CHC NEWS

A newsletter for community health council members and staff

Shortages of nurses and GPs

The NHS faces a staffing crisis according to the Royal College of Nursing and the British Medical Association.

Nurses

Nurses' leaders say that 8000 NHS nursing posts are vacant and that some wards have been unable to fill 25% of their posts. The problems have been confirmed by a Health Department survey which found that 80% of English hospitals are having difficulty in recruiting nurses. There is pressure on both retention and recruitment: a third of students drop out before completing a nursing course and numbers leaving within two years of qualification are rising. To make matters worse, one in four nurses will be eligible for early retirement by the year 2000. At the RCN annual conference, Christine Hancock, general secretary of the RCN, warned that unless these problems are overcome "there won't even be an NHS in ten years' time". She said that pay is the critical factor determining whether nurses stay in the NHS, although the job also needs to be made more attractive through training and giving nurses more control of health care.

Daily Telegraph/Guardian/Independent 20 April

GPs

At a BMA conference, doctors' leaders warned of a similar impending crisis among the country's 32,000 GPs. Nearly 1000 posts are currently vacant and a "time-bomb" is waiting to go off in inner city areas where many current GPs came to this country from overseas. These doctors moved here before immigration laws were further tightened in 1985 making it very difficult for others to follow, and nearly all of them are due to retire within 10–15 years. In addition, more and more GPs are retiring early. With fewer young doctors training to become GPs – numbers fell by 14% between 1989 and 1995 – there are not enough to fill the vacancies. Dr John Chisholm of the BMA said that the main reasons for the problems were low morale, a feeling among doctors that they could not control their careers and increasing demands made by patients and the government.

Daily Telegraph/Guardian 16 April

Duty to ensure quality

Health ministers have expanded on the announcement in the English NHS White Paper that NHS trusts will be given a legal duty to ensure quality of services. This means that NHS managers could face court action if they do not meet standards of patient care. Under the latest proposals, all hospitals will be required to appoint a doctor, nurse or other clinical professional to take charge of quality issues. This person must report regularly to the board and the board must produce an annual report on clinical governance. Trust chief executives will carry the ultimate responsibility for ensuring quality of services.

While organisations in the primary and community care sectors must also identify a senior clinician to take a lead in quality issues, "arrangements for clinical governance must be proportionate to the size of the organisation". However, as primary care groups move towards being trusts, they must put in place all the aspects of clinical governance.

The government hopes to legislate on the duty to ensure quality in 1999 and will shortly produce a consultation document on other aspects of clinical governance.

DoH press release 13 April, Telegraph/Independent 14 April

In this issue:

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

GPs as proxies

GPs do not act as reliable proxies for their patients, according to an interim King's Fund report on total purchasing (TP). Under this scheme GPs can commission all hospital and community health services for their patients.

When TP was introduced, the NHS Executive stated that "purchasing delivers more appropriate care for patients when GPs are involved and particularly where [they take] on the direct control of resources used by their patients". For this to be true, GPs must understand their patients' needs. But the King's Fund team, who as part of a wider study investigated the ability of five TP groups to improve community and continuing care, found that only one of the groups explicitly involved patients in commissioning decisions.

One GP commented "We do liaise with patients, but to try to make it politically correct through patient user groups – I'm afraid it just doesn't wash". However, another agreed that GPs involved in TP must change, saying "If we want to have more responsibility, there will have to be more vertical accountability".

The findings echo a recommendation carried at ACHCEW's recent Special General Meeting, part of which reads: "We are concerned about the tendency towards professional domination of the NHS and the extent to which GPs are used as proxies for patients."

Doctor 23 April, King's Fund website

The King's Fund website (http://www.kingsfund.org.uk) gives information on its activities and publications. It also gives a useful listing of health news items which have appeared in the national and regional press.

On the road to an insurance-based NHS?

Government plans to raise more funds for the NHS from charges for the treatment of patients who have been in road accidents were strongly criticised in the Royal College of Nursing conference.

Under the Road Traffic Act, hospitals can charge drivers of vehicles involved in accidents £21.30 for treatment of each injured person. They can also charge the driver's insurance company up to £2949 for in-patient treatment and up to £295 for out-patient treatment. However, some hospitals have never used their powers to make these charges. Government ministers have instructed hospitals to be more rigorous in obtaining this money from insurance companies. The government also intends to legislate so that hospitals can charge insurance companies the full cost of treatment, which comes to over £100m a year across the NHS. The legislation would stop hospitals from charging patients directly.

In 1995 ACHCEW's AGM passed a motion calling for the repeal of the relevant sections of the Road Traffic Act. It was argued that singling out one group of patients for charges eroded the principle of a service free at the point of delivery. The precedent could be used to justify charging other groups of people. The same arguments were used in the RCN conference: the move could start the NHS on a slippery slope towards an insurance-based service. Nurses were also concerned that charging for treatment could add to the distress of patients at a time when they need to avoid anxiety.

Guardian/Independent 22 April

Doctors out of court

The secretary of state for health, Frank Dobson is seeking ways of keeping "lawyers out of hospitals, doctors out of court". In a letter asking for ideas, he has acknowledged that "Mistakes will, of course sometimes occur, and lead to patients being harmed in a way that could have been avoided or prevented. When that happens, it is entirely right that they should be able to claim compensation for the pain, distress and other consequences". However, he opposes the assumption that if something goes wrong, then it must inevitably be someone's "fault". Litigation cost the NHS £245 m in 1996/97, up 17% from the previous year. ACHCEW takes the view that avoiding the costs of litigation is, in general terms, a good thing, but that the system must not short-change individual patients by making litigation more difficult.

In his letter, Mr Dobson asks for suggestions on:

- how to reduce the occurrence of events which give, or might give, rise to claims
- how to keep patients' expectations of the NHS reasonable
- how to improve the way in which the NHS deals with clinical negligence claims when they do arise.

He would also welcome views on other relevant issues.

If CHCs want to give their views, they should respond to Mrs Liz Ryan, Complaints and Clinical Negligence Policy Unit, Room 3E58, Quarry House, Quarry Hill, Leeds, LS2 7UE **by 30 June**.

Times 30 April, Letter from Frank Dobson

Hungry In Hospital

There have always been complaints about hospital food – hardly surprising given that caterers typically have a budget of £2 per patient per day. But ACHCEW's publication of *Hungry in Hospital* in January 1997 redirected attention from complaints about cheese that tastes of plastic to the more fundamental question of whether patients can eat enough when in hospital. Appetising and well-balanced menus are necessary for the health of patients, but they are not sufficient by themselves. It is estimated that between 10% and 40% of older people admitted to hospital are already malnourished, and their condition can be exacerbated by difficulties in eating, a lack of appetite and a failure of some hospital staff to give at-risk patients the care and support they need at meal times.

Following the publication of *Hungry in Hospital*, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) re-emphasised the responsibility of nurses for ensuring that patients are appropriately fed. In a recent article in the *Health Service Journal*, Barbara Miller reports on what nurses and others have been doing to ensure that food is given the priority it deserves as an essential part of patients' treatment – some of the examples she highlights are shown in the boxes.

Health Service Journal 23 April

The Royal College of Nursing conference discussed food in hospital, acknowledging that some patients are inadequately fed. A number of speakers commented that they had too many tasks to give enough attention to helping patients with eating. There were also complaints about inadequate meals and lack of availability of food at night. The RCN general secretary called for more flexible hours and higher staffing levels.

Times 22 April

Resources for providers

- *Eating well for older people*, The Caroline Walker Trust. Sets out nutritional guidelines for healthy eating in residential and nursing homes and for meals on wheels and lunch clubs. Available from Broadcast Support Services, PO Box 7, London W3 6XJ.
- *CORA*, a computer program developed from the above guidelines by DGAA Homeline. It analyses the nutritional content of menus made up from a database of 800 recipes. The results of the analysis shown in bar charts. Where the results do not meet recommended guidelines, recipes which are causing the problem are identified and alternative dishes suggested. Available for £130 from DGAA on 0171 396 6700.
- The Hospital Caterers Association *Good practice guide* on food service standards at ward level. Available for £20 from the HCA on 01795 842222.

Examples of good practice

- **South Tyneside Healthcare Trust** has developed the role of clinical nutrition nurse specialist and has established a multidisciplinary nutrition support team of doctors, nursing, dieticians and pharmacists, chaired by the clinical nutrition nurses specialist. The team aims to integrate professional groups, provide education and clinical training and ensure a standardised, cost-effective approach.

  A working group with nurses and catering staff has also been set up to look at general nutritional issues. The group has introduced screening for every adult patient within 48 hours of admission. About 50% of patients are found to be at risk. In these cases, nurses have been given authority to take action such as ordering high protein/high energy meals. The weight and dietary intake of these patients are monitored each week and those who continue to be at high risk are referred to the nutrition support group.

  The director of nursing has been closely involved with the initiatives and can take up issues that arise at board level.

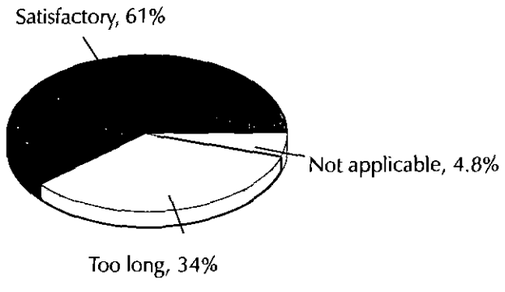
- In the **Oxford Radcliffe Hospital** a food quality group is led by a board non-executive director. The group set up a working party of nurses to look at practical ways of improving food in hospital. One of the working party's recommendations is that each ward should nominate a nutritional link nurse who will receive extra training in nutrition, and a nutrition co-ordinator for each shift who will liaise with catering staff and ensure that patients have the right food and right cutlery to be able to eat it.

ACHCEW is continuing to pursue the issue of food in hospital and will issue a follow-up Health News Briefing in due course.

Surveys Of GP Services

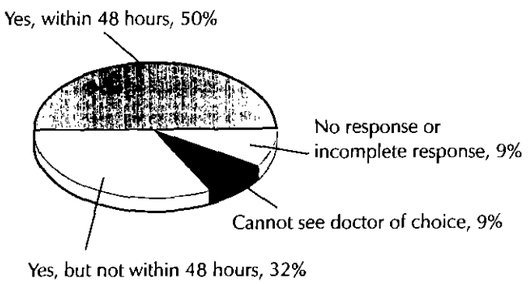
Do you think that the time it takes to get a routine appointment with a doctor is:

Source: Cheshire Central CHC (419 responses)



Can you see the doctor of your choice? And if so, how soon after your request?

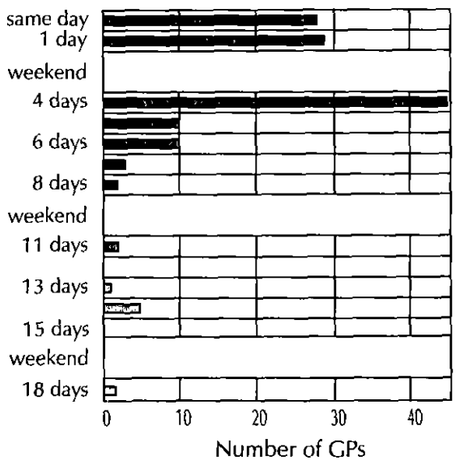
Source: Torbay & District CHC (1167 respondents)



Waiting time for routine appointment with own GP

Excluding GPs who were on holidays or courses

Source: Hillingdon CHC



When can I see my GP?

A batch of recent CHC surveys approached the question of the time it takes to get a routine GP appointment in different ways (see graphs on left).

Cheshire Central CHC's substantial questionnaire was filled in by 427 of its 500 healthwatch panel members. Its questions ranged from common ones about access to an unusual one for CHC surveys: on whether the surgery had taken the patient's blood pressure in the last 5 years.

The South Devon survey was of 1167 patients at 25 practices. The CHC has published the aggregate results and sent anonymised results relating to each practice to the relevant GPs. These individual results are being treated in confidence by the CHC.

Hillingdon CHC approached GP practices directly, asking how soon a patient could be given an appointment to see his/her own GP if a request was made on the day of the survey. The survey included only a few questions, but they provided useful, focused information.

Recent CHC publications on GP services

Healthwatch GP services survey
Cheshire Central CHC

Review of GP practice information for patients
Newcastle CHC

"When can I see my GP, please?"
Hillingdon CHC

Going to see the doctor in South Devon
Torbay & District CHC

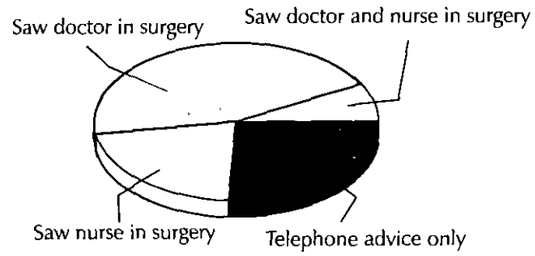
Nurse advice lines

At its recent Special General Meeting ACHCEW welcomed the introduction of the new 24-hour nurse-led helpline, NHS Direct. The use of telephone advice lines is also gaining ground in general practice, and seems to be popular with patients.

A piece of research in a South Tyneside general practice looked at the impact of introducing a practice nurse advice line. The graph below shows what happened in the cases of 1262 patients who had requested to see a doctor on the same day. The survey followed up 271 patients who received telephone advice only. Of these 88% were very or fairly satisfied with the nurse telephone advice. However, 132 of this group had had a repeat consultation within 4 weeks. The authors comment that this does not necessarily mean that the nurse advice was inadequate: some of the patients involved had been advised to make a routine appointment.

Results of telephone consultation with nurse

Source: British Journal of General Practice, April 1998
(1262 telephone consultations)



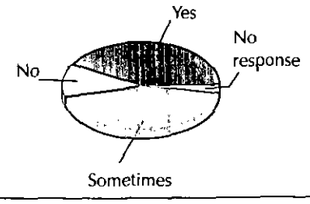
In ACHCEW's view, it is too early to come to conclusions about the suitability of nurse telephone advice lines. The issue offers opportunities for evaluation by CHCs in partnership with local GPs.

In the recent healthwatch survey by Cheshire Central CHC, a high proportion of respondents thought that they would find the service useful, at least on some occasions (see graph below).

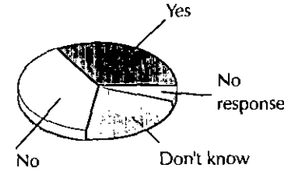
Patient views on telephone advice

Source: Cheshire Central CHC (427 respondents)

Would you find it useful to have advice from the practice nurse over the telephone?



Do you think you would visit the doctor less often if it were easier to have advice from your doctor or practice nurse over the telephone?



Patient Information

Putting people in the picture

Deborah Olszewski and Lyn Jones for the Scottish Association of Health Councils and Scottish Health Feedback

This literature review garnered information from over 300 articles, books and conference reports about:

- what types of information patients want and need
- ways that have been found to deliver this information; and
- the impact of information on health gain and patient satisfaction.

Its findings and discussion are thought-provoking, and its reference list would be useful to any CHCs doing work in this field, as would its suggestions for further research.

Research consistently confirms that patients in the UK would like to receive more information, and the reviewers identified genuine intentions to achieve benefits for patients. However, they also question some assumptions that seem to underpin the provision of health information. An insufficiently critical acceptance of these assumptions has limited areas of research and may have sent practical developments in the wrong direction.

> "Current thinking seems to concentrate on people in their role as patients, not in the context of their wider lives."

For a start, it is people rather than patients who want information – that is, they want it in the context of their wider lives. Although patients most often seek more information about clinical matters, they do not generally do so in order to make treatment choices. Their priority may be to use the information to control the impact of illness and treatment on personal, family, social and economic life. In practice, the information provided to patients tends to be given in separate categories, although people may want to use the various categories in combination. However, there has been very little social research into how people use health information – research which could help to give strategic direction to the design and content of patient information systems.

> "People 'don't know what they don't know'. This means that needs for information develop over time."

Information seems to be conceived of as a "product" – selected, packaged and transmitted to patients by "information channels". But in reality the gathering of information by a patient is a learning process in which the patient formulates questions, seeks answers and formulates more questions, sometimes slowly and with difficulty. There seems to have been very little research into this process and there is little evidence that current "information channels" are able to learn from the public about how to improve what they do. Both are needed if information systems are to give adequate support and encouragement to the people they serve and to help them to decide what kinds of information would be most helpful to them.

AROUND THE CHCs

Brent CHC has referred to the health secretary Brent Health Authority's proposal to close 43 continuing care beds at Wembley Hospital. The health authority proposes to close 43 beds at the hospital, while opening 34 beds at two other hospitals and setting up a community rehabilitation team at one of them. The CHC reluctantly went ahead with the referral to the secretary of state, saying that the benefits of the proposals had not been proven nor had the alternatives been adequately discussed. Sally Kirkwood, chair of the CHC, said that "on this occasion their minds were closed and we felt we were simply being told to take our medicine". The health authority denies that the consultation process was inadequate.

Health Service Journal 23 April

Kensington, Chelsea & Westminster CHC is to raise concerns with the health secretary about how a decision was reached to withdraw £1.7m of NHS funding from the Lighthouse, a leading centre for people with HIV and AIDS. However the CHC is stopping short of making a formal complaint about lack of consultation. As a result of the funding decision, the purpose-built Lighthouse is to be sold, although only last February the four London health authorities which funded beds at the centre agreed to their refurbishment. The CHC's concerns are reflected in a report commissioned by the Inner London Commissioners' Group. The report criticised the consultation over changes in HIV services for lack of evidence of users' needs, patterns of service use and service effectiveness. It also said that the consultation used inappropriate language and failed to make it clear why changes were being proposed, so that service users interpreted the proposals negatively. The CHC has agreed to co-operate with Kensington, Chelsea & Westminster Health Authority over the setting up of a joint working group to consider the future provision of residential services for people with AIDS.

Health Service Journal 23 April

Coventry CHC has been looking at the operation of a "Flexi-Bus Mobile Health Clinic" which provides child health surveillance services in part of the city. The bus was introduced to improve the clinic environment, to be nearer to users and to increase efficiency. However, the clinic met some local opposition and its introduction was followed by a fall in attendance. The health authority asked the CHC to undertake this study and to come up with ideas for future new uses of the bus.

The CHC identified a number of problems with the bus, such as space and access difficulties for adults accompanied by more than one child. On the other hand some users were very enthusiastic about it. The CHC concluded that the flexi-bus and its staff give a good standard of care to those who use it, however it is not providing for *all* children in the area and so cannot provide preventive care for these children. One of the suggestions from the CHC is that the bus could be used as a mobile resource by health visitors, from which they could operate a more personal, home visiting service targeted at areas where poor use is being made of child health clinics.

Child health clinics – the flexi-bus
Coventry CHC

NHS Equality Awards

The health secretary has launched an awards scheme to reward outstanding examples of equal opportunities practice in patient care or employment.

What is required?

Awards will be given to selected initiatives which take forward the government's agenda on equality, i.e.:

- reducing health inequalities
- improving access to services for our diverse communities
- using everyone's talents fully
- equipping staff with the skills to serve all users well
- fair treatment for all our staff including respect from patients

Initiatives will need to show that they have a demonstrable impact; that they work with users to bring about change; that the resulting change can be sustained; and that the initiative can be applied to similar situations throughout the NHS.

What is the award?

Successful applications will receive £5000 to spend on developing the project. The initiatives will also be publicised widely.

Who can apply?

"Any individual or team working in the public or voluntary health organisations in England ... engaged in clinical, support or administrative activities in a hospital, general practice, community environment, training organisations, authority or commissioning body."

- There will be awards for different sizes of organisation.
- Partnerships between NHS and users, voluntary organisations, local authorities or others are particularly encouraged to apply.

Applications must be in by 26 June.
Applicants will need to submit a one-page résumé of the project and a detailed report.

Freephone: 0800 731 8920 for further details and a registration card.

North Thames Region

How to dismiss a CHC member

In ACHCEW's 1996 AGM Reg Pyne (East Herts CHC) spoke of interference in CHC work by the then "CHC manager" employed by the North Thames Regional Office – it was, he said, "a worrying cloud on the horizon". His fears seem to have been justified, although now the regional office has turned its attention to the chair of Barnet CHC, Elizabeth Manero, rather than to CHC staff.

Elizabeth Manero has proved a very effective chair, leading the CHC in demanding answers about the closure of Edgware General Hospital's casualty department and in mounting a legal challenge against Barnet Health Authority for deciding to impose cuts of £700,000 without public consultation. Indeed, Barnet CHC has been described as one of the most effective CHCs in the region by one of the regional officers.

It came as a shock, therefore, when Barnet CHC – and all the other CHCs in North Thames – were faxed the first page of a document entitled "Elizabeth Manero – Options" which seemed to be outlining the grounds on which a regional office might terminate an individual's CHC membership. The embarrassed director of corporate management at the regional office has since written to Elizabeth, apologising for the mistake in sending the fax, assuring her that the title was used only as "shorthand" – an example of "misplaced humour", and confirming that no complaint had been made about Elizabeth or Barnet CHC.

A false dilemma

Despite the apology, the regional officers' perception of their role remains problematic. They believe that it is difficult for one part of the organisation to support a CHC if that CHC is opposing health authority decisions which are in turn being supported by another part of the regional office. Yet why should this be difficult? Regional offices are supposed to ensure provision of support and training for CHC members and staff, and to monitor CHC performance through "light touch" management. The establishing arrangements say nothing about regional offices "owning" CHC policies and decisions. Thus the question of where a regional office's "loyalties" should lie need not arise.

Implications for independence

However, North Thames Regional Office does think that its "differing role with the two players [CHCs and health authorities]" needs to be "squared", and this perception raises further questions. In a letter to Frank Dobson, Toby Harris, the director of ACHCEW, has pointed out the incident implies that regional officers:

- are prepared to consider action against a CHC member purely to prevent the CHC from carrying out its legitimate functions effectively; and
- may not give government ministers objective and impartial advice on disputes and referrals.

Since April 1996, a CHC member can be removed on the grounds that the member's behaviour/actions are "not in the interest of the health service". CHCs have been concerned that this clause could be used to attack their autonomy – fears which may well increase after this incident. Toby has called for a review of the grounds on which CHC members can be disqualified and for an appeal procedure in case of disqualification.

West Midlands Region

Disputing government policy

Another swipe at the independence of CHCs has come from the chair of the West Midlands Regional Office, Clive Wilkinson. In a meeting with CHC chairs and chief officers, he said that CHC members should not dispute government policy. The issue came up in a discussion of the private finance initiative (PFI), in which Dave Harding (South Birmingham CHC) suggested that other options could usefully be pursued in parallel with the PFI approach. Mr Wilkinson said that if CHC members felt that they could not support PFI as an appropriate funding mechanism, they should resign from the CHC.

Ann Raschke, the chair of the Association of West Midlands CHCs has written to Mr Wilkinson asking for clarification. She said that while many CHCs have difficulties in accepting that major capital developments should be funded through PFI, they accept that health authorities cannot change this policy and that CHCs must work to ensure that the best possible services are delivered within any PFI proposal. In general, CHCs recognise the need to work with other parts of the NHS within the framework of existing policy. However, she asked whether he felt that CHCs should not raise any concerns about PFI proposals, even as a preamble to more specific contributions. She also asked whether his comments were intended to cover all government decisions. She pointed out that CHCs might want to criticise a policy decision to, say, introduce a charge for visits to a GP. CHCs want to protect their role in representing the views and opinions of local communities to the health services, even where this opinion does not coincide with government policy decisions.

Legal services

Two volunteers have joined ACHCEW's legal officer, Marion Chester, to support her in providing legal services to CHCs. **Jane Tepper** is a solicitor who will be working in the office from Mondays to Thursdays assisting with CHC enquiries. **Antonia Ford**, who is assisting on Fridays, will be concentrating on setting up a library and databases of relevant legislation, case law and other material. Both are likely to stay until September this year.

Treatment for mental disorder – the Bournewood case

Further to the briefing sent out to all CHCs in February, readers may be interested to know that the Mental Health Act Commission has now produced a Guidance Note on the implications of the Court of Appeal judgement for the detention and treatment of those who do not have capacity to consent. In essence they point out that the judgement means that adults who cannot consent to a wide range of treatments for mental disorders (possibly including care) cannot be detained even if they do not know they are being detained, unless that detention for treatment is sanctioned under the Mental Health Act. The guidance is detailed. Copies are available on request from Marion Chester, ACHCEW's legal officer.

The House of Lords is due to hear an appeal from the mental health trust in question in early June, although it is not clear when the judgement will be made available. CHCs will be advised of the outcome and its implications. In the meantime representations have been made to the Lord Chancellor's Department concerning the balance which needs to be struck to protect the civil rights of vulnerable adults who do not have sufficient mental capacity to consent to or refuse treatment, whilst not imposing too onerous a burden on those responsible for their treatment and care.

Marion Chester, legal officer

Psycho-surgery without consent

Leeds CHC has raised the issue of how adults without capacity are to be protected from those medical practitioners who may wish to carry out psycho-surgery (this term includes lobotomies) to treat mental disorders. ACHCEW has made representations to the effect that such treatments should never be carried out without the consent of the patient and that, where the patient has no capacity to consent, then the treatment should never proceed, at least not without a court order.

Special General Meeting

ACHCEW held a Special General Meeting on 27 April to consider its response to the Green Paper, *Our Healthier Nation*, and to the White Papers, *The New NHS* and *NHS Wales – Putting Patients First*. The 52 draft recommendations were approved, some of them with amendments. The meeting also carried a motion requiring Standing Committee to convene a working group to review the establishment, role, functions, sources of membership and current operation of CHCs.

The meeting was addressed by the secretary of state for health, Frank Dobson, who was a little more definite about the future of CHCs than he had been in *The NHS NHS* White Paper. While reiterating the need to look at how the role of CHCs might develop, he expressed the view that CHCs will be around for a long time to come.

Details of the meeting have been sent to CHC offices.

The **Health Perspective** for June summarises ACHCEW's view of the NHS White Papers.

A more detailed response is given in a **Health News Briefing**, which is being sent to CHC offices.

Chair and vice-chairs

We have received nominations for the posts of chair and the two vice-chairs of ACHCEW. Elections will take place at the AGM in July.

Nominations for chair:

Joyce Struthers	North Beds CHC
Alan Kerr	Gateshead CHC
Kath Stephenson	Chester & Ellesmere Port CHC

Nominations for vice-chair:

Alan Hartley	York CHC
Michael Downing	North Herts CHC
John Kotz	Mid Essex CHC

AGM NEWS

A plea for help with *AGM News*:

I would be very grateful if any delegates to this year's AGM could offer any help with *AGM News*, which is produced each day of the conference: writing, proofreading, photocopying ... or anything. Even a little help makes an enormous difference in a very busy few days. If you can help, please contact me on phone/fax: 01407 730 442.

Nicola Bennett-Jones