCEW's legal officer, Marion Chester, has now been in post for just over a year. Her first annual report shows that Marion has received 701 enquiries from 147 CHCs (61 of these being "follow-up" enquiries). By far the largest number of enquiries have been about consultation rights (see graph) and the number of these enquiries has been rising. Feedback from CHCs suggests that, in most cases, CHCs have been able to obtain a satisfactory outcome after seeking legal advice from ACHCEW. However, in a significant number of cases, CHCs have needed ongoing support and advice.

ACHCEW Legal Services

Subject of enquiries received from September 1996 to September 1997



Survey on ACHCEW services

ACHCEW has now compiled the results of this survey to which 84 CHC contributed (40% response rate). On rating the relative importance of ACHCEW services the role of ACHCEW in promoting CHCs scored the highest and ACHCEW leaflets and poster the lowest. A large majority of respondents thought that ACHCEW should devote more resources to promoting CHCs, a request which ACHCEW intends to respond to over the coming year.

CHC News

CHC News was well received, with an overwhelming majority saying that it was topical, clear and relevant. Asked what element of *CHC News* was most useful, opinion was almost equally divided between the general News section and Around the CHCs. Some improvements were suggested. A few people said that *CHC News* is too wordy and that more illustrations would help. We agree, but are not in favour of one suggestion that we should use clip art. So if there are any cartoonists out there who could provide topical illustrations, we would be grateful. Also, if you want to send in photos with a relevant piece of news, we would try to use them. Any computerised images would be especially welcome since they are the easiest to use.

Another suggestion was that there could be more contributions from individual CHC members and staff – this is down to you! We welcome all contributions.

Trust Board Meetings

Readers will be aware that the health secretary, Frank Dobson, has asked NHS trusts to hold their board meetings in public. ACHCEW has written to CHC offices on the subject providing a list of points which CHCs and trusts might like to consider in order to ensure that meetings are genuinely open.