CHC NEWS

A newsletter for community health council members and staff

Prescription charge evasion to be a criminal offence

The government has announced plans for legislation to make evasion of prescription charges a specific criminal offence. It is estimated that prescription fraud by patients costs some £90 million a year – additional money is lost due to fraud by health professionals. While fraud by the latter can involve very large sums (in one recent case it is believed that £500,000 was involved), fraud by patients is likely to involve only a small amount on any one occasion. This makes it inefficient to charge alleged offenders under the Theft Acts. The government intends to introduce legislation which would make prosecution easier and provide a deterrent by imposing a penalty charge in cases of evasion.

In addition, the government has announced an action plan of other measures including improved security of prescription forms, new checks on eligibility for exemption from charges and establishing confidential "hotlines" for staff who believe that other NHS practitioners are defrauding the system.

It is also intended to make more use of information technology to detect fraud. ACHCEW has recently responded to an NHS Executive consultation document on Electronic Data Interchange – the electronic transfer of prescription information from GPs to pharmacists. While ACHCEW recognises that detecting fraud may be one advantage of such a system, the Association gives a higher priority to safety of dispensing, patient confidentiality and convenience to patients.

DoH press release 7 January
ACHCEW/NHSE correspondence

NHS patients wait longer

The gap between waiting times for NHS and for private treatment has widened as NHS trusts have taken on more private work. A report published in the *1998 Fitzhugh Directory of NHS Trusts* shows that in 1996/97 the private income of trusts rose by 14% to £249 million. NHS patients now have to wait twice as long as private patients for investigation of possible breast cancer, six times longer for a heart bypass operation and ten times longer for a cataract operation. In 1990 private patients waited on average 11 days for all operations, and NHS patients 32 days. By 1996, the number of private patients had risen by 25%, and private and NHS patients waited 10 days and 42 days respectively. There may also be longer waits for NHS patients to see a specialist in the first place.

Guardian/Times 26 January

Nursing home reports to be published

From April, health authorities will be required to publish their inspection reports on nursing homes and private hospitals and clinics, bringing these services into line with residential homes – social services have had to publish their inspection reports since 1994. In May the charges for health authority inspections are to be raised by 40% and for social services inspections by 13%.

DoH press release 19 January

Assessing performance

Following the NHS White Papers, we can expect a flurry of consultation papers on the details of proposed changes. The first of these – *A National Framework for Assessing Performance* – has been published. Copies have been sent to CHCs and responses are requested by 20 March.

In this issue:

ISSUE 18, FEBRUARY/MARCH 1998

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

Complaints statistics

The Department of Health has published statistics on complaints about the NHS in England during 1996/97 – the first year of the new NHS complaints procedure.

Although the total number of complaints had not risen since the previous year (at just under 130,000), complaints about GP services had risen (to about one complaint per GP), and those about Hospital and Community Health Services had fallen.

The graphs show some of the figures – the DoH leaflet shows more detail about the subjects of the complaints. A high proportion of independent reviews are not completed within the target time. Performance at local resolution is slightly better, with 66.7% of complaints going through this stage within the target time and 29% outside it.

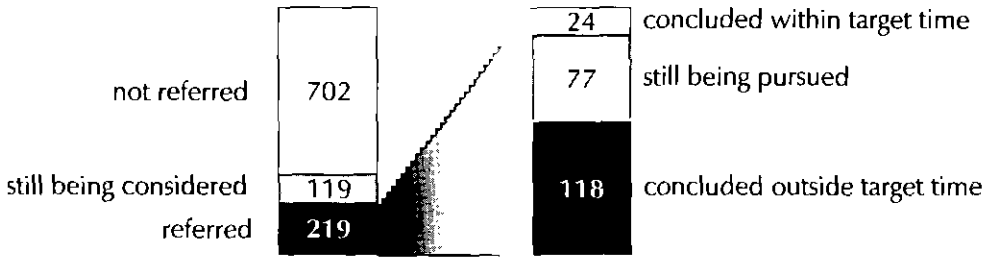
Handling complaints: monitoring the NHS complaints Procedure, England 1996/97
DoH, PO Box 410, Wetherby, West Yorks, LS23 7LN, £6

Independent review

Referrals to review panels and performance against targets, England, 1996/97

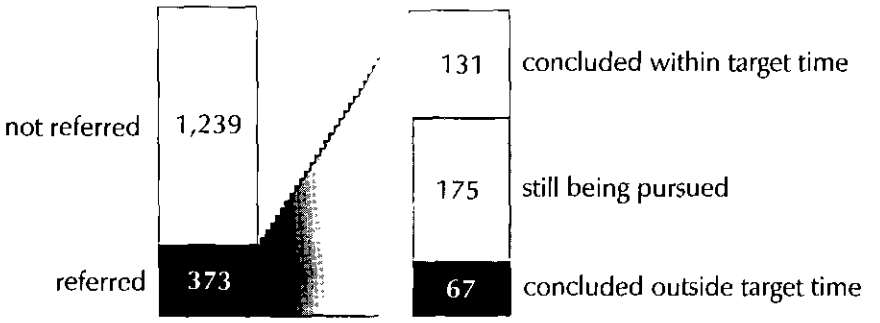
Family Health Services (FHS)

1040 requests for independent review (2.8% of FHS complaints)



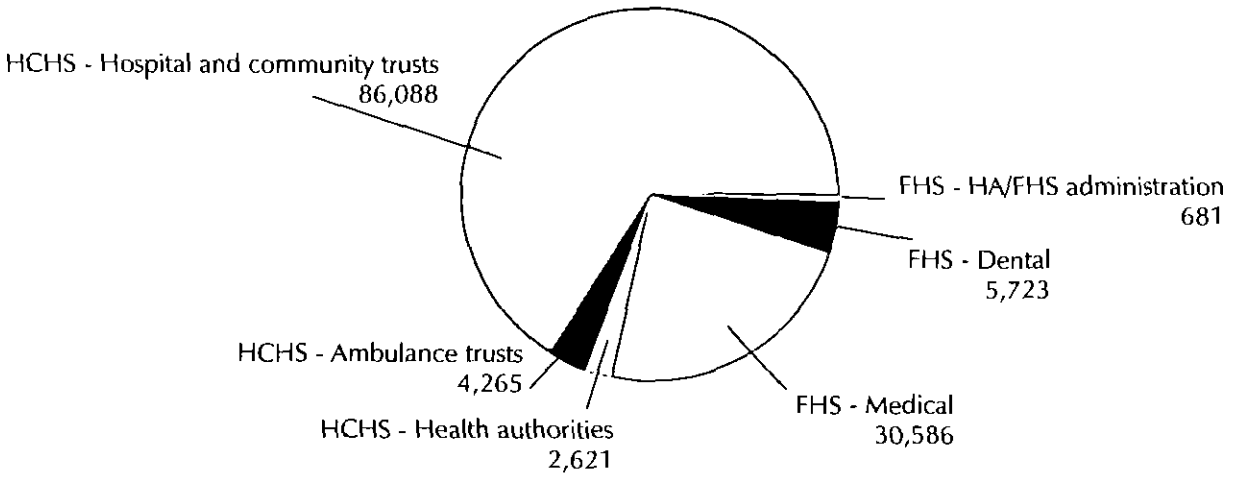
Hospital and Community Health Services (HCHS)

1612 requests for independent review (1.7% of HCHS complaints)



Breakdown of written complaints made in 1996/97

Complaints about Hospital and Community Health Services (HCHS) and Family Health Services (FHS) in England, by type of organisation



Source:
Handling complaints: monitoring the NHS complaints procedure, England 1996/97, DoH

The NHS - Know Your Rights
Forthcoming survey of CHCs

As highlighted in the last *CHC News*, the Public Law Project is carrying out a nationwide survey of CHCs, as part of a lottery-funded project looking at the operation and effectiveness of the NHS complaints procedure and at users' rights to information about the NHS.

The survey offers a unique opportunity to find out, on a national scale, the difficulties health service users face when seeking redress for their grievances, and in gaining access to the information they need for effective participation in decisions about their health care and the provision of local health services more generally.

Although the survey is long, PLP has tried to ensure the questions are quick and easy to answer, so that it is not too time-consuming for CHC staff to complete. It will be sent out in April.

As well as providing data for a national analysis of the NHS complaints procedure, the survey will form the foundation for further in-depth research in seven case study areas throughout the UK. The aim is to interview complainants, CHC chief officers and health service staff about their experiences of local procedures for handling complaints and requests for information, with the purpose of identifying good and poor practice.

Based on the research results, practical guides will be produced to help NHS users and their representatives make the best use of the complaints system, and also clarify rights of access to health records and information about the NHS as a public institution. These guides will be available to all CHCs and other advice agencies at the end of the project in the autumn of 1999.

If you would like to discuss the project or think you can further assist PLP's work, please contact: Henrietta Wallace, NHS Project Researcher, Public Law Project, Room B608, Birkbeck College, University of London, Malet St, London WC1E 7HX; phone 0171 467 9805.

Slovenia welcomes ACHCEW's experiences of complaints systems

Gary Fereday, a member of the ACHCEW information team, was invited to Slovenia in February by the Slovene Consumers' Association to address a workshop on Patients' Rights, Complaints Procedures and Patient Support. The workshop brought together representatives of consumer organisations, the health ministry, health insurers and the medical profession to hear about experiences from Britain and Germany, including the NHS complaints system and the Patient's Charter.

From the Ombudsman: Complaints about removals from GP lists

The Health Service Ombudsman, Michael Buckley, has given his views to the London Complaints Consortium on dealing with complaints about the removal of patients from GP lists. He said:

"GPs are free, under the NHS terms of service, to remove patients from their lists without giving any reason. However, it is my understanding that the NHS complaints procedure is not restricted to the obligations of GPs under their terms of service. Indeed, a Panel considering a complaint should not attempt to investigate, or express a view about, whether GPs are in breach of their terms of service. As providers of public services, GPs implicitly accept an obligation to adhere to certain standards. This includes trying to make a success of the doctor–patient relationship. If this has not happened they should be willing, apart from exceptional circumstances, to explain to the patient why the relationship has to end."

Handling complaints

GPs: "GPs should respond substantively to complaints from, or on behalf of, patients who have been struck off."

Conveners: "If patients remain dissatisfied and ask for a Panel, conveners should consider such complaints like any other. They should not automatically reject complaints where the GP has given a reason such as that in his/her view the doctor–patient relationship has broken down."

Complaints Panels: "It is open to the Panel to find that the GP had unreasonably exercised the right to remove a patient, or had caused hardship or distress by communicating the decision insensitively."

The Ombudsman: "I may investigate a complaint if I believe that the complainant may have suffered avoidable hardship or injustice through a GP's actions – this could include removal from a list. I would try to see if the GP had acted reasonably and responsibly.

"I would be concerned about instances where the decision to remove a patient may have been in direct response to a complaint. It is essential that patients should not be deterred by fear that they may be struck off the GP's list – otherwise confidence in the new complaints procedure will be undermined. Advice from the General Medical Council is that doctors should respond to complaints promptly and constructively."

THE NHS WHITE PAPERS AND ...

... primary care

White Papers on the NHS have now been published for England, Scotland and Wales. Though they share many features, particularly in relation to quality of care (see *CHC News* Issue 17), there are significant differences in relation to the organisation of primary care. The Scottish and Welsh White Papers also allow for future development of policy by the Scottish Parliament and the Welsh Assembly respectively.

In **England**, primary care groups (PCGs) of GPs and community nurses will be set up under the oversight of health authorities (HAs). They will typically cover a population of 100,000. PCGs will gradually take over responsibility for commissioning acute and community services within the HA's health improvement programme (HIP). In time PCGs may progress to become primary care trusts. These trusts will not generally take responsibility for specialised mental health or learning disability services.

In **Wales**, local health groups (LHGs) will be set up to bring together GP practices, other health professionals, social services departments and voluntary organisations and will "often" be chaired by a GP (the Welsh White Paper makes less explicit mention of involving nurses than the English version). LHGs will usually be coterminous with unitary authority boundaries. At first LHGs will be sub-committees of health authorities and will be assigned budgets from the HA, although the HA will retain ultimate control of the budget. LHGs will be able to redeploy resources between acute care, community care, prescribing, GP staff, premises and computers. Any future decisions about setting up primary care trusts will be for the Welsh Assembly.

In **Scotland** primary care trusts (PCTs) will be funded to provide primary services, including GP services, mental health services and community hospitals. (As in England and Wales, GPs retain their independent contractor status). PCTs will not commission acute care, which remains the responsibility of health boards (equivalent to HAs). General practices will have the option of joining together to form local health care co-operatives which will have the right to manage a budget, allocated from the PCT, for primary and community services. These co-operatives will cover "natural communities" of between 25,000 and 150,000 people.

The government has also published a Green Paper on public health, which ACHCEW covers in the **Health Perspective** for March.

... CHCs

The three White Papers make different comments about CHCs, but in all cases it is clear that the CHC role is up for debate, and that CHCs will need to prove that they have a useful part to play.

The **English White Paper** merely states that the government recognises "the important part played by CHCs in providing information and advice, and in representing the patient's interest". It also says that the government will "explore new ways of securing informed public and expert involvement in ... decisions".

The **Welsh White Paper** mentions CHCs more often and states that they "have a role to play in pulling together local views", although it also envisages other ways of tapping the views of communities such as surveys, focus groups and citizen's juries. It is explicit about the need to look again at the roles and responsibilities of CHCs, saying that the status quo is not a realistic option. The Welsh Office will be "looking afresh" at the implementation of the Community Health Council Regulations 1996 and will publish a consultation paper this year on ways of engaging the public in the planning and oversight of NHS services. Although local health groups (see left column) must make arrangements to involve, consult and respond to the local community, there is no mention of CHCs in relation to LHGs.

The **Scottish White Paper** states that local health councils (LHCs – equivalent to CHCs) will work co-operatively with health boards (equivalent to HAs) and agree how LHC activity can be focused for maximum effect. The roles listed for the new primary care trusts do not include any mention of LHCs or public consultation.

In its February meeting ACHCEW's Standing Committee discussed ways in which CHCs could use the forthcoming changes as an opportunity to develop their role. In addition to feeding into the development of health improvement programmes, CHCs will need actively to forge links with primary care groups and local health groups. CHCs have much to offer these groups in terms of understanding the views of local users and experience of monitoring services, but they will need to prove locally that this is the case.

Standing Committee has agreed to convene a Special General Meeting to discuss the White Papers. In the meantime it will encourage regional associations of CHCs and the Association of Welsh CHCs to promote networking so that CHCs can share good practice over developing new links with health professionals.

CHCs at a crossroads

The future of CHCs has also been up for debate in some recent journal articles.

Susan Pickard sets out to consider ways in which CHCs may be able to carve out a niche for themselves, but in fact her article outlines more problems than solutions, and she concludes by asking whether CHCs are an anomaly in today's NHS.

Since the purchaser-provider split was introduced in 1991, the CHC's statutory role has overlapped with that of the health authority, and health authorities are increasingly experimenting with ways of involving the public which by-pass CHCs. At the same time, CHCs have an expanding role in complaints, but have not received extra funding, so that their ability to provide an effective service in any of their roles is diluted. The CHC's relatively weak position is exacerbated by the fact that individual CHCs have evolved differently, so that users cannot be seen to have a *national* watchdog. The author suggests that structural concerns need to be addressed in the areas of: CHC mergers; membership; staffing, resources and accommodation; and roles and relationships.

The clearest advice in the article is that CHCs can be strengthened by joint working and, in some cases, by mergers. One model suggested is larger CHCs supplemented by community forums which would involve CHC members, co-optees and "interested individuals". This, says the author, would encourage members to have a more strategic focus, but would not preclude involvement in local matters. But the suggestion begs the question of how far CHCs should be turned into a body of "professionals" when their strength lies in offering an informed lay opinion.

In each area she considers, the author implies that CHCs would be strengthened by more standardisation. She also states that their future strength depends on an increasing understanding of public opinion and on increasing public representativeness. The difficulty is how to combine the two goals.

A pair of articles in *The Health Summary* offer contrasting views of CHCs. Dr Paul Lambden warns that CHCs risk becoming a "health vestigium" submerged in anecdote and trivia. He is dubious of their ability to carry out their many roles given the level of funding and sceptical of whether they achieve much that internal auditors could not achieve. He believes that CHCs are important, but insists that they must lay out clear business plans and proposals for evaluation. Sarah Head presents a much more optimistic picture, drawing on 14 years experience as a CHC member and chief officer. She outlines a wide range of achievements and calls on CHCs to evaluate their performance so that both the local community and the NHS can be aware of what has been done on their behalf.

The Future Organisation of CHCs, Sue Pickard
Social Policy and Administration, September 1997, Vol 31(3): 274-89.
Dynamism or Dinosaur, Dr Paul Lambden
Effecting Change? Sarah Head, Chief Officer, East Birmingham CHC
Both in The Health Summary, December 1997, pp 7-10

Reaching young people

CHCs often find it difficult to make useful contact with young people. Norwich CHC has set up a new project to find out what young people think about the NHS and to develop ways of involving them in feeding back their experiences. The CHC has made contact with youth-related local projects and services and has set up a steering group of ten people who will take the project forward.

Registering support

Swindon & District CHC has opened a book in the CHC office for people to sign if they support the building of a proposed hospital in the area. Despite some local objections to the new hospital, the CHC carefully considered the issues and concluded that the proposals offer the best way forward. The book the CHC has opened gives an opportunity for those who agree with the CHC to register their views.

No confidence

The Association of Welsh CHCs has passed a vote of no confidence in the way in which the "consultation" exercise on a proposal to create a single ambulance trust for Wales was carried out. The "consultation" presented only one option of a single trust and offered little genuine opportunity for debate (for more details see *CHC News* issue 17). The Association's development officer, Sue Wilshere, has raised concerns that the same mistakes may be made when formal public consultation is undertaken into proposals to reduce the number of hospital trusts in Wales.

A plea ...

from Alan Hartley, member of Standing Committee

Could CHCs always bear in mind that neighbouring, affected CHCs may not have been consulted about substantial changes?

In a recent case, a reconfiguration of services proposed by Wakefield HA involved the possibility of closing an A&E unit at Pinderfields Hospital in Wakefield or at Pontefract General Hospital. The HA consulted Wakefield and Pontefract & District CHCs, but not York, Leeds or East Yorks CHCs, whose populations were also affected.

Patient Participation Project

Salford CHC and Salford Community Health Care NHS Trust

This useful survey asked people aged over 60 about their experience of district nursing and podiatry services. Among English-speaking clients, the appreciation of services was very high. Interviewers felt that the people they interviewed were very self-sufficient and did not expect many services. Clients felt that their expectations were met, and even exceeded, by district nurses. The nurses, however, felt that expectations were high and in particular that clients did not understand the implications of a "15 minute general chat" (the "friendliness" of nurses was highly valued by clients).

A separate section of the report is devoted to Yemeni speakers, and their experience is markedly different from that of English speakers. There were barriers, both cultural and linguistic, to accessing services, with the result that some Yemeni people were not receiving services for which they were clearly eligible. Since some could not read Arabic or English, the provision of Arabic leaflets is not always an adequate solution. In addition health staff need to take the initiative since many people in this group tended to access the health services only for isolated incidents and did not have a concept of continuing care.

The report makes many detailed recommendations relating to local services. It also includes appendices on how the findings are to be disseminated and how action is to be taken on each recommendation, and by whom.

Sexual health and people with special needs

Southport & Formby CHC

This needs assessment into a very sensitive area makes interesting, if rather worrying, reading. The research team investigated the sexual health needs of people with learning disabilities through focus groups and interviews. The overall picture to emerge is one of insufficient knowledge and uncertainty.

Respondents with learning disabilities wanted more opportunity for discussion of sexual issues. However, many could not see their GP on their own and in any case did not feel that what they said would be treated in confidence by GPs, teachers or keyworkers. Very few felt they could talk to their parents about sexual feelings. Many wanted to spend time alone with boyfriends/girlfriends, but had very little opportunity to do so.

Most **parents/carers** interviewed said that they worried about sexual activity. But the overwhelming feeling to come over from this group was a need for more support, information and involvement. Uncertain how to broach sexual issues with the people they care for and lacking faith in the ability of some professionals to give appropriate advice, many parents/carers put off dealing with the topic while others deny that discussion is needed. Among those who agreed with the need for sex education, there was a feeling that parents/carers should be more involved so that the process was shared between the home and the school.

There was also a sense of uncertainty among **professionals responsible for the education and training of people with learning disabilities**. They felt that they were vulnerable to accusations of abuse if they attempted to discuss sexual issues with their clients and that they did not have the specialised training needed. As a result services lack co-ordination and are often provided only on an "as and when it is needed" basis.

The CHC's report has been very well received and is being used as a working document locally with the aim of influencing health service provision.

Report on survey of reasons for attendance at the accident & emergency department of North Tyneside General Hospital

North Tyneside CHC

This survey was prompted by an increase in the number of people using the A&E department and comments by staff about "inappropriate attendances".

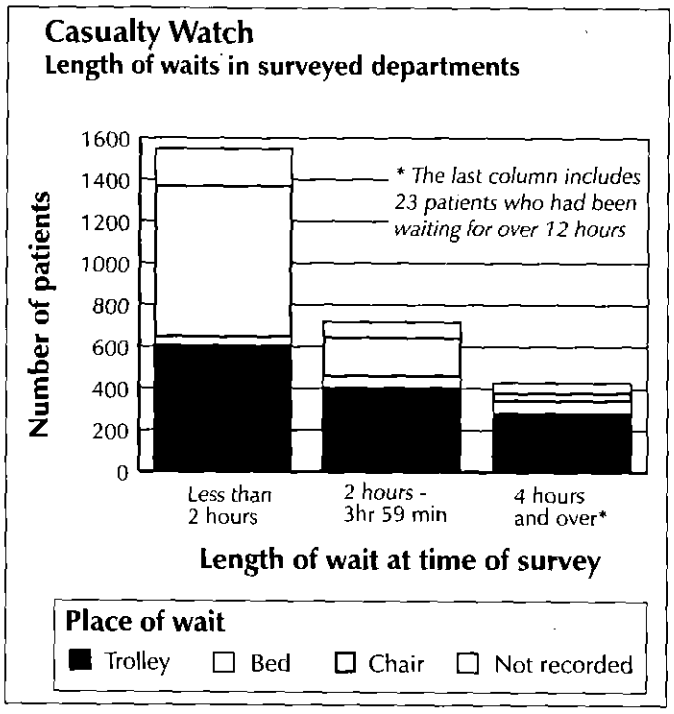
Although 27% of respondents said that they could have seen their GP instead, many of these patients as well as other patients had a logical reason for attending A&E: needing X-rays, GP surgery closed, time to get GP appointment and a belief that they would have been sent to hospital anyway. 31% of the whole sample had been advised to attend A&E by a professional person, usually a member of GP practice staff. One of the CHC's recommendations is that consideration could be given to setting up a minor injuries unit, or at least a way of managing primary care patients, within the department.

A similar comment is made in a recent publication by the NHS Confederation, *Tackling NHS emergency admissions: policy into practice*. This says that primary care centres in hospitals can deal with minor injuries and ailments and streamline the A&E process. In Homerton Hospital in Hackney, for example, a primary care unit has treated 13,000 patients over two years, markedly reducing pressures on the A&E department. Since its introduction there has been an 80% reduction in complaints about waiting times.

Casualty Watch

ACHCEW's Nationwide Casualty Watch was successfully carried out on 26 January with help from Southwark CHC and the members and staff of 148 CHCs in England and Wales as well as four Health and Social Services Councils in Northern Ireland. Many thanks to all those who took part.

Data were collected from 190 A&E departments to give a picture of how long patients had been waiting at the time of the survey. The longest wait was of a 60 year old man with asthma who had been waiting for 37 hours – he was on a trolley. Full results have been sent to CHCs.



Casualty Watch received wide coverage in the press and media, with all the national daily broadsheets including articles about it. This ruffled a few feathers in the Department of Health, and the health secretary Frank Dobson hurriedly issued a press release describing the survey as "flawed". This was partly because four of the long waits had been on a well staffed assessment ward in Halifax General Hospital – although ACHCEW pointed out this fact in the notes accompanying the survey results. Other objections were that St Mary's Hospital Paddington had had to close a ward due to a diarrhoea outbreak and that the Royal Liverpool Hospital (where seven waits of over 12 hours were listed) has only just opened a new ward to ease discharge delays. However, as Toby Harris points out in his reply to Mr Dobson, while it is understandable that some departments will be under particular stress at any one time, this does not alter the fact that some patients have to wait for an unacceptable period.

Standing Committee has agreed to repeat the national Casualty Watch in January 1999. In the meantime it is hoped that regional associations will carry out more frequent regional exercises. ACHCEW will be evaluating the procedures used on this occasion to look at whether the guidance on data collection needs to be amended.

Legal Service – a thank you to CHCs

Since September 1996 legal advice and support to CHCs has been provided through ACHCEW. However, as explained in the last issue of *CHC News*, the NHS Executive decided to put this contract out to a competitive tender, causing concern that the current service would be lost. CHCs raised the matter with their MPs and regional offices and many wrote directly to the health secretary. The outcome has been that the tendering process was abandoned and the service will continue to be provided from ACHCEW. The remaining problems are that:

- Welsh CHCs are not included in the NHS Executive's arrangements, and
- the funding provided does not correspond with the resources needed to meet the current level of demand. CHCs may need to ask the NHS Executive for an increase in the budgets for the service.

Disclaimers in mental health wards

In recent meetings Standing Committee has considered the use of disclaimer notices in mental health wards. One notice, for example, states that the NHS trust concerned does not accept responsibility for patients' property unless it has been handed over for safe custody. ACHCEW wrote to the health secretary suggesting that such disclaimer notices should not be displayed in mental health wards since patients may be incapable of protecting their own property or, in some cases, of understanding the notices. In reply, the health minister Paul Boateng said that although he accepts that the use of such notices in mental health wards could be criticised, the Department of Health is unwilling to issue general instructions to hospitals to restrict information given to patients. The appropriate procedures should be decided at a local level, and CHCs may want to take the matter up with local NHS trusts. It might be helpful, he suggests, to include disclaimers in information sent to patients before admission in order to discourage patients from taking valuables into hospital.

"And now for the next 50 years"

ACHCEW AGM
– dates and deadlines

This year's AGM/Conference will be held in Birmingham from Tuesday 14 July to Thursday 16 July. The Secretary of State for Health, Frank Dobson, has agreed to address the conference.

Deadlines

Receipt of motions from CHCs:	12 March
Nominations for Chair and two Vice Chairs:	28 April
Amendments to motions:	28 April

Training diary

ACHCEW has arranged the following training courses for May – June 1998. Further details have been sent to CHC offices.

Course	Date	Location
Consultation procedures	5 June	Birmingham
Chairing and facilitation skills	22 June	Nottingham
An introduction to quantitative research skills – survey and questionnaire design	11 June	Nottingham
An introduction to qualitative research skills – focus groups and semi-structured interviews	7 May 14 May	Bristol Darlington
CHCs and primary care	19 May 4 June 16 June	Exeter Llandudno Oxford
Community care – where are we now?	6 May 28 May	Reading Birmingham
Using the media effectively	5 May	Birmingham
Using broadcast media effectively	12 May	Cardiff
Facilitation skills	11 May 20 May	Cardiff London
The new NHS and the role of the CHC	2 June 17 June	Birmingham London
Health, race, ethnicity and the CHC	18 May 8 June	Leicester Bradford
Improving your writing skills	19 May	Oxford
Understanding how the CHC works	25 June	Darlington
Understanding corporate governance	21 May 19 June	London Liverpool
Newsletter writing and design	23 June	Liverpool
Advanced writing skills	9 June	London
Advanced media skills – press and radio	3 June	London
Understanding the finances of NHS trusts and health authorities	15 May 18 June	Bristol Manchester

HA board meetings

A meeting is being arranged between ACHCEW and the NHS Executive to discuss the openness, or otherwise, of health authority meetings. Some London CHCs have complained that their health authorities have been going into private session when they should not in order to discuss sensitive issues which are of great local interest, apparently on the advice of regional offices. Waltham Forest CHC, for example, says that a series of secret HA board meetings led to proposals for £14m of cuts affecting mental health, drugs and alcohol and community nursing services. ACHCEW's legal officer, Marion Chester, has commented that the current legislation gives health authorities a great deal of discretion about going into private session. But she has also pointed out that as public bodies, HA boards must pass a resolution to exclude the media and the public before they do so.

Marion has called on the government to tighten up legislation so that the range of issues which HAs can consider in private is more clearly defined. She has also called for clear guidance requiring all health bodies, including health authorities, to consider decisions to discuss business in private in the light of the government's commitment to openness. The NHS Executive has agreed to discuss the issues with ACHCEW before it issues forthcoming guidance on access to NHS board meetings – the guidance is likely to cover health authorities as well as trusts.

ACHCEW/NHSE letters;
Health Service Journal 8 January

Consultation – the legal requirements

Marion Chester, ACHCEW's legal officer, has prepared this Health News Briefing which has been sent to CHC offices.