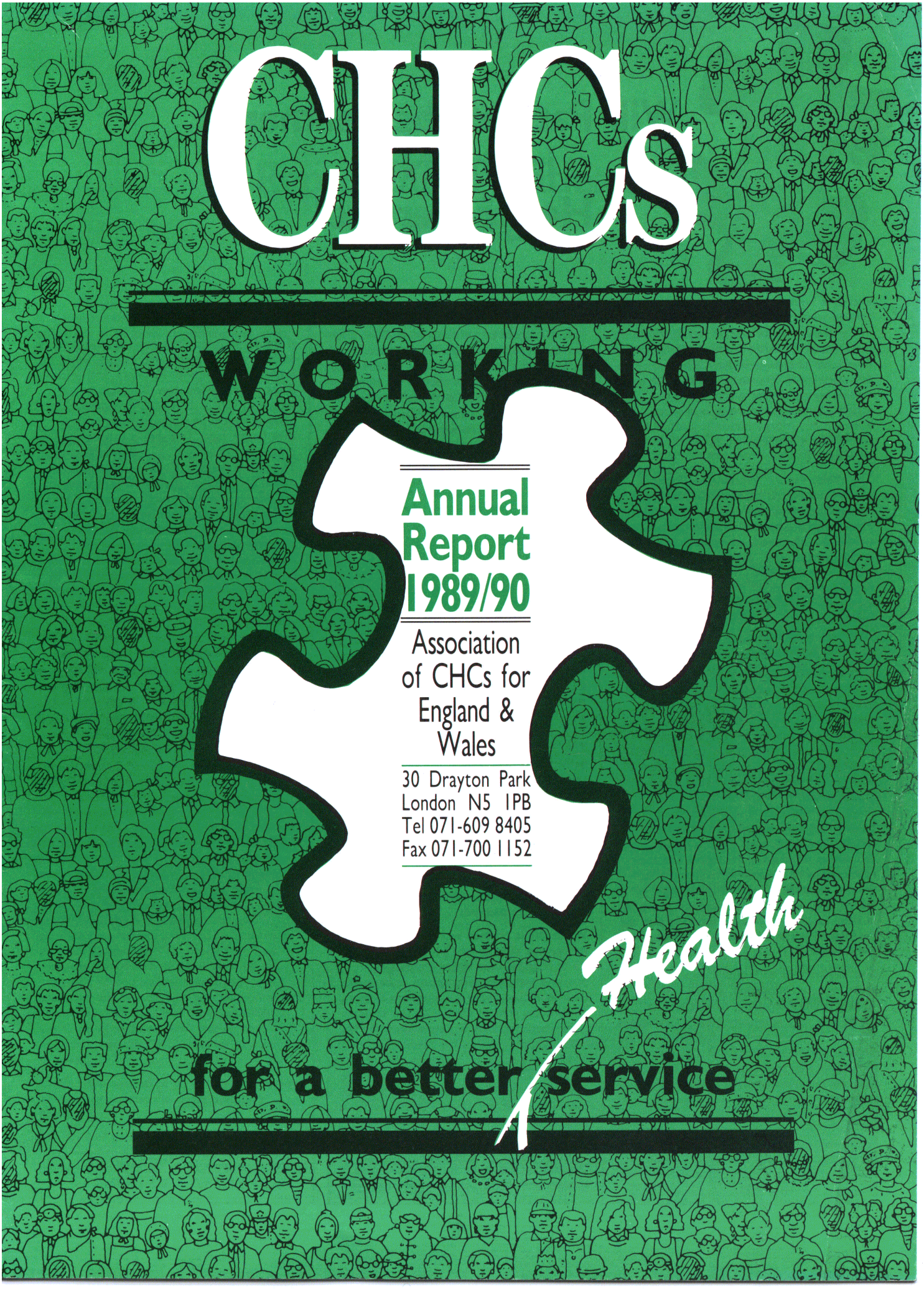
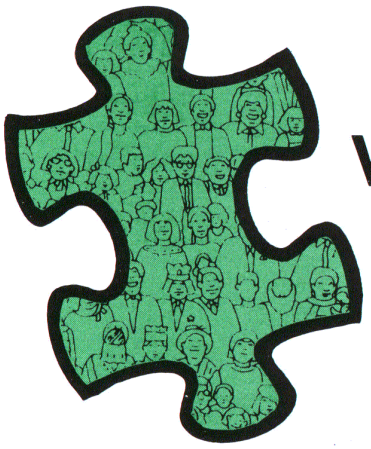

CHCs
WORKING
Annual Report 1989/90
Association of CHCs for England & Wales
30 Drayton Park
London N5 1PB
Tel 071-609 8405
Fax 071-700 1152
Health
for a better service



Will Patients be Partners in the New Health Service?

Everyone knows that the National Health Service seems to be reorganised on average every three years or so. Sir Roy Griffiths, the Deputy Chairman of the NHS Policy Board, has commented that such restructuring is "enormously disruptive and creates turmoil under a semblance of action." On each and every occasion, however, the reorganisation is justified by claims that it will improve services to patients.

The White Paper, "Working for Patients", which outlined the current changes, began with an introduction from the Prime Minister, who promised that the proposals would "put the needs of patients first" and concluded that the "patient's needs will always be paramount." That same White Paper promised that "the interests of the local community will continue to be represented by Community Health Councils, which act as a channel for consumer views to health authorities and to FPCs.

Such a principle is important because there is much concern that patients' interests may become marginalised in a contract-based system of health care. A wide variety of organisations, ranging from the Institute of Health Services Management to the Psoriasis Association, have argued that the system of user/patient representation needs to be strengthened. As the IHSM have put it, there is a "need for a significant counter-bureaucracy for consumer representation. In future, CHCs will need a much firmer foundation in terms of resources and their relationships to the community, and a far greater capacity to take an informed independent view of health service provision in their locality. It will be important that the necessary investment is made to produce these results."

The Department of Health's response to these representations has, at the time of writing been, if anything, to restrict the future role of Community Health Councils in the new NHS and certainly has failed to take on board what is necessary if patients' representatives are to have an effective input into the key decisions which will affect patients' interests.

For example, the Department seems to take the view that CHCs should not have any role in respect of individual NHS Contracts and are ready to change the Regulations, so as to avoid it being mandatory for CHCs to be consulted by DHAs about their plans for contracts. Yet, NHS Contracts are intended to be much more than mere commercial documents. They are supposed to be the key vehicle through which DHAs (as "purchasers" of services) will determine what services are to be bought from "providers" and, in particular, are to contain the detailed specification of the standards of service to be provided. However, to exclude CHCs from being consulted on such matters is to make a mockery of their role in representing patients' interests. How can patients be partners in the new NHS if their representatives are not able to comment on what services are to be bought and on the quality standards to be set?

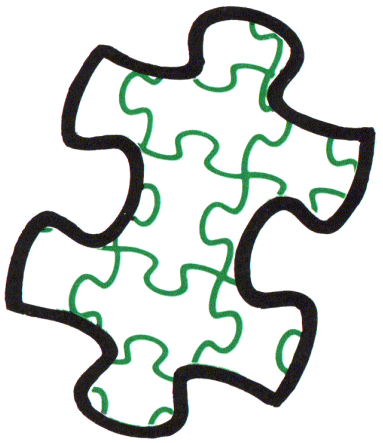
The Department also seems to believe that CHCs should not have any role in respect of GP fund-holding practices. It is, nevertheless, the Government's expectation that increasingly services will be purchased by such practices rather than through DHAs. The implication of excluding CHCs from the activities of fund-holding practices will be to remove a major part of NHS care from the scrutiny of patients' representatives.

The Department is also considering limiting the rights of CHCs to be consulted on the closure of hospitals or on changes of use, removing any special role CHCs might have in commenting on the establishment of NHS self-governing trusts, and restricting CHCs' rights to visit premises.

When this is coupled with proposals to reduce the number of CHCs in Wales from 22 to 9 and similar major changes in Scotland and Northern Ireland, it begins to look as though there is a concerted effort to limit the role of CHCs. At the same time, there has only been the most limited consideration given to the resources that CHCs need to carry out their present tasks, let alone what will be needed in the future. The average CHC has a budget of £35,000, out of which it is expected to pay two staff, rent its premises, service a Council of 18-24 members and protect the interests of a quarter of a million people. The Department's attitude to ACHCEW also appears ambivalent with the Association's funding frozen for the fourth year in succession.

If the Department of Health is serious about patient representation and, indeed, about the rhetoric of their own Ministers, then rather more commitment than this needs to be shown to CHCs. It is widely recognised that patients should be made partners in their own health care. This should happen not only at individual level, but also collectively. This would mean a wider recognition of the major contribution that CHCs can make to the way in which the NHS operates. CHCs, as the users' representatives, should be able to make an input into the key decisions affecting patients. This must imply an involvement in NHS Contracts and in fund-holding practices, a proper commitment to consultation and using the experience and expertise of CHCs and their members in validating the quality assurance work of health authority managers. Only with a strong and effective independent voice can the consumers of the NHS be adequately protected in the 1990s, and the Department of Health will need to decide whether they are really serious about that protection or whether their commitment to patients is nothing more than window-dressing.

CHCs Representing Patients' Interests



It is vital for CHCs to participate widely and effectively at all levels of planning and to be fully involved in discussions on service provision if they are to represent the views of users of health services as extensively as possible. One way in which CHCs have a statutory right to participate is by attending the meetings of the District Health Authority and the Family Practitioner Committee. These meetings are usually held monthly or bi-monthly and are open to the public. The CHC observer at DHA and FPC meetings can provide a valuable opportunity for the service users' point of view to be heard.

Attendance at meetings

We asked CHCs which parts of District Health Authority meetings and Family Practitioner Committee meetings they were able to attend to find out what these statutory rights mean in practice.

86% of the 115 CHCs who responded to this questionnaire stated that they attended both the public part of DHA meetings (Part I) and the confidential part (Part II). In areas which had Part III sessions, which related to personnel and staffing matters, most CHCs did not attend. Rather fewer CHCs, that is 55%, stated that they were able to attend Parts I and II of FPC meetings. It appears that the relatively newly acquired right, gained in 1985, to attend these meetings has yet to be implemented fully. Of those 15% of CHCs who have encountered problems with the CHCs' statutory rights to attend these meetings, the vast majority were those who had experienced problems with the FPC meetings. Difficulties included ensuring papers were received, reluctance to allow CHC observers to attend Part II of meetings, particularly if these involved the discussion of complaints. One CHC Secretary was not allowed to speak on the White Paper at the DHA meeting, whilst the Chair of another DHA had to be reminded that the CHC observer had a right to speak.

CHCs were also asked to outline the extent of their participation in other statutory bodies.

The level of participation in these bodies is high, whether it is observer or full membership: 77% for JCCs, 56% for JCPTs, 92% for MLSCs and 85% for LECs. Most CHCs are involved to a varying extent with other health authority working groups. The most common issues looked at by these groups are health promotion and education, drug advisory committees, HIV/AIDS, quality assurance, cervical cytology and breast cancer screening, equal opportunities, disability, the elderly, ethnic minorities, children, terminal care and bereavement services and family planning. Only 15% of CHCs stated that they did not have representatives on any health authority working groups.

Consultation

CHCs have the duty to represent the interests of residents of their Districts and users of services provided by their Health Authorities. They have the right to be consulted by DHAs and FPCs on any proposals under consideration for any substantial variation or development in services. This is a key issue for CHCs if they are to play an integral role in the planning process and to feed in the views and needs of consumers.

In practice it seems that consultation is patchy in some areas and very full in others. We asked CHCs how many times they had been consulted under HSC(IS)207 (Closure or Change of Use of Health Buildings), October 1975, in the last year:

No. of times consulted	No. of CHCs
0	29%
1	31%
2	20%
3	10%
4	5%
5 or more	5%

At least half of the CHCs in each of the above categories felt that the Health Authority was receptive to the CHC's comments: 57% of those who were consulted once; 86% of those who were consulted twice; 82% of those who were consulted three times; 83% of those who were consulted four times; and 50% of those who were consulted five or more times. CHC comments as a result of consultation can have a considerable impact:

"Plans to rationalise numerous family planning clinics were radically altered (and clinics saved) following the CHC submission."

One third of CHCs said they were satisfield with the levels of DHA consultation on planned service developments and that they were consulted widely and at an early stage.

"Member and officer involvement at an early stage, even in pre-consultation planning. All formal consultation takes place within a mutually agreed timetable."

"The CHC receives early information on planning proposals — sometimes before members of the Health Authority working group."

In spite of a generally reasonable level of satisfaction with the level of DHA consultation with the CHC, it appears that there are still some DHAs which do not make much effort to include the CHC in the planning of services. For example, 16% of CHCs were either not consulted at all or were very dissatisfield.

"We are not consulted, we are informed."

"The DHA is very reluctant to involve the CHC in the planning of service developments."

"They don't consult, and deny they need to."

CHCs expressed more satisfaction with the level of consultation by the FPC; 72% said it was adequate. Most CHCs see the level of consultation improving, particularly since the installation of new General Managers to FPCs.

STATUS			
	Full	Observer	No
Joint Consultative Committee	20%	48%	32%
Joint Care Planning Team	32%	16%	52%
Maternity Services Liaison Committee	67%	14%	19%
Local Ethics Committee	65%	12%	23%

When Things Go Wrong in the NHS

CHCs' Relationship with DHAs and FPCs

As far as CHCs' relationship with their DHA was concerned, 37% felt that they had an excellent relationship.

"Relationships have always been excellent in terms of consultation, co-operation and information sharing."

"Good working relationship, developing to meet changing circumstances of local health services following Government White Papers. Independence of CHC is acknowledged and respected."

48% felt that relations were reasonable, and only 15% stated that relations were distant and poor.

"They would rather we didn't exist, then the Chairman and Officers could do what they liked unchallenged."

"Lack of trust and understanding between CHC and DHA, generated by DHA which sees the CHC as an unnecessary evil."

Relationships were sometimes better with DHA officers than members. In spite of the White Paper changes and financial difficulties which could put strain on the relationship between CHCs and DHAs, there seemed to be a considerable level of satisfaction in this area.

Similarly, 14% of CHCs stated that relations with the FPC were very good and 74% stated that they were adequate. This impression of good working relationships somewhat undermines statements in Department of Health documents that any enhancement of CHCs' role would be met with hostility by both managers and clinicians.

Gathering Consumers' Views

We also asked CHCs how the DHA or FPC ensures that it receives the views of health service users. 18% of CHCs said that the DHA and the FPC were not doing anything in the way of questionnaires, public meetings etc. and avoided the public as much as possible. The vast majority of DHAs look to the CHC to channel the views of users and many have commissioned the CHC to undertake surveys on the Health Authority's behalf.

Helping patients and their relatives and carers with complaints does not form one of CHCs' statutory duties and they do not receive any extra resources for undertaking this work. However, most CHCs recognise the importance of this time-consuming and often complex work and have built up considerable experience in assisting complainants.

Official statistics would seem to indicate that the number of people with complaints about their NHS care or treatment is very, very small. Whilst CHCs have always accepted that as a percentage of total doctor/patient consultations the level of dissatisfaction is small, they have also maintained that the official figures mask a much greater level of dissatisfaction which is never officially articulated. For this year's Annual Report we wanted not only to reflect more accurately the real scale of patient discontent but also to pay tribute to the enormous amount of work being undertaken by CHCs in helping people to express their grievances. In addition we have sought comment from CHCs on how well the NHS responds to criticism from its users.

Our figures would indicate that the true nature of complaints is indeed much higher than is shown by official figures. For example, the number of complaints about GPs and dentists received by CHCs is over eight times the number formally investigated. Including all those complaints never reported to CHCs we can see that the number of complaints formally investigated represents only the tip of the iceberg.

To try and gauge how many people go on to formalise their complaint, we also asked CHCs to give us figures for the number of people they helped to pursue complaints. Our figures indicate that CHCs are fulfilling a much needed role in assisting those who feel that the health service has let them down.

Complaints pursued with assistance of CHC* in 1989

FPC Informal Procedure	833
FPC Formal Procedure	832
General Medical Council	42
Clinical Complaints Procedure	1297
Health Service Commissioner	118

* Figures from 107 CHCs (55% of ACHCEWs members)

The Most Common Complaints

- Communication breakdown
- Unsympathetic/rude/unresponsive attitudes on part of staff
- Waiting lists for treatment
- Refusal to undertake home visits
- Cost of dental treatment

	Complaints received by CHCs*	Complaints formally received	Complaints formally investigated	Complaints Upheld
source:	ACHCEW	DoH	DoH	DoH
GPs	4235	n/a	1162	299
Dentists	1851	n/a	436	175
Hospital Care	7568	29956	963	n/a
Community Health Services	1971	5030	113	n/a

*We asked CHCs to tell us how many people approach them over a year with a complaint. This figure was to include all those cases resolved by the CHC, forwarded through official channels and those taken no further. 107 CHCs (55% of ACHCEW's Membership) responded to our questionnaire.

- Inadequate community services
- Removal from GP's list
- Early discharge leading to recurring health problems
- Transfer of long term patients to private care
- Clinical error

CHCs told us that at the root of almost all complaints is a breakdown or failure in communications, even where this does not form part of the initial complaint. One CHC told us that over a quarter of complaints it received related to doctors not taking their patients' illnesses seriously enough. Unfortunately it is often those most vulnerable who seem to be let down by professionals:

"A woman desperately worried about her husband's acute chest pains phoned her GP at 3am. He asked her if she knew what time it was and told her to contact the surgery in the morning. He refused a request for an immediate home visit. The man was taken to hospital that night, quickly admitted to intensive care and kept in under observation for a week."

"An eighty year old couple wanted to transfer to a GP nearer their home but were told that the doctor's list was full. Investigation by the CHC showed this to be untrue. However, by this time the original GP was also being unhelpful and the FPC had to be brought in to assign the couple to a GP."

"The FPC's decision not to uphold a serious complaint relating to a death in March 1988 was not relayed to the complainant until July 1989."

What Do CHCs Think Of The Complaints System?

The overwhelming comment from CHCs regarded the time that complaints take up, linked with Secretaries' lack of formal training in helping complainants. Many CHCs noted that elderly patients are often reluctant to pursue complaints because they have continuing medical needs and fear that their care may be affected by complaining. Others commented on the obstacles to complaining: the difficulty in obtaining a second opinion, the impossibility of getting access to medical notes, the bureaucratic and over-legalistic procedures which seem also designed to intimidate.

"Professionally biased — weighted against the complainant — defensive attitude of DHA investigating officers"

is how one CHC summed up its experiences. Another commented:

"The length of time the procedures take, and in particular with the FPC procedure the degree of bureaucracy involved (ie the number of formal letters and the procedure for time limits for replies which is usually interpreted liberally for the practitioners and strictly for complainants)

"Initially the DHA tends to reply to the areas of the complaint which they can justify and ignore those parts in which they are at fault — this simply lengthens the process."

"The FPC is not a complaints procedure and does not seek to address problems perceived by patients. The DHA sees making a complaint as a nasty thing to do, this pervades the system."

What Do Patients Think?

According to CHCs, few emerge satisfied from the ordeal of the NHS complaints procedures:

(They) "rarely produce an unequivocal apology with an explanation of how they have changed procedures to ensure it does not happen to anyone else."

"Not many go through all the way — tend to get fed up/feel too stressful".

"Complainants feel that the hospital systems are complicated and weighted towards the medical profession".

One particular problem highlighted by this CHC was:

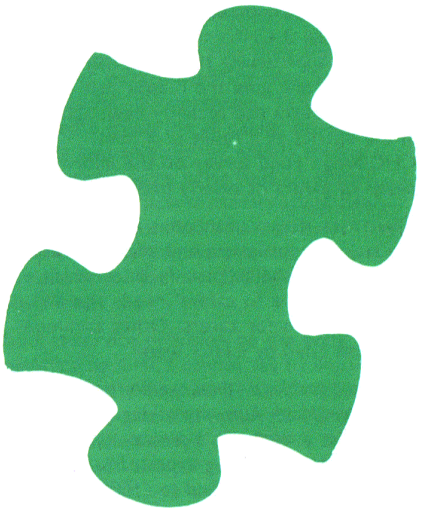
"The lack of access to medical notes in which complainants suspect that pejorative statements are made."

What Is The Answer?

ACHCEW feels it is time to scrap procedures which are obviously not working and replace them with a system that genuinely puts the emotional, practical and financial needs of patients first. The health service must recognise that not all its users are satisfield with the service they receive and the Government should recognise the valuable role currently being undertaken on a shoestring budget by CHCs.

A Users' Model Complaints System

- The DoH should assume responsibility for publicising complaints mechanisms.
- There should be strict time limits for dealing with complaints.
- All complainants should have access to free independent and confidential advice.
- Health Authorities should adopt a more positive attitude to comment and criticism.
- All complaints should begin with an initial investigation to determine how the complainant wishes to proceed.
- All complainants shall have a right to conciliation and/or a full enquiry.
- Complaints should be investigated by an independent panel, drawing on medical expertise.
- All health workers should comply with complaints procedures.
- Complainants should receive a full explanation of the outcome of any enquiry.
- Compensation should be awarded on the basis of need rather than proving negligence.



CHCs Caring for the Carers

The Government White Paper, "Caring for People", outlines new proposals for the provision of care in the community and suggests that local authorities should take carers' needs into account when making arrangements for service provision. In spite of the recognition of the contribution and commitment of carers to community care services, there is no duty to consult carers built in to the NHS and Community Care Bill. If the needs of carers are genuinely to be acted upon, there needs to be careful assessment of both who the carers are and the difficulties which they face. We wanted to try and determine the extent to which CHCs are already providing advice and support for carers and the role that CHCs can play in acting as a channel for carers' views.

Who Contacts the CHC and What Are Their Problems?

94 CHCs responded to our questionnaire on carers. Of those who were able to give an estimate, 41% said that no or very few carers approached their CHC; 34% said the proportion was 10-20%; 15% said that the proportion was 20%-50%; and only 10% said that over 50% of those people approaching the CHC are carers. 28 could not estimate the proportion of people that approach the CHC who are carers. The number of carers approaching the CHCs has increased in two thirds of cases over the last year. Of the 3 CHCs that said the number of carers approaching the CHC had decreased, one gave the reason that three carers' workers had recently been appointed in the district as a result of a joint CHC/King's Fund survey on the information needs of carers of elderly people.

There was almost unanimous agreement that the lack of appropriate and adequate respite care services and support facilities which were responsive to carers' needs was a major problem for carers. Other common problems cited by CHCs were:

"Financial problems: these were often brought on by the Health Authority asking them to find a place for a relative in a private nursing home and then the carer being expected to pay the "top-up" as DSS only fund to £180 and charges are £220."

"Not knowing where to turn, especially if initial contact with GP is unhelpful."

"Frustration — often passed from one statutory agency to another."

"Lack of domiciliary services and support, eg home bathing, day and night sitting, provided by health and local authorities."

"Lack of information about aids, eg commodes, stairlifts etc."

Other problems mentioned were difficulties in arranging transport for the physically disabled, particularly in isolated rural areas and a general lack of funding for support services, such as chiropody, meals on wheels and home helps.

Local Support for Carers

95% of CHCs said that initiatives were being taken locally, either by the Local Authority, Health Authority or voluntary organisations, to promote or support self-help groups for carers. It appears that voluntary organisations have taken the lead on this and are plugging the gap left by statutory provision.

"Many of our voluntary organisations are in effect carer self-help/support groups, set up because of the lack of statutory activity."

Crossroads Care Attendant Schemes have been set up in many areas and other organisations which were frequently quoted as taking an active part in the provision of self-help support groups were MIND, Age Concern, the National Schizophrenia Fellowship and Alzheimer's Disease Society. However, there were some good examples of initiatives taken by the Health Authority and Social Services, particularly those financed via Joint Funding programmes.

"Short-term Respite Care for children with a mental handicap was funded jointly by the Health Authority and voluntary organisation."

"The Health Authority through the Support Team have organised self-help groups for relatives of terminally ill people."

"A Carers Charter and booklet has been published and a Carers Liaison Officer appointed."

How Are CHCs Helping?

The vast majority of CHCs are involved in giving assistance to carers in a number of ways. They can help carers collectively in the locality by setting up self-support groups and by providing meeting space and photocopying facilities. 20% of CHCs have pushed for and been involved with the setting up of local Crossroads Schemes.

"The CHC was involved in initiating the setting-up of a joint support group for mental illness, resulting in two of the groups' members being invited to join a partnership group with Health Authority/Social Services."

"We have produced a tape-slide presentation on services for carers."

"The CHC played a lead role in the formation of a Carers Working Party and helped produce a carers leaflet."

Some CHCs have also produced local guides to services for carers and guides to local private and voluntary residential homes. CHCs can also help carers on an individual basis:

"Those who come for advice, information or as complainants are given the appropriate assistance."

Our questionnaire uncovered a number of key inadequacies in the support services currently provided by District Health Authorities and Local Authorities for carers. In addition to the perennial problem of the lack of adequate respite care, these include the following:

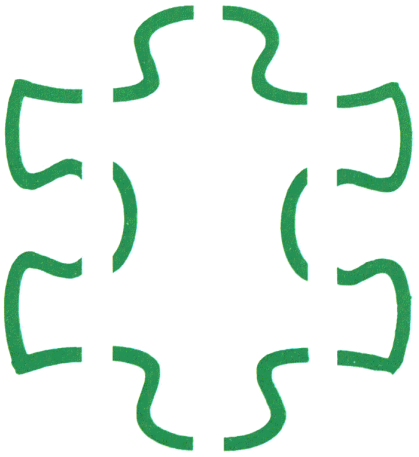
"Lack of awareness of their problems — both physical and emotional/psychological. Failure to consult properly in determining the level of support required."

"The problems are financial. In the areas of provision of services acute services dominate. Community services therefore have the hardest time in competing for ever diminishing resources."

"Lack of co-ordination between local authorities and the DHA."

"Acute shortage of occupational therapists and physiotherapists to advise carers and treat patients, especially those who cannot attend clinics."

"Pressure on community nurses and change of role to mainly medical issues means, for example, no bathing service."



A Crisis in Health Service Funding?

"Few services are appropriate to ethnic minorities."

"The emphasis is now on nursing home care in the private sector — carers are not getting help at home and are being "persuaded" to send relatives to the private sector ... and being left to fund increases in costs when raised by the homes over DSS levels."

"Poor understanding by GPs of the services available."

In spite of the statutory and voluntary initiatives being taken in some areas and the various support services which CHCs are providing, our survey clearly identifies many areas in which carers' needs are not being addressed. Local Authorities, Health Authorities and voluntary groups should be adequately funded and supported to take further steps to meet these needs. The Government's lip service to carers and their contribution must be underwritten with the necessary resources to make this a real commitment and to ensure that carers are given a meaningful choice, including the choice not to care if the personal cost is too great.

Despite government reassurances that funds to the health service are at an all time high, reports throughout the year have focussed on hospital closures, cancelled operations and lengthening waiting lists. Over the last year CHCs have been increasingly expressing concern and anxiety about the financing of hospital and community services. ACHCEW therefore decided to undertake its own survey to determine the extent of underfunding and how this is impacting on patient care.

109 CHCs responded to our questionnaire (56% of ACHCEW's membership), of these 78 (71%) reported that their health authority has had to make significant adjustments to budgets over the year to avoid a deficit. For most, overspending was the result of a combination of higher than anticipated inflation and pay rises and also over capacity and increased activity. Only a small proportion quoted previous overspending or historical underfunding as the main reasons for this year's problems.

Perhaps the most obvious consequence of underfunding is the closure of beds, wards or indeed whole facilities to save money. 26% of CHCs told us that their health authority had made PERMANENT closures in services and 55% told us about TEMPORARY closures to try to balance budgets.

Permanent Closures

Details of units	% of CHCs mentioning
Elderly care ward	11
General surgical ward	7
Small hospital	7
Obstetric/Gynaecology ward	4
Community dentistry	3
Family planning clinics	2
Psychiatric hospital	2
Social sterilizations	1

Temporary Closures

Details of unit	% of CHCs mentioning
General acute wards	27
Surgical beds	12
Elderly care wards	8
Obstetric/Gynaecology wards	7
Rehabilitation beds	3
Psychogeriatric wards	2
Continuing care wards	2
Accident & Emergency department	1
Other services	6

Other ways for health authorities to try and save money include postponing new developments and freezing staff posts. 48% of CHCs told us that their health authority had taken this latter course. Some of the examples included: restrictions on over-time; cessation of all health promotion work; 90 posts frozen in acute unit; freezing of community nursing posts. The most common staff shortages are occurring in the para-medic specialities with speech therapists and occupational therapists being the worst affected. One CHC reported 190 posts frozen at their District General Hospital.

Many CHCs reported that their health authorities were postponing new, and often badly needed, developments. 13% of CHCs reported a freeze on all capital developments and 7% said services for elderly mentally infirm people were being held up. Other delays included new maternity units, new psychogeriatric wards, a new pharmacy and community services. In one district the completion of the new DGH has been postponed.

Cuts in service provision on the scale being reported by CHCs cannot fail to impact on patient care. We asked CHCs to tell us about the impact the cuts were having on waiting lists; cancelled operations, discharge arrangements and community health services. The quotations come from the CHCs themselves.

41% of CHCs told us that the increasing length of time patients wait for treatment is

a cause of much anxiety in their district with orthopaedics and gynaecology generally being the worst hit:

81% of medical admissions are now emergencies."

"There is now a two year waiting list for all joint replacements."

"The gradual worsening of the health of patients on a waiting list increases the care/tests/pre-op preparation when they are finally admitted to hospital and can lead to longer convalescence."

As well as longer waiting lists many more patients are having their operations cancelled, often at very short notice. This is stressful, irritating and can be intensely inconvenient. 37% of CHCs told us this was a significant problem in their district:

"People have to ring in on a daily basis on the off-chance that they may be offered a bed."

"One woman was told by an angry gynaecologist that after the cancellation of her operation he could no longer estimate when she would be admitted. He told her to contact the general manager who had shut the beds."

"As part of an in-patient survey it was established that in the main acute unit, 11% of 'booked' patients had had a previous admission postponed."

"30% of planned admissions are cancelled."

"In opthalmology there is not enough equipment. People have pre-meds only to be sent home."

For those patients who do eventually get into hospital, pressure on beds is often leading to shorter stays and hurried discharge. Whilst nobody likes being in hospital longer than necessary, the trend towards very early discharge has worried many CHCs. Early discharge has implications for the recovery of patients and the likelihood of post-operative complications. There is also great concern that when discharge is arranged quickly, continuing care, especially of more vulnerable groups such as the elderly, is not undertaken in a systematic fashion. This just means additional pressure on community health services and informal carers who are left to find alternatives to hospital care.

"Extremely low average length of stay in teaching hospitals with no discharge policy aimed at individual patients"

"Continual worries about early discharge — one healthy patient who died from peritonitis was discharged two days after a hernia operation."

"Sometimes patients cannot be discharged because there are no consultants available to authorise discharge."

The effect on cuts in the acute sector is often most keenly felt in the community services. These services are themselves often most likely to be cut because they are seen as lower profile or less political than cuts in hospital services. 39% of CHCs told us that their primary concern was with cuts in community health services to balance the budget. Again it is often the most vulnerable groups such as the elderly who suffer because of cuts in community nursing, chiropody etc:

"Evening nursing services have been curtailed, domicilary visits by physiotherapists have been reduced and the home laundry and incontinence service has been severely cut."

"With the decrease in hospital services, particularly for elderly people, there is an increasing burden on already overstretched community care services."

"Early discharge leads to more demands on community services, but there has been no transfer to cash from the acute sector to match."

"The 'rationalisation' of chiropody means that the mobile service has been discontinued. Community occupational, physio and speech therapy services are under particular stress."

Within health authorities, the cuts in services are leading to low staff morale and high staff turn over. Shortages of clerical staff mean that notes, letters and X-rays are increasingly going missing: one CHC even reported that shortages in staff meant patients getting 'lost', with people being admitted to inappropriate wards and sometimes being moved two or three times.

The experience of CHCs reflects other national surveys in demonstrating the pressures imposed by an increasing elderly population, high inflation and staff costs and increasing demand due to advances in medical technology and government targets. Only a sustained substantial increase in health service funding will end the regular end-of-year cuts and closures which typify our underfunded health service.

CHCs
Working for a Better Health Service

The strength of CHCs lies in their diversity, their comprehensive local knowledge, their links with the local community via voluntary and other groups and their statutory rights in relation to management. This section of the Annual Report highlights some of the initiatives taken by CHCs over the last year — regrettably space prohibits us from giving a fuller account of CHCs' achievements.

NORTH MANCHESTER CHC

organised a day conference for people who use mental health services. About 70 people came to discuss ways of improving services and increasing user-participation. There was a vast range of experience represented among people who attended and the day was structured to let people talk in small groups and exchange ideas. Many expressed dissatisfaction with services although the tone of the conference was very constructive.

NORWICH CHC

campaigned to save rural and suburban family planning clinics from closure and opposed cuts in services in the central clinic. Public awareness was raised through the local press and leaflets and after several months Health Authority plans were modified to save the rural clinics and increase services in the central clinic.

RHYMNEY VALLEY CHC

have carried out a survey of the health needs of elderly people in Upper Rhymney Valley, an area of particular social deprivation. Nearly 2000 people responded to the questionnaire which covered all aspects of life from disability to housing. It showed that major carer support comes from daughters of elderly people and highlighted a great lack of visiting from GPs, health visitors and other community services. Lack of public transport also presents many problems of access to health care. It concluded that many old people are at risk from poor standards of living.

WEST LAMBETH CHC

have recently appointed a development worker to establish and support a Patients' Council in a major psychiatric hospital undergoing closure. While it is still early days the CHC have high hopes of giving patients a voice in their future and encouraging self-help.

ROTHERHAM CHC

took up a complaint with the Health Authority about the X-ray department. The Authority then agreed to involve the complainant in planning improvements to the department. A meeting was held between managers, the CHC secretary, the complainant, a doctor and the head of the department to discuss the working of the department. The outcome of the meeting was very positive and the suggestions made by the complainant were acted upon.

BASILDON & THURROCK CHC

have campaigned for a breast screening service accessible to local people. The Regional Health Authority had planned a static unit in a neighbouring district but were eventually persuaded to set up a mobile unit. This will greatly improve the access to this service for local people.

BATH CHC

carried out a survey of charges in private nursing homes, particularly to look at the situation of people needing full DHSS support. They found that the maximum level of benefit available did not even come close to meeting the minimum average charge in nursing homes. The effect of the Government's Community Care plans will be to increase the number of people living in residential and nursing homes who are subject to a 'care gap'. The CHC concluded that the current proposals for Community Care funding are not adequate. The issue has been taken up by a local MP.

KIDDERMINSTER & DISTRICT CHC

successfully opposed the moving of their GP Maternity Unit to another district. After a packed CHC public meeting of 250 people the Regional Health Authority went back to the drawing board and agreed to CHC and District Health Authority demands to retain the unit and only to transfer an Obstetrics Unit between other districts.

LEEDS EAST CHC

carried out a survey of terminal care by contacting carers of people who had died recently. The CHC researcher and a member presented the report to the Health Authority's Joint Working Party on Care of the Terminally Ill. The Family Practitioner Committee has taken on board the items relating to GP communication with carers and the report has been received with enthusiasm by local hospices and carers who have contacted the CHC in the wake of local publicity.

NORTH BEDFORDSHIRE CHC

have worked closely with the local Sikh community to lobby successfully for a Punjabi-speaking GP for Bedford. Two new surgeries have been established in areas where provision had always been low.

WESTON CHC

have worked with the District and County Council and the voluntary sector to produce an information pack called 'Weston Made Easy' for disabled residents and visitors. It has proved very popular and will do much to enable people with disabilities to enjoy Weston to the full!

ISLE OF WIGHT CHC

stimulated a joint review of services to amputees involving the Health Authority, the CHC, the ambulance service, physiotherapists, and many other people giving services to amputees. One major problem that affects amputees is transportation to mainland services for artificial limbs and appliances. Two initiatives are now under way: a survey of all registered amputees to get their opinions on all aspects of their treatment and care and the production of an information booklet for amputees on services and support available to them.

SOUTHEND DISTRICT CHC

became aware that patients with special needs on acute nursing wards were not receiving the care they needed. Patients with physical handicaps, mobility problems or communication difficulties were left to fend for themselves for feeding, personal hygiene and comfort. This was made worse by the use of agency staff. The CHC persuaded the District Health Authority to produce a policy dealing with the training of staff, consultation with patients and carers and a simple check list of tasks to raise nursing standards. Hopefully this will improve the lot of people who don't become more mobile and independent during their convalescence.

DURHAM CHC

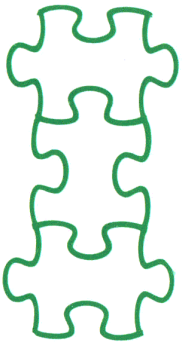
have launched a "Tell the CHC" campaign. A leaflet telling people what the CHC can do for them is being delivered to all 60,000 homes in the district over a two year period. Responses to the leaflet will allow the CHC to represent more fully the local population and broaden its base of support.

SOUTH GWENT CHC

have been involved in the formation of a Patients' Participation Group in General Practice. This included helping to establish the PPG in a large local practice and organising a seminar on the subject. This has also helped to spawn an active and campaigning 'Newport Health Forum' and a support group for carers.

SALISBURY CHC

have played a positive role in the provision of community care for people living in psychiatric institutions by introducing the charity 'Turning Point' to the District Health Authority. The charity will provide homes within the community to replace old run-down wards and save the Authority £100,000 per annum. Turning Point insist that this saving is to be ploughed back into health services for elderly mentally infirm people. This shows the positive role CHCs can play in making community care a reality for people in psychiatric institutions.



The Work of ACHCEW 1989/90

The Association has set itself two general objectives: firstly, to provide information and advisory services to member CHCs, to assist member CHCs in their work and to promote good practice; and secondly, to represent health services users at national level. These objectives have been broken down into a series of more detailed work tasks as part of ACHCEW's work programme. Inevitably, for the last year this programme has been dominated by issues arising from the NHS White Paper "Working for Patients" and the National Health Service and Community Care Bill. However, the overall work of the Association is summarised in the sections which follow.

Membership of the Association

The number of CHCs who are members of the Association has continued to increase. In 1989 there were 190 member CHCs. Since then eight more CHCs have rejoined the Association. This gives the prospect of 198 CHCs (92.1% of the 215 in England and Wales) being in membership in the current year. The trend over the last few years is as follows:

1985	174
1986	179
1987	181
1988	185
1989	190
1990	198

This level of support from CHCs for the work of the Association is most welcome and reflects the need for CHCs to work together in the light of the rapid changes currently taking place in the National Health Service.

A key issue for the future is, however, going to be what happens when Health Authorities merge as envisaged in the White Paper "Working for Patients." Certainly, a number of Regional Health Authorities are said to be considering substantial reductions in the number of Districts in their Regions. All recent DHA mergers have been followed by the merger of the relevant CHCs. Inevitably, if this were to happen on a significant scale this would have a major impact on the Association's income. However, the arguments about CHC mergers are by no means clear-cut. CHCs are after all intended to provide a locally-based mechanism for NHS users to be represented. If mega-DHAs are created, the Health Service will be increasingly remote from its users, which strengthens the argument for CHCs which represent definable local communities. ACHCEW is currently examining this issue with a view to producing some guidelines on how users should be represented at local level.

Meanwhile the Welsh office has conducted a consultation exercise on a proposal which would reduce the number of CHCs in Wales from 22 to 9. ACHCEW responded by suggesting that the consultation document be withdrawn and replaced by a study of the public's needs and a reassessment of how they can best be met within the CHC network in Wales. The Welsh office's final proposals had not yet emerged at the time of writing.

Information Service

The Information Service maintains a database of information on reports produced and surveys conducted by CHCs, together with information on other reports and publications whose contents may be of relevance to the work of CHCs. All CHCs are encouraged to forward reports and surveys to ACHCEW and over a thousand of these are now held by the Association. This data source is of increasing interest to academics and other organisations. An annual listing of CHC reports and surveys is published and circulated widely to CHCs and others interested.

Much of the Information Team's time is spent on responding to requests for information and advice from member CHCs. Considerable use is made by member CHCs of this service and the number of enquiries runs at the rate of about 140 per month. Other organisations and academics, some from overseas, also approach ACHCEW for information, particularly about the role and work of CHCs and a standard information package is available.

Community Health News

"Community Health News" is the newsletter produced by the Association. Although primarily for member CHCs, there are an increasing number of subscriptions from other organisations, the press and those interested. It has been published ten times during the course of the year, along with six special supplements on the NHS White Paper "Working for Patients". Until February 1990, "Community Health News" was edited by Judith Cook with considerable input from the ACHCEW Information Team, but after the fiftieth issue Judith Cook has handed on the editorship to Ken Howse to enable her to concentrate on another major writing project. The Association is immensely grateful to her for the contribution she has made over the last few years.

"Community Health News" is intended to be a mixture of news and comment, coupled with the occasional feature, plus reports on the major activities of CHCs, publications received and conferences and meetings. An increasing emphasis is given to items of interest from journals and on news items that CHCs may otherwise have missed. The choice of which items to include and which to cover at greater length is never easy, and we continue to rely on CHCs letting us know of their activities or drawing our attention to items for inclusion.

Health News Briefings

A number of "Health News Briefings" have been published during the year. These are primarily for the information of member CHCs, but they are circulated more widely as a contribution to debate and discussion on current health topics. Increasingly, the "Health News Briefings" themselves attract considerable press and media attention and much follow-up work is done in discussing their contents with other organisations.

Homelessness and Health

"Homelessness and Health" was published in September 1989. This argued that the NHS fails to provide a proper service to homeless people, even though they are more prone than the general population to physical illness and have a higher risk of suffering some form of mental ill-health or dependency on

alcohol or drugs. The paper noted that many GPs are unwilling to take homeless people on to their lists and as a result many homeless people rely inappropriately on hospital accident and emergency departments for medical care and often miss out on the community care support they need. The paper argued that much more positive efforts should be made by Health Authorities and by Family Practitioner Committees to identify the health needs of homeless people and to make sure that they receive appropriate medical care.

The Provision of Core Services in the NHS

"The Provision of Core Services in the NHS" was published in October 1989. This examined the idea contained in the White Paper "Working for Patients" that Health Authorities should designate some of their services for local residents as "core" which would need to be provided locally. This paper argued that there were some services which should, in effect, always be provided locally because their effectiveness would be undermined if they were less accessible. The paper concluded that other services ought to be provided locally unless it could be shown that there was a clear benefit to the service user if they were provided further afield.

NHS Complaints Procedures

Two Briefings were issued on the NHS Complaints System. The first published in October 1989, reported on a special ACHCEW seminar held the year before which had examined the existing NHS procedures for handling complaints. The paper warned that patients could have little confidence in procedures which were largely invisible, confusing, bureaucratic and time-consuming. The second paper, published in March 1990, proposed a users' model for NHS complaints, which would seek to satisfy the emotional, practical and financial needs of the complainant.

CHCs: Fifteen years on and into the 1990s

Two papers were published in November 1989, looking back at the first fifteen years of CHCs ("Representing the Consumer: Community Health Councils 15 years on") and ahead in the light of the proposed changes in the NHS ("Effective CHCs for the 1990s").

The first of these pointed out that since their inception in 1974, CHCs have been remarkably successful in:

- promoting local community interests in the NHS, particularly for those groups who are least able to get the best from the health service.
- promoting quality in health services, by surveying patient satisfaction, monitoring services and assessing unmet needs.
- providing a link between the NHS and the public, obtaining public views on local services and setting up networks to involve local groups in planning local health facilities.
- promoting individual rights, by assisting individual complainants, helping people to get the best use of services and encouraging the NHS itself to be more user-friendly.

The second paper was the report of the ACHCEW Panel of Inquiry into the future role of CHCs and argued that the CHC remit should be made more explicit to cover the nature, range and content of NHS contracts placed by local Health Authorities and to monitor all health care provided to their local population. The paper argued that CHCs are already under-resourced for the work they do and that CHCs need to be independent of the health authority/FPC structure and that a new system of establishing and resourcing CHCs should be considered.

Quality Assurance and CHCs

"Quality Assurance and the role of CHCs" was published in January 1990. This argued that too many Health Authorities are reluctant to make their services more user-friendly and that an independent voice is necessary in assuring quality if patients' concerns are to be properly recognised. The paper concluded that patients should be involved with management in identifying problems, in specifying the aims of quality assurance initiatives, in setting standards and in agreeing and monitoring changes. Many CHCs are already actively involved in such work, but it is clear that health authorities could do much more in this area.

Cervical Cytology Screening

"Cervical Cytology Screening — getting it right" was published in February 1990. This argued that the cervical cytology screening call/recall system was an extremely ambitious programme that had had a number of teething problems. The paper made a number of recommendations, suggesting ways in which the information provided to women could be improved and results followed up more effectively with better support being given to women with a positive smear result. The paper also advocated screening every three years, rather than every five.

Papers are also due for publication on the new general medical practitioners' contract and the CHC role in NHS contracts. A Health News Briefing was also circulated to member CHCs on the use of Computers by CHCs.

Other Publications and Publicity Material

ACHCEW's general leaflet, "CHCs — Working for a Better Health Service", continues to be widely used by member CHCs to introduce the role and work of CHCs. Three posters to go with the leaflet were produced during the year and circulated to member CHCs.

ACHCEW has also produced a general leaflet, in conjunction with the National Consumer Council on "Patients' Rights". This again is widely used by CHCs but also by many other advice organisations. In addition, many individual copies are requested by the general public. The leaflet has now been produced, following a grant from the Department of Health, in Urdu, Bengali, Punjabi, Gujerati, Hindi, Cantonese, Vietnamese, Turkish and Greek. It is hoped that a version in Armenian will also be available shortly. A Welsh version of the leaflet has also been produced by the Welsh Association of CHCs, in conjunction with ACHCEW and the Welsh Consumer Council. A poster promoting the leaflet will also be available soon, along with a poster-sized statement on equal opportunities for display by CHCs.

ACHCEW has also prepared a paper for CHCs on "Dealing with Racist Clients" and

this has been circulated to CHCs. Also circulated to CHCs have been papers on the Government's White Paper "Caring for People", on the House of Commons Social Services Committee report on the Government's proposals for the NHS, and on CHC involvement in private and voluntary sector provision and in the work of local Social Services Departments. ACHCEW has also updated and reissued its "Directory of Community Health Councils".

Conferences and Seminars

A special ACHCEW seminar was organised in May 1990, entitled "Working towards Health for All: CHCs, the NHS and our Multi-Cultural Community." The main aim of this was to develop the awareness of CHCs of their responsibility in ensuring that they and the NHS itself respond to the needs of black and minority ethnic communities.

Responses to Consultation Documents and representations on behalf of CHCs

A significant amount of staff time is devoted to considering consultation documents, issued by the Department of Health, other Government Departments, or other external agencies and, where appropriate, submitting responses in line with the Association's policy. Over the last year these have included:

- Out-patient services (National Audit Office)
- Draft food hygiene regulations (DoH)
- Patients' access to manual health records (DoH)
- Children as day case admissions (National Association for the Welfare of Children in Hospital)
- Draft guide-lines on anonymous HIV testing (DoH)
- Draft guidelines on local research ethics committees (DoH)
- Lay participation in preliminary screening (General Medical Council)
- Medical Audit in FPCs (DoH)
- Medical Audit in Hospital and Community Health Services (DoH)
- Independent Inspection Units (DoH)
- Nurse prescribing (DoH)

Individual CHCs have also asked ACHCEW to make representations on their behalf or on respect of issues which concern them on a wide range of issues. Many such matters have been considered by the Standing Committee and pursued with the DoH or other bodies as appropriate.

External Relations

The Association continues to try and create a high public profile for CHCs and for the concerns of patients. Regular contact is maintained with the specialist press, with health correspondents on the national newspapers and with relevant programmes on radio and television. A range of news releases have been issued over the year both highlighting ACHCEW publications and activities and in response to Government announcements and other events. This has led to substantial coverage for the Association and its publications. There have also been an increasing number of requests for comment on other current health concerns.

ACHCEW is part of the wider consumer movement and good links are maintained with other consumer bodies. Regular meetings and discussions take place with our sister associations of Health Councils in Scotland, Wales and Northern Ireland. There is frequent contact and joint working with the National Consumer Council, the Patients' Association, the College of Health and the Consumers' Association. ACHCEW also participated in and ran a fringe meeting at the 1990 National Consumer Congress.

The Association has also worked closely with a range of other patient-oriented voluntary organisations in considering the NHS and Community Care Bill. Under the auspices of the National Council for Voluntary Organisations, a variety of groups have come together and met regularly to consider the progress of the Bill, possible amendments and lobbying activities.

There are also good working relationships and regular meetings with the National Association of Health Authorities, the Institute of Health Services Management and discussions have also been held with the Association of Directors of Social Services, the Royal College of Physicians, the Royal College of Surgeons, the Pharmaceutical Society, the British Medical Association and many other organisations. Good working links exist with the Health Education Authority, the National Community Health Resource and with various parts of the King's Fund.

Finally, there is regular contact between the Association and the Department of Health. ACHCEW has been pleased to have constructive discussions with Mr Roger Freeman MP, Parliamentary Under Secretary of State for Health. Regular discussions take place with the policy division of the Department with responsibility for CHCs and there are increasing links with other parts of the Department. There was however, some disappointment at the Department's decision not to increase the Association grant for 1990/1. The grant has now been set at £50,000 for four years without any uplift for inflation.

Parliamentary Contacts

More than 60 detailed Parliamentary Briefings have been prepared and sent to MPs and Peers on particular aspects of the NHS and Community Care Bill and a number of meetings have been held with individual Parliamentarians to discuss these. Although these have not led to major changes to the Bill, they have clearly informed debate and have led to a number of helpful clarifications by Ministers of Government intentions in respect of the Bill and its operation.

Standing Committee and Working Groups

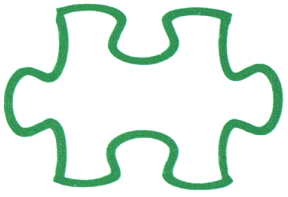
Since the AGM in 1989, the Standing Committee has met on four occasions. Meetings have focussed on current issues affecting the NHS, ACHCEW initiatives and publications, and on policy concerns raised by member CHCs.

The Honorary Officers of the Association have also met on a regular basis throughout the year, but in addition have always been available to provide direction, support and advice. Individually their work has been substantial and has been much appreciated by ACHCEW staff.

The Officers, together with members of the Standing Committee and Staff, have also represented the Association at a variety of meetings and conferences. This has been important in ensuring that the work of CHCs attains a high profile and has also meant that the views of users of services have become more widely recognised and understood.

The Director has also had a substantial degree of contact with regional groupings of CHCs. This has helped to make sure that ACHCEW is better informed about the views of member CHCs, but has also provided an opportunity for the Association to report back on its activities. Another major channel for this two-way flow of communication has been the Standing Committee, whose members are appointed as regional representatives to enable this to happen more effectively. Close links have also been maintained throughout the year with the Society of CHC Staff.

Finally, input into the work of the Association comes from the Standing Committee's Working Groups and from the networks of CHC members and staff developed to comment on particular issues.



Chairman's Message

Dear Colleagues,

This has been an eventful year, to say the least, in the life of the National Health Service. As public "watchdogs", our role has been to seek some protection for the user in the face of a sharp wind of change; this has demanded the qualities of patience and perseverance, diplomacy and some clairvoyance. The officers and the Standing Committee have given a high priority to work relating to the passage of the NHS and Community Care Bill through Parliament, as the nature of patient services will inevitably be much influenced by this piece of legislation. Changes directly affecting patients may not be apparent in the words of the Act itself; its significance is that it enables government administrations, local managers and practitioners to execute changes that will have a substantial — and possibly detrimental — impact on the users.

As an Association, we have sought to provide a positive input into the public debate whilst retaining, as we must, our political impartiality. A number of detailed parliamentary briefings have been prepared during the course of the debate.

As a statutory body offering leadership and co-ordination to nearly 200 member Councils across England and Wales, the Association needs, and indeed has a right to expect, the practical support of Government. ACHCEW has presented a strong case to the Department of Health, based on its growing workload and output, for increased funding, and support for a development programme to include much-needed training for CHC members and staff. The position, however, is that our grant for 1990-91 remains at the same cash level as it has been for the last three years and whilst we are grateful for the Department's continued support, we must impress upon Ministers the need for more in order that we can fulfil our role to best effect.

The need to strengthen CHCs is no less important. This must be a two-fold process: Councils themselves must be concerned about their own effectiveness and the quality of their service, and in this the Association can provide vital support to the extent that its resources allow. But if their credibility and public profile are to be protected and enhanced, CHCs also need formal rights of representation and consultation that are relevant to the emerging pattern of health care, with sufficient resources to carry them out. The statutory definition of CHCs' role and functions, which Government is not presently disposed to revise, is less than helpful, having regard to the new structure, based as it is on providing services through a system of contracts and on the growth of NHS care in private and independently controlled establishments. It is not at all clear how CHCs will be able to represent and protect the users at the point of delivery, or how they can properly monitor the quality of service. Whilst forging voluntary links with all health care establishments, within and outside the NHS, is desirable, informal relationships can be no substitute for updating and clarifying our *statutory* rights as independent watchdogs.

Community Health Councils, like the health service itself, are not immune from change. In Wales, we face a major restructuring exercise which will significantly reduce the present number of Councils. In England, where the normal pattern is already one CHC per health district, the impact on CHCs of any forthcoming mergers between districts will need to be closely monitored. We note with interest the proposed changes for Scotland and Northern Ireland and I believe it is to the benefit of all that we maintain a liaison between each of the national associations.

As an Association, we are very fortunate to have a small but highly committed team of staff, ably led by Toby Harris. We owe them a debt of gratitude. I would also like to thank my fellow officers, Rita Lewis and Ross Thomson, and members of the Standing Committee, for their support and their loyalty to ACHCEW and all it stands for.

Yours sincerely,

Hywel Wyn Jones **Chairman**

Association of Community Health Councils for England & Wales 1989/90

Chairman: Cllr Hywel Wyn Jones (Ceredigion CHC: Wales)
Vice Chairman: Mrs Rita Lewis (Croydon CHC)
Honorary Treasurer: Mr. Ross Thomson (Stockport CHC: North West Region)

Members of the Standing Committee

Cllr. Mrs. Margaret Hall (Northern Region)
Mr. Gordon Mullis (Yorkshire Region)
Cllr. E. E. Jones (Trent Region)
Mr. Harry Place/Mrs. Kath Currie ((East Anglia Region)
Mr. George Wenham/Mrs. Wyn Pockett (North Thames Region)
Ms. Doreen Scott (North East Thames Region)
Mr. Jim Terry (South East Thames Region)
Dr. Heather Wood (South West Thames Region)
Miss Rachel Worsley (Wessex Region)
Mr. Frank Harris (Oxford Region)
Mrs. Kay Summerell/Mr. Les Godwin (South West Region)
Mrs. Margaret Hayes (West Midlands Region)
Mr. Harry Cunningham (Mersey Region)
Ms. Pat Leahy (North West Region)
Mr. Cliff Fenton (Wales)

Secretary Observers

Mr. Tony Richards	Northern, Yorkshire. Mersey, North West Regions
Mr. Dag Saunders	Trent, East Anglia, Oxford, West Midlands Regions
Mr. Graham Girvan	North West, North East, South East, South West Thames Regions
Mrs. Ann Covell	Wessex, South West Regions
Mr. Danny Davies	Wales

DoH Observer
Mr. Philip Chinque

Society of CHC Staff Observer
Mrs. Joy Gunter

Staff
Toby Harris — Director
Chye Choo — Chief Administrative Officer
Hazel Fisher; Richard Pawson (from March 1990) — Information Officer (Health Policy)
Belinda Gumburd; Carole Auchterlonie (from October 1989) — Research/Information Officer
Suzanne Tyler — Development Officer
Leigh Bryan; Anne McClean (from November 1989) — Secretary/PA to the Director
Rose Walter — Clerical Assistant (p/t)
Judith Cook; Ken Howse from February 1990 — Newsletter Editor (p/t)

- There are 215 **Community Health Councils** (CHCs) in England and Wales. Their job is to keep under review the operation of the Health Service in their districts and to recommend improvements. They have to be consulted on any substantial development or variation in service.

  CHCs were set up in 1974, in response to evidence that NHS care was not sufficiently patient centred and to make a clear distinction between the management and public representation functions of the NHS. CHCs were given the role of representing the interests of patients and the community to managers of the health service.

  The budgets and staffing of CHCs is determined by Regional Health Authorities (by the Welsh Office in Wales) and there are variations in the levels of both throughout England and Wales.

  CHCs have been responsible for starting the process of opening up the NHS to the public and have kept the needs of vulnerable NHS users in the forefront of debates about resource allocation.

- The **Association of Community Health Councils for England and Wales** (ACHCEW) was set up in 1977 to provide a forum for member Community Health Councils, to provide information and advisory services to CHCs and to represent the user of health services at a national level. CHCs are not obliged to be members of ACHCEW but most are.

  CHCs pay an annual subscription to ACHCEW based on their own annual budget. Additional grants from the Department of Health, Health Education Authority and other bodies supplement ACHCEW's income.