CHC NEWS

A newsletter for community health council members and staff

ACHCEW Commission

In February, the Commission on Representing the Public Interest in the Health Service, set up by ACHCEW, invited CHCs to submit written evidence. The chair of the Commission, Will Hutton, has now invited other organisations to send written evidence, concentrating on five initial areas of inquiry:

- public interest and representation
- accountability
- consultation
- how proposed changes to the NHS may require different and new systems of accountability
- the role of CHCs.

Some CHCs are taking steps to assess local opinions to supplement the views of CHCs in their evidence. In March ACHCEW's Standing Committee agreed that it would be helpful for CHCs to consider a standard list of questions rather than having to reinvent the wheel for each local survey. As a result, ACHCEW has sent to CHC offices a questionnaire aimed at members of the public. CHCs are, of course, free to use or not use the questionnaire or to amend it as they see fit.

The deadline for written evidence is 31 May 1999.

U-turn on Welsh CHCs

CHCs in Wales have been given a reprieve by the Welsh Secretary, Alun Michael ... or perhaps they haven't. The situation is far from clear.

Last September a Welsh Office consultation document *Involving the Public* was critical of CHCs and proposed that their functions should be cut down. The Welsh Office appeared to favour a proposal for fewer CHCs which would have a health authority focus.

In March, Mr Michael unexpectedly announced a "reinvigorated model of federated CHCs". There will be 28 CHCs (up from the present 22) based on nine federations (and nine "office locations"). The structure is intended to enable CHCs "to reflect local views more effectively and exert greater influence at health authority and trust level".

Beyond this basic outline, little has been spelt out and CHCs in Wales have many questions. The Association of Welsh CHCs (AWCHC) has been told that the changes are "resource neutral". This begs many questions, for example about staffing levels. There are likely to be problems with office relocations because of travel times and existing leases for offices. Beyond these practical questions, there are policy issues such as how CHCs will relate to the federations, especially where neighbouring CHCs favour different approaches.

Mr Michael has promised early consultation with AWCHC. But then, he had promised consultation before his March announcement, and this did not happen. Indeed, he even seems to have caught his civil servants by surprise. In view of the sudden change of direction, 200 CHC members who were due to stand down in April have been asked to stay on for another 18 months.

Welsh Office press release 15 March, Health Service Journal 19 March

HSSCs in Northern Ireland

At present in Northern Ireland there are four health and social services councils (HSSCs – the NI equivalent of CHCs). In a recent publication, *Fit for the Future*, the government proposes that a new regional HSSC "could replace the four existing councils to provide a stronger regional voice for the public".

ISSUE 30, MAY 1999

In this issue:

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES
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CHC evaluation framework

A Performance Evaluation Standards Framework for CHCs is being circulated to CHC offices. It has been developed by ACHCEW and the Health Quality Service, building on the work of individual CHCs and Regional Associations. The purpose of the framework is to give CHCs an assessment tool which will help them to identify areas for improvement and to demonstrate objectively their effectiveness and value for money. The framework does not prescribe what work programme a CHC should carry out.

The content

The framework lists 99 "standards statements" grouped under eight headings. Each statement is graded as "essential" (for example because of a legal requirement) or "desirable". They relate to:

- consultation
- representing the public interest in local relationships
- reviewing NHS services
- empowering the community
- feedback from users
- facilitating information provision
- management arrangements
- external management relationships

The process

CHCs using the tool are advised to carry out the following steps:

- Establish an evaluation plan, including whether to go for self-assessment or peer review.
- Carry out a baseline audit – assessing where the CHC stands relative to each standards statement.
- Develop an action plan in response to the baseline audit (selecting those standards statements which are relevent to your CHC's activities).
- Evaluate performance against the action plan. Report on the evaluation, highlighting good practice. The report will form the basis of further action plans for service development.

ACHCEW hopes that as many CHCs as possible will decide to use the tool in reviewing their work. After the framework has been in use for a year, we will ask for feedback from CHCs and develop the framework accordingly.

Staffing changes at ACHCEW

Readers who have used the services of ACHCEW's policy team will be sorry to hear that Ben Griffith is to leave ACHCEW after many years. Ben has developed a particular talent for producing submissions to consultation documents and has recently done a lot of work on the Private Finance Initiative. Sadly, ACHCEW is also losing Amanda Allen, our receptionist/admin. assistant. Amanda's roles have included preparing each month's *CHC Listings*.

Ben's departure is going to involve some changes in the ACHCEW office. Frances Presley, who is currently the enquiries officer, will move over to the policy team. Instead of appointing a replacement enquiries officer, ACHCEW will appoint a press officer. The effect will be to shift resources from enquiries towards work that makes ACHCEW a more effective national voice for CHCs – something that the great majority of CHCs have been calling for. It is hoped that the press officer will be a resource for all CHCs, assisting them in dealing with the media and raising media interest in specific issues.

AGM motions for debate

The AGM Arrangements Committee has selected 12 motions for debate at ACHCEW's AGM in July. The subjects of the motions, and their proposers, are:

- **Legislation on Organ Donation**
  Bristol & District CHC
- **Doctors' Charges for Medical Evidence to Disability Benefit Appeal Tribunals**
  North Hertfordshire CHC
- **Future of Acute General Hospital Services**
  Kidderminster & District CHC
- **Administrative costs of Primary Care Groups/Local Health Groups**
  Burnley, Pendle & Rossendale CHC
- **Ambulance Services**
  Gloucestershire CHC
- **GP Appointment Waiting Times**
  Greenwich CHC
- **Mental Health Compulsory Treatment Orders**
  North Staffordshire CHC
- **Primary Care Group Boards and CHC Membership**
  Northumberland CHC
- **NHS Pharmaceutical Regulations**
  North East Wales CHC
- **Provision of Dental Services**
  Cornwall CHC
- **Health Promotion Audit**
  South West Association of CHCs
- **Private Finance Initiative**
  South Birmingham CHC

Copies of the motions have been sent to CHC offices.

The legal team at ACHCEW has produced a batch of Health News Briefings which have been sent to CHC offices:

- **The Data Protection Act 1998: implications for patients' rights**
- **Patient Confidentiality: implications of new guidance from the General Medical Council**
- **Use of Human Organs after Death**

Secretary of State referrals

ACHCEW recently carried out a survey of CHCs' experiences of referrals to the Secretary of State. Of the 157 CHCs which responded, 43% had made a referral. By far the most common reason for a referral was a dispute with the health authority over consultation (78%). The responses about how the referral process worked indicate considerable dissatisfaction with the process, in particular about openness and accountability (see graph). In addition, many CHCs reported delays on the part of the office of the Secretary of State. CHCs made many suggestions for improvement, including:

- procedural guidance and standardised forms
- independent resolution procedures
- time limits for each stage
- access to information forming part of the Secretary of State decision
- explanation of reasoning behind the decision
- the opportunity to meet with ministers/Regional Office
- procedure to ensure that Secretary of State decisions are not undermined.

Proposals on insulin pens

ACHCEW has recently responded to an NHS Executive consultation on proposals for the provision of insulin injection pens and needles. Pen injectors are more convenient for most users than hypodermic syringes. The proposals are that:

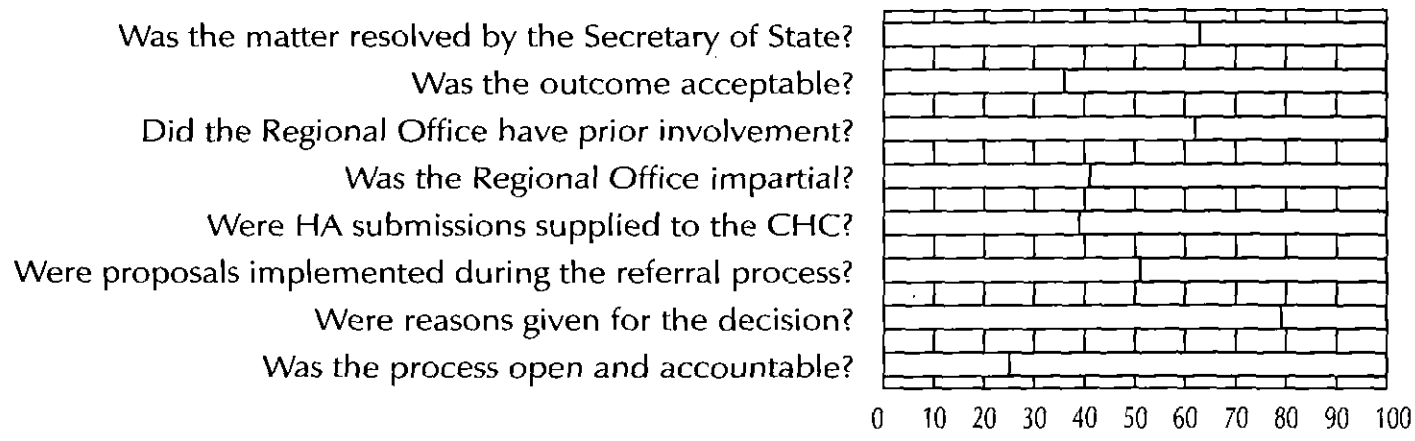
- reusable pen injectors should be available on NHS prescription
- pen needles should be available on NHS prescription
- pre-filled (i.e. non-reusable) pen injectors should **no longer** be available on NHS prescription

The first two proposals have been welcomed by ACHCEW. The British Diabetic Association (BDA) estimates that about 400,000 people either purchase their own needles or use syringes to inject insulin, in some cases because of the cost of pen needles. Being able to obtain pen needles on NHS prescription will be to the advantage of many of these people.

However, both ACHCEW and the BDA have expressed misgivings about the proposal to remove pre-filled pens from the list of devices that can be prescribed on the NHS. A minority of people may find it difficult to transfer from non-reusable to reusable pens, for example people with arthritis or poor eyesight and people with learning difficulties. The BDA has urged the government to ensure that non-reusable pens remain available for existing users who are considered vulnerable.

Both ACHCEW and the BDA have also pointed out the importance of informing all those who will be affected by the changes well in advance.

CHC perceptions of the referral process



IN BRIEF: SOME NHS NEWS

Steps towards the New NHS

Many of the institutional arrangements for the New NHS promised in the Labour Government's NHS White Paper a year and a half ago are now in place. On 1 April:

- GP fundholding was abolished
- primary care groups and local health groups were formally established
- the National Institute for Clinical Excellence started to operate.

Waiting lists: good news and bad news

The number of people on NHS waiting lists for in-patient treatment fell by 39,700 in February to 1,119,700, bringing the figure below that inherited by the Labour government when it came into power. The number waiting for over 12 months had fallen to 50,900 and none had been waiting for over 18 months. The Health Secretary, Frank Dobson, now intends to press on to meet his promise of reducing lists to at least 100,000 less than in May 1997.

Mr Dobson is also turning his attention to improving out-patient waiting times, a focus that is urgent in view of a huge rise in long waits for a first out-patient appointment. Department of Health figures show that the number of patients waiting over 12 weeks for an out-patient appointment following a written GP referral rose from 248,000 in March 1997 to 467,000 in December 1998 (an 88% rise). This increase has not been evenly spread. The Liberal Democrats have analysed the figures to show that over the same period, the number of women waiting over 12 weeks for a gynaecology outpatient appointment rose from 8000 to 18,000 (up 125%). The increase in trauma and orthopaedics was from 54,000 to 103,000 (91%).

DoH press release 30 March, Sunday Telegraph 14 March

CHC SURVEYS: CONTINENCE SERVICES

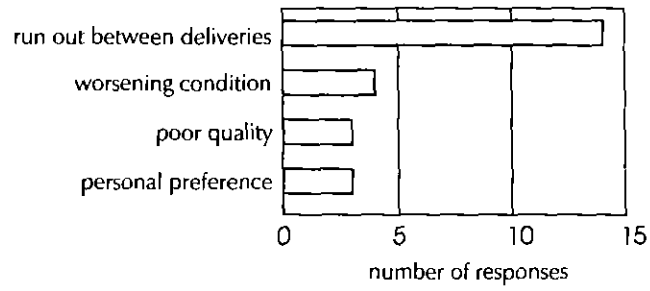
Continence survey, North West Regional Association of CHCs
Assessing users' views of the local continence service, Stockport CHC

Last autumn the Department of Health set up a review of continence services. In view of this and in view of concerns raised by CHCs, the NW Regional Association of CHCs surveyed its member CHCs, asking about budgets, product supply, assessment and waiting lists. Only a few CHCs reported budget reductions, although funding was perceived as too low in many areas, partly because of the growing needs of an ageing population. MORI research suggests that 6 million people in the UK are incontinent compared to the estimate of 3 million which forms the basis of current guidance.

Over half of the CHCs reported service restrictions, with some areas providing the service only to terminally ill patients. Health authorities are required to fund the provision of incontinence supplies to people living in independent residential homes (but not nursing homes) in the same way as for people in their own homes. There were some concerns about the service provided by staff in residential homes in which incontinence may be "managed" through the use of products rather than by trying to improve or cure incontinence.

As well as contributing to the regional survey, Stockport CHC has carried out its own user survey. There are long waiting lists, but satisfaction is high among existing users. The vast majority were happy with the home delivery service. 10% were unhappy with the quality of supplies, some saying that this had deteriorated. The highest level of dissatisfaction (16%) was with the quantity of supplies. Of 130 respondents, 21 said that they buy extra supplies for the reasons given in the graph.

If you have to buy extra supplies is this because:
Respondents could tick more than one box
Source: Stockport CHC Continence Survey



The Continence Campaign is a coalition of patient groups, politicians and continence care professionals, working together to improve continence care. If you are interested in campaigning for better care in your area, you may like to use a pack produced by the Campaign in conjunction with the RCN. For more information contact: Gill Kirk, Policy Adviser, Phone: 0171 830 3494; fax: 0171 830 8444.

Accident & Emergency Departments

Casualty Watch has been a great success in raising long waits in A&E as a national issue. However this can be achieved only by keeping the information to be collected as simple as possible. The results are useful for comparisons between areas and over time, but are limited in what they tell us about local A&E services or about the reasons for long waits in A&E. Two recent CHC publications show the value of more detailed qualitative and quantitative research. Both concerned A&E departments where the average waiting times were among the top ten in the nationwide Casualty Watch.

Tracking patients

One of the most illuminating parts of the research carried out by Redbridge CHC at King George Hospital was the tracking of selected patients through A&E for eight hours with later follow up. On one of these occasions 13 patients were tracked whose total waits in A&E ranged from 15 to over 29 hours. The department was very busy. Many of the cubicles had two people in, including one in which a patient was "desperately trying not to go to the toilet" – an act which would have to be performed within touching distance of another occupant. Relatives were distressed at having no privacy, possibly when they were seeing a family member for the last time. Staff felt that the shortage of space made it impossible to work efficiently. To be fair to staff, they made every effort to ensure the comfort of patients in a difficult situation. And to be fair to King George Hospital, it is trying to remedy some of the problems identified – new cubicles, for example, have been completed. But there is no easy answer to the basic problem: that there are too few beds on wards to accommodate patients entering through A&E.

Communicating decisions

Soon after 7.00 a.m. the researcher was aware that the patients being tracked had undergone all necessary tests and assessments and in most cases were likely to be admitted when a bed became available. However, most patients remained in A&E until the afternoon. What is more, over half the patients and relatives were not aware of whether there was a plan to admit, a situation which added to their anxiety while they waited.

The CHC report comments that communication with patients is excellent when the department is quiet, but can deteriorate at busy times. The CHC recommended that the trust should consider employing staff "with a clear role of patient liaison/communication, specifically for A&E". At the time of a revisit after the survey, the researcher felt that positive steps had been taken to improve communications.

Reception area and reception staff

Several respondents to a questionnaire at King George Hospital, Redbridge, commented on how helpful the reception staff had been. At St George's Hospital, Tooting, by contrast, it can have come as little surprise to observers from Wandsworth CHC that one of the respondents to its survey was "extremely angry at the system and attitude of reception staff". CHC observers found that reception staff were efficient in booking patients and extremely helpful and kind to the members of the CHC. However, they comment on the unacceptable attitude of those same staff towards the public in general, and towards ethnic minority clients in particular. One example was that staff did not replace toilet rolls in the female toilet even when they were told none was available. They intimated that these toilets were only "for them" and that CHC observers could use the staff toilet, which was "much nicer". A grubby, dilapidated and cold reception area can only have added to the pressure on both staff and patients.

Some A&E staff in Redbridge had asked for security screens to be installed round reception for the protection of staff. Interestingly one of Wandsworth CHC's suggestions to improve the situation in St George's was the opposite. The CHC felt that the A&E reception area might breed aggression and it recommended that "consideration should be given to removing security partitions around the reception desk."

Patiently waiting? A report of research into waiting times at King George Hospital A&E Department – patient and staff views
Coral Booth for Redbridge CHC

St George's Hospital A&E Department 24 Hour Survey
Wandsworth CHC

Funding boost for A&E

The Treasury has announced an extra £430m of capital funding over three years to refurbish A&E departments and GP surgeries across the UK. £120m is to be made available in 1999/2000, most of it going to A&E. The boost is in addition to £30m extra funding for selected A&E departments announced in February. Schemes being funded include treatment and play areas for children, improvement of waiting areas and moderning resuscitation equipment.

Guardian 10 March

NHS Direct

Research published by Sheffield University indicates that that NHS Direct, the nurse-led 24-hour helpline, has proved very popular with people who have used it. The survey of over 1000 users found that:

- 97% were satisfied or very satisfied with the service
- 92% thought they were given exactly the right amount of information
- 90% found that they advice they received worked well in practice.

NHS Direct has handled about 75,000 calls over the last year, and over 40% of the calls have been about young children. At present 20% of the English population is covered by the service and the whole of England should be covered by the end of 2000. It is predicted that when the service is working nationally, it will be contacted by 20% of the population each year.

DoH press release, 23 March

Health information on the Internet

Concerns are often raised about the quality of health information available over the Internet. A study by Dr Peter Eachus of the Department of Health Sciences at Salford University investigated the quality of the sites likely to be accessed by people using standard search engines (such as Yahoo and Infoseek) to find out about coronary heart disease. He analysed the first 20 sites returned by each search engine. He rated the quality of sites on a scale from 1 (for sites set up by university medical schools) to 8 (sites set up by lay members of the public) and 9 (not relevant).

The highest number of sites returned were those of health centres or similar (rating 3) followed by private health organisations (rating 5). There were none from self-help groups and very few from lay members of the public. Dr Eachus concludes that searchers would have an excellent chance of finding a good source of information quickly. However, he comments that this may change and "in the absence of regulation and control, users of this information will have to remain vigilant".

Comment

Given Dr Eachus's rating of lay information, one can only wonder what "regulation and control" might mean. People using the Internet can be expected to reject sources which do not suit their needs – and it may be that a lay opinion is just what the searcher is looking for. Systems are developing to give quality accreditation to information on the Internet, and doubtless this is useful. But it is a far cry from "regulation and control".

Internat. Journal of Health Promotion & Education, 37 (1): 1999

Publications

The Doctor's Internet Handbook

Robert Kiley, the Information Service Manager at the Wellcome Trust, has written this introduction to medical information on the Internet. It covers medical databases, consumer health information, quality and evidence-based medicine. For details see http://www.roysocmed.ac.uk/handbook.htm

Telemedicine

ACHCEW has recently distributed a Health Perspective on Telemedicine, i.e. treatment at a distance, usually conducted through electronic audio-visual links. The Health Perspective welcomes the benefits of telemedicine, but points out possible dangers in terms of provider responsibilities, communication difficulties, referral procedures, confidentiality and access to records.

TACKLING RACIAL HARASSMENT

Despite the enormous contribution that members of ethnic minority communities have made to the NHS, incidents of racial harassment and racism generally are all too common in the service. The government has prioritised action to tackle discrimination and ensure equality of opportunities in employment in the NHS. Good practice exists, and has been adopted by some NHS employers, but so far it has had a limited impact. To help remedy the situation, the NHS Executive has issued an action plan on tackling racial harassment.

The aims of the action plan are to:

- inform users and providers of NHS services that racial harassment will not be accepted
- ensure that this message is widely disseminated and visibly present
- deter perpetrators
- ensure that NHS staff have the knowledge, structures and skills to fulfil these commitments
- give black and ethnic minority staff the confidence and support to challenge harassment effectively.

An accompanying Health Service Circular (HSC 1999/060) summarises action needed from NHS boards and chief executives. at a local level. Copies have been sent to CHC chairs. The report, *Tacking Racial Harassment in the NHS: a plan for action*, is available from DoH, PO Box 410, Wetherby LS23 7LN.

Are they being heard?
A study of patients' perceptions of the new NHS complaints procedure in primary care

Newcastle and North Tyneside CHCs

The local resolution stage of the NHS complaints system clearly presented considerable obstacles for the respondents to this survey. Newcastle and North Tyneside CHCs contacted all the people who had approached Newcastle & North Tyneside Health Authority or the two CHCs about a primary care complaint over a 6-month period. Of the 49 responses, 34 concerned a complaint against a GP and 10 a complaint against a dentist. Of these, 12 fell at the first hurdle and had not contacted the practice concerned. Even among those who did take the complaint further, a large number did not feel they could discuss the matter with the practitioner concerned. In addition, complainants were faced with late or no replies to letters, a perception that they were not being taken seriously and other barriers to resolution. By the time of the survey, only 4 of the 34 GP complainants and 2 of the 10 dental complainants said that the complaint had been resolved. Only one of the GP complainants was satisfied with the outcome.

Health Which? survey on complaints to the GMC

The Consumers' Association is conducting research into patients' experiences of making a complaint about a doctor to the General Medical Council (GMC). It intends to publish the results in *Health Which?* later this year.

To carry out the research the Consumers' Association needs to identify as many people as possible who have made, are making or have considered making such a complaint. It is placing adverts in the national press and has also asked CHCs if they could help. When complainants have been identified they will be sent a questionnaire (no later than 21 May and to be returned by 28 May).

For further information phone Sally Williams or Suzanne Clark on 0171 830 6000.
Alternatively, individual patients who want to respond can ring freephone 0800 920 196 to ask for a copy of the questionnaire.

1000 years experience in NHS complaints
The evidence of CHC officers

Kay Wong for the Society of CHC staff

CHC officers are constantly faced with a dilemma. They know the value of their complaints work – for the complainants they help, for other NHS users and for their own understanding of local NHS services. Yet they have difficulty in balancing this role with the need to provide CHC members with services.

This report draws on the comments of 238 CHC officers. The title even understates their experience – between them they have been involved in NHS complaints work for over 1300 years. They offer a wide range of help to complainants – from being someone to talk to at a time of distress, though advice and help with putting complaints together, to support at meetings. These services are offered in a context of increasing pressure. Since 1996 NHS purchasers and providers have been obliged to tell complainants that the CHC is there to "help and advise" them, but CHCs have received no extra funding to meet this expectation. In addition to receiving an increasing number of referrals, CHCs are being referred ever more complex and difficult cases.

The conclusion is not that CHCs should seek to reduce this role, but that their contribution should be recognised through specific funding and professional support. The contribution of CHCs should be maximised by agreeing clear lines of responsibility between CHCs and the Commission for Health Improvement and the National Institute for Clinical Excellence. This would enable evidence from complaints to be used to draw early attention to problem areas. Another priority is for information from CHC complaints work to be aggregated nationally using a standardised system for collecting and reporting information.

AVMA and legal aid

Action for Victims of Medical Accidents (AVMA) has recently entered into a contract with the Legal Aid Board to provide "merits screening" in some clinical negligence cases. The Board will be able to refer applications for legal aid to AVMA when it is considering refusing an application.

Reaching the decision to go ahead with this arrangement proved difficult for AVMA. There is a risk that some victims of medical negligence and some CHCs might see AVMA as part of the Legal Aid Board – the authority that can effectively stop someone from pursuing a claim. However, in the end AVMA decided that this risk was outweighed by the desirability of having a knowledgeable, independent organisation to screen claims. If AVMA doesn't carry out the role, some other person or organisation will, possibly someone who is antagonistic to clinical negligence claims. In addition, AVMA does not believe that it helps to grant legal aid if a claim has little merit: this is likely only to dash a victim's expectations at a later date.

The Involving Users project

A project on involving users in improving the delivery of local public services was set up in April 1997 with a steering group drawn from the Consumer Congress, the National Consumer Council and the Service First Unit (then the Citizen's Charter Unit) of the Cabinet Office.

The Project has produced a main report and four companion case studies reports (on housing, benefits, healthcare and education).

- The main report, ***Involving users: Improving the delivery of local public services*** presents succinct guidance based on lessons from local pilots. It has made an effort to pay attention to users' involvement in decisions, and not simply how to research their views. It also discusses the project's experience of involving apparently "hard to reach" groups.
- ***Involving users: Improving the delivery of healthcare*** describes how Leicester Royal Infirmary NHS Trust worked with black and minority ethnic communities to draw up a service improvement action plan. The project team found that even well-intentioned staff may have a fear of the unknown and simply not know where to start. The report comments that the best way of overcoming this fear is to do some research about the community and to evaluate it. There were also lessons about appropriate consultation methods and taking into account just how isolated some communities can feel.

The reports can be ordered from the Service First Unit Publications Line on 0345 223242.

ON THE WEB

The National Primary Care Research and Development Centre based in Manchester University has various research areas, including accountability and user involvement in primary care development. Under "Quality of care" on its website, it includes two documents which may be of interest to CHCs and lay members of PCG boards:

- a General Practice Assessment Survey which is a questionnaire aimed at patients
- a handbook on quality assessment in general practice, which includes as an appendix a brief questionnaire called a "Patient enablement instrument".

The website address is http://www.npcrdc.man.ac.uk/

Mobilising local opinion

The Channel 4 programme, the *Mark Thomas Comedy Product*, has unearthed an obscure law which can be used to force a district council to hold a referendum on a matter of local concern. The legislation applies to areas in England and Wales with a parish council – it does not apply to metropolitan areas.

Parish council meetings can be arranged at the request of six or more local government electors living in the parish. If at a meeting, 10 people or a third of those attending vote for a referendum, they can force the district council to hold one.

The procedure has been used in Wakefield to establish the strength of local opposition to a PFI deal. The district council at first refused to hold the poll, but backed down under pressure from a local newspaper. In the event, there were big votes in favour of government funding of hospital redevelopment and against PFI. The poll is not legally binding on decision makers, but will put pressure on local MPs to call for cancellation of the scheme.

Red Pepper April 1999 and
Marion Chester, ACHCEW legal officer

CABx IN HEALTHCARE SETTINGS

Over 100 Citizens Advice Bureaux (CABx) receive funding from health authorities, totalling £2,079,778, to provide services in healthcare settings. CABx in Birmingham have taken the lead in the development, and there are now CAB health projects in 46 sites around Birmingham, ranging from GP surgeries to mental health day centres and outreach services.

One of the main services that CABx offer patients is advice on money matters: in one project three-quarters of clients received additional state benefits after consulting the CAB. Clients are also able to get on-the-spot advice on issues such as employment and housing. By offering services in these settings, CABx reach clients who would not otherwise consult them, notably people with disabilities, people with chronic illnesses, older people and people with mental health problems. There is anecdotal evidence that the intervention of CABx has played an important part in lifting some patients out of depression. Research is underway to evaluate more rigorously the health impact of access to advice in healthcare settings.

Do you have CABx working in health care settings in your area? *CHC News* would be interested in hearing your views on what they have to offer and how they relate to CHCs.

Target, Our Healthier Nation, DoH, Issue 33, March 1999