annual report 1992/3

ASSOCIATION of COMMUNITY HEALTH COUNCILS for ENGLAND and WALES

ANNUAL REPORT 1992/3

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APOCALYPSE POSTPONED?

The first two years of the NHS internal market have not so far produced the dramatic consequences that some predicted. Partly this is because of the 'Safety First' message that emanated from Richmond House in the run up to last year's General Election and partly because purchasers have yet to exercise the full range of their power.

It is likely that 1993/4 and 1994/5 will start to see the internal market really begin to operate as purchasers adjust contracts more explicitly to reflect price and quality. As a consequence of this, services may be switched from one provider to another, referrals to some units may be restricted, and increasingly detailed 'protocols' may be developed to govern the use of extra-contractual referrals.

As this starts to have an impact, a number of issues are going to arise. Will closures happen in a random and unplanned way as a result of small fine-tuning decisions of a multiplicity of purchasers? Will the system be regarded as working if centres of excellence come under threat of closure because they cost more for each patient treated than other units? Will some facilities be duplicated or over-provided in the interests of so-called competition?

Community Health Councils will be monitoring these developments closely. Presumably the NHS Management Executive will be doing so as well. However, if things go wrong, who will be able to intervene? Ministerial statements imply a laissez-faire approach. Nevertheless, common sense suggests that the market will need some form of regulation — or at the very least some form of planning. Certainly, in the United States the principle of markets being regulated is a well accepted one and in the UK the privatised industries each have their own regulatory body.

There is, however, nothing comparable for the NHS. There is no longer any NHS planning system worthy of the name. Regional Health Authorities are to be slimmed down and virtually nothing has been heard of the Clinical Standards Advisory Group since it was set up.

If the internal market in the NHS is here to stay, then a debate is urgently needed on how that market is to be regulated both to ensure that patients' and service users' interests are protected, but also to make sure that public resources are used sensibly and efficiently.

This is important for a number of reasons. Regulatory mechanisms are necessary as a safeguard against fraud and corruption. Effective systems are necessary to make sure that the NHS internal market operates in a way which is above suspicion. Similarly, processes to monitor the use of external consultancy firms are probably needed to ensure that contracts to such firms are properly let in fair competition and that value for money is obtained.

It is a fallacy to assume that a 'market' automatically produces an optimal allocation of resources. In terms of economic theory, this only results in circumstances where there is perfect competition between a multiplicity of suppliers and purchasers. The nature of the Health Service is that the market is far from perfect. In any one area there may be only one purchaser (the DHA). Even if there are GP budget holders they will be much less significant in terms of purchasing power than the DHA, unless they have banded together to form a consortium. On the provider side, there may in practice be only one Trust which is able to offer local services.

The danger is that the NHS will end up with all the paraphernalia of a market but will lose the ability to plan provision effectively to make the best and most effective use of the resources available. CHCs are already indicating that they foresee problems of this nature arising over the next year or so. The need for independent monitoring on behalf of the patient's point of view has never been more necessary.

APOCALYPSE POSTPONED? continued

The status of CHCs is therefore of key importance. Particularly when there is no effective system of regulation, an independent advocate for the interests of those using services is essential. To do this effectively, CHCs need to be adequately resourced, their work needs to be respected and valued within the NHS and they need to be seen to be clearly independent of the local health service structures.

The last eighteen months have seen an increasing emphasis placed by both NHS purchasers and providers on consulting CHCs and involving CHCs in their work. This is welcome and will hopefully be reinforced by new guidance codifying these changes. Some improvement in resources has also been seen, but given the substantial increase in workload faced by CHCs, it is still clear that CHCs are under-resourced for the work that they do.

The long-term independence of CHCs may also be influenced by the changes in RHAs. Some RHAs have in fact sought to intervene in the work of the CHCs they establish. Such practices infringe — at least in principle — the independence of CHCs. When such efforts are with a view to increasing the performance or enhancing the skills of CHC members and staff, then the objectives are clearly laudable. However, the temptation remains for RHAs to abuse their 'parental' relationship with the CHCs in their region. As RHAs become smaller organisations, the status of CHC staff may become less clear-cut, and there may be pressure to devolve functions or require particular activities from CHCs. It should be clear, however, that CHCs cannot do their job unless their independence is safeguarded and protected. In the long term this may require consideration of different establishing arrangements for CHCs. A logical time to do this would be now — at the same time as reviewing how the NHS market is to be regulated. Both steps are in the public's interest and both would help make sure the new NHS really does meet the needs of those who use its services.

"IT SAYS HERE..."

CHCs give their opinions on the first year of the Patient's Charter

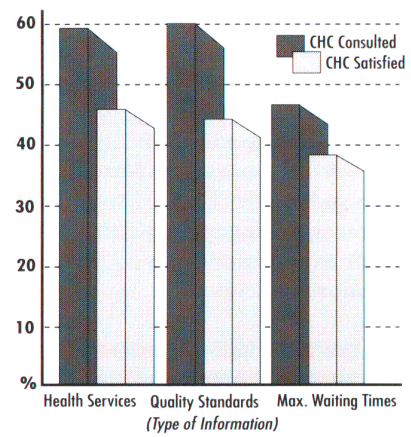
Since its introduction in April 1992, the Patient's Charter has met with a perhaps predictably mixed reception. Views have differed not only on the level of its achievements but also the purpose of the Charter. Some saw its strengths as a list of *'do's and don'ts'* which can be specifically referred to when arguing a case with NHS staff. Others felt its main aim is to raise a general awareness amongst patients, of their rights in relation to health care. Although many CHCs felt it is too early to realise the full effect of *'Charterism'*, there is little doubt that, whatever the reasons, patient expectations are on the increase and this is having a substantial effect on many workloads. But are the promises being kept?

We asked CHCs about their views and involvement with respect to the three new Rights and nine Standards introduced as part of the national Patient's Charter. We also asked about the development of local charters which are the responsibility of District Health Authorities. Questionnaires were received back from 107 CHCs, representing 54% of ACHCEW's membership.

Information to patients

The first national Charter Right states that patients are to be given detailed information on local health services, including quality standards and maximum waiting times. We asked whether local health authorities had sought CHC views on how best to publicise this information locally and whether CHCs considered the arrangements to be satisfactory.

Fig. 1 INFORMATION TO PATIENTS
(Charter Right 1.)



In many cases, information was not considered to be 'user friendly' or easily accessible, often only being available on request; this was particularly evident in relation to maximum waiting times. The importance of quality was stressed time and again:

> 'Information is vital to the proper use of health services. The Patient's Charter will be a valuable spur to providing good information services. But it is not an easy task, or a cheap one. You need the resources, the information itself, the people to give it, and support for these people. All of this must be of the very highest calibre. And you need to invest enough to make your information service an integral part of your quality assurance structures. (Brighton CHC)

Waiting times

The drive to eliminate all waiting times in excess of two years seems to have taken effect in most areas. Despite a significant 22% of CHCs reporting waits in excess of two years, most referred to 'one or two patients only'. Where problems were reported, they were mainly in relation to Orthodontics, Trauma & Orthopaedics and Ophthalmology. It is interesting to note that, excluding figures for Gynaecology, the Department of Health records only 23 waits for elective admission in excess of two years, throughout England (Hospital Waiting List Statistics: England, at 30 September 1992). These were for:Plastic Surgery (11); Trauma & Orthopaedics (8) and Neurology (4). Information from CHCs therefore suggests that the official statistics for England may be under-stated. (Equivalent statistics for Wales show a much higher figure of 1,319 patients waiting two years or more at 30 September 1992).

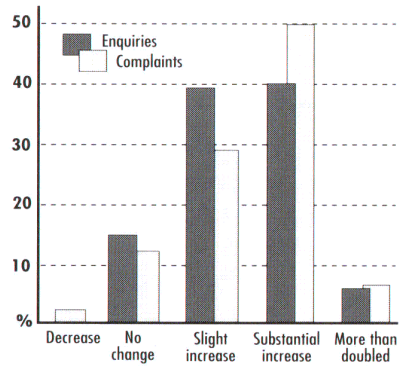
More than half the respondents felt that local efforts to keep waits below two years had resulted in negative effects elsewhere. Shorter waits were adversely affected in most areas and cases were reported of priority being given to patients with less clinical need than others. There were also several examples of patients having to wait for considerable periods before being placed on the 'official' waiting list — thus questioning whether published figures were truly representative of the national situation.

In addition to this, a (by now familiar) list of services were being withdrawn. This included: certain plastic surgery and homeopathic treatments, removal of wisdom teeth, vasectomy and gender reassignment.

Complaints

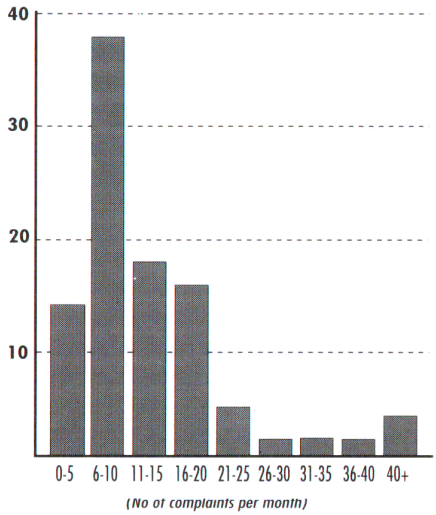
Figure 2 shows how both enquiries and complaints work has increased since April 1992 — 86% have seen an increase, of which 58% considered it to be substantial and another 8% said it had doubled; 61% of CHCs believe that the Charter was the major cause of these changes.

Fig. 2 CHANGES IN ENQUIRIES/COMPLAINTS
(Since April 1992)



Although it is difficult to determine an accurate figure, the typical CHC probably handles an average of around ten detailed complaints each month (Figure 3).

Fig. 3 COMPLAINTS IN A TYPICAL MONTH



(The average number of enquiries is even more difficult to establish with any accuracy due to differences in recording systems and definitions but is probably in the region of 30-50 detailed enquiries per month.)

The majority of CHCs were satisfied with the overall manner in which NHS complaints were being dealt with by the relevant Chief Executive or General Manager — despite a large number of comments about unacceptable delays in responding. Some patients became frustrated with 'bland' or 'patronising' responses and a lack of assurances that action was being taken to rectify the situation.

> '(The complaints system) is good in parts. Principal problems are delays, replies not addressing questions, no explanations of what will be done as a consequence.' (Salford CHC)

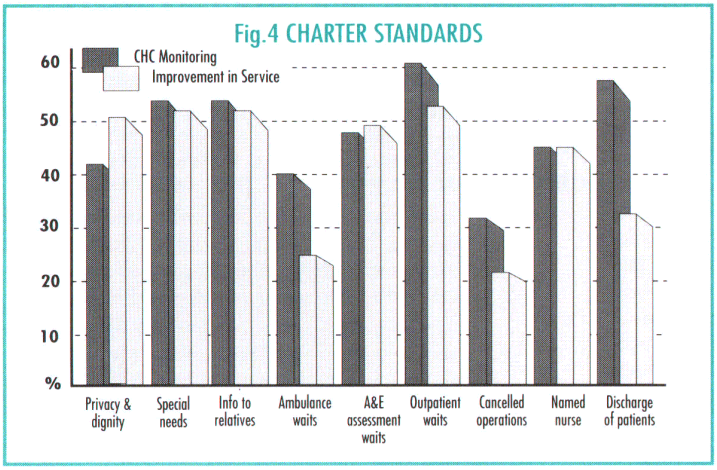
> 'My only reservation is that two clients who have come to the CHC for advice about stage 3 of the complaints procedure have indicated the Trust complaints officer has said she can do as much for them as the CHC can. They are only referred specifically when it gets to stage 3 or litigation is being considered' (Hastings CHC).

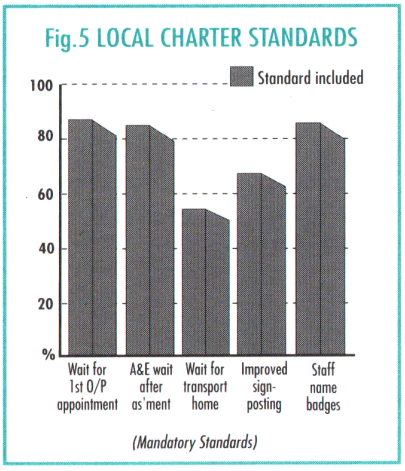
National Charter standards

Following the Department of Health's guidance last year, encouraging CHCs to play a full role in monitoring the Patient's Charter, we asked whether CHCs had been involved in monitoring the nine new Charter standards and whether their introduction has led to an improvement in the relevant service.

The results in Fig 4 are revealing in that the greatest CHC involvement and the greatest improvement both relate to the standard requiring patients to be seen within 30 minutes of an appointment time in outpatient clinics. This same standard is also reported by CHCs as being the one which NHS Units are having most difficulty achieving. In contrast, there are also considerable problems with cancellation of operations, yet less than a third of respondents had been involved in local monitoring arrangements and a mere 22% felt that the introduction of this standard had led to improvements.

All in all, more than half the respondents (54%) were aware of specific examples of where at least one of the new standards was clearly not being met. Most CHCs, however,





did report some improvement in service in the areas specifically covered by the Charter.

Good practice

Despite these difficulties, there have been many examples of local progress directly resulting from the National Charter — usually where joint working is evident from the outset and the CHC has been involved in planning, publicising and monitoring the aims and results of the Charter.

Improved access for patients with disabilities; greater recognition of cultural differences; the introduction of a Triage nurse into A & E Departments and a review of the needs of patients with learning disabilities were all cited as notable improvements. Other CHCs commented:-

> 'I have found the main value is that the patient can wave the Charter about and say 'it says here....' This really has changed staff attitudes and resulted in improvements. It also gives administrative staff a stick to beat the medics with!' (Dewsbury CHC)

> 'There are notices advising patients not to wait patiently in outpatient departments, if it is more than 15 minutes beyond their appointment time' (Pontefract CHC)

> 'Business cards have now been introduced for community staff' (Winchester & Central Hampshire CHC)

> 'The National Charter is focusing NHS managers' minds on quality issues — however, finance still remains the most important issue!' (Chorley and South Ribble CHC)

Local charters

Health Authorities have been asked to develop and publicise their own charters to contain a range of standards which they are expected to meet locally. 87% of CHCs reported that a local charter had already been produced to cover their area and, of this group, more than three quarters had been involved in its drafting. The Department of Health recognise that local charter standards will vary in both content and style; this disparity is in fact often the strength of locally-based initiatives. However, there are five standards which must be specifically included and use common definitions. Our survey showed that the extent to which the local charters already produced actually covered these five standards varied tremendously, considering the fact that they are all mandatory (HSG(92)36 states that *'All parts of the health service will need to confirm that the Rights and Standards,* ***both national and local****, set out in the Patient's Charter are being achieved'.)*. For example, only 54% told us that the local charter included a standard on waiting times for NHS transport home.

Most CHCs (79%) believed that the local charter had been properly publicised: this was predominantly via door-to-door leaflet drops, use of the local press and posters/leaflets displayed throughout NHS premises. CHCs had been directly involved in several 'one-off' initiatives such as health awareness days and joint press launches.

CHCs were, however, far from confident about monitoring arrangements; with less than half satisfied that recommended methods such as patient surveys and complaints analyses, were being adequately conducted.

CHCs In The New NHS

Community Health Councils are making ground in the new NHS. Purchasers, Trusts and fundholders are less wary of CHCs and the communities they serve. Relations are improving between CHCs and several Trusts and Health Authorities. Major problems remain in primary care as fundholders and FHSAs appear less enthusiastic about local accountability.
One hundred and fourteen CHCs responded to our survey – 57 per cent of ACHCEW's membership.

Fundholders

Many fundholding GP practices are finding it particularly hard to communicate with the communities they serve. 90 per cent of Community Health Councils have never been consulted about fundholders' purchasing plans and 87 per cent have never even been informed about them. Nearly half of the CHCs which have tried to see contracts struck by fundholders have found this impossible, despite Government assurances that these are public documents.

In fact, CHCs have been hard pushed to monitor fundholders given all the other demands on their time.

45 per cent have not sought sight of fundholders' contracts and 83 per cent have not attempted to see fundholders' annual accounts. 45 per cent of CHCs report that they have had no contact with fundholding practices on their patch. Where there has been contact, 27 per cent of CHCs assessed their relations with fundholders as good or very good and 22 per cent as poor, leaving 51 per cent describing the situation as satisfactory.

> 'CHC members have met GPFHs and prospective GPFHs. They have welcomed us and explained their plans etc. All have agreed to include CHC visiting rights in contracts with local providers. FHSA has agreed to monitor this is done. One or two have expressed interest in working with CHC on consumer satisfaction with services provided through contracts. This will be pursued. Only 1 GPFH practice so far has not made arrangements to meet CHC — known difficult practice.'

Trusts

Relations with Trusts are generally happier. Half the CHCs reported that no Trusts had been established on their patch when the survey was conducted early this year, although several had Shadow Trusts due to take over in April 1993. Of the rest, 62 per cent said their relations with local Trusts were good or very good and only 8 per cent poor, leaving 31 per cent saying the situation was satisfactory.

Trust Boards are required to meet in public only once a year and they are not required to consult about major changes in their services. 40 per cent of CHCs say their local Boards hold formal meetings 10-12 times a year while 36 per cent say they meet 4-6 times a year and 18 per cent only 1-3 times. 50 per cent of relevant CHCs are never invited to these meetings but 46 per cent are always invited. 51 per cent are never sent background papers while 38 per cent are always sent copies. 59 per cent are never allowed to speak at Trust Board meetings but 37 per cent are always given speaking rights.

42 per cent of CHCs say they are consulted by local Trusts about substantial changes in services and 33 per cent are consulted sometimes. One in four report that they are not consulted by Trusts. CHCs complain about learning of changes from the local press, about Trusts which 'only consult if we get to hear of things happening' and about 'constantly having to ask for information'.

> 'We are given, informally, information about changes — usually by Medical Directors/Business Managers, often in confidence...We meet, informally, with the Chief Executive and Chairman bi-monthly. We are told of all the good things they are doing. We are not told of the extent of their financial difficulties or the cuts made to stay within budget — we get this info. through other sources ie staff who moan to Members during visits.'

> 'Regular monthly meeting between Chief Exec. of Trusts and Chief Officer. Joint training of Trust Non-Execs and CHC Members being initiated...Membership of patients' groups and quality group. Well supported visits. Free access to managers over any problem. Quick reaction to negative comments — things put right as soon as possible. Developing and committed relationship.'

District Health Authorities

Only a quarter of Health Authorities now hold formal meetings 10-12 times a year, which was commonplace before the NHS reforms. 62 per cent of DHAs meet formally only 4-6 times. This means that many decisions are made outside formal meetings and therefore away from public view.

All Community Health Councils (except one) are invited to all HA public meetings. 97 per cent are given speaking rights, a marked improvement on the position immediately after the 1990 reforms. Similarly, 90 per cent of CHCs now receive background papers, almost back to old levels. Only 60 per cent of CHCs' representatives are always allowed to stay for private sessions of Health Authority meetings with 14 per cent sometimes allowed to stay (eg for 'Part II' but not 'Part III') and 26 per cent never.

CHCs at Health Authority Meetings

	1993	1991	Pre-1990
Invited to meetings	99%	99%	100%
Given speaking rights	97%	87%	98%
Not allowed to stay for private sessions	26%	28%	11%
Sent background papers	90%	78%	92%

In a letter to Health Authority Chairs in February 1992, the then Health Minister Stephen Dorrell said that CHCs should be able to *'contribute to the process of local target setting'* in relation to the health of the local population. 14 per cent of CHCs report that they have had a major role in target-setting with 68 per cent reporting some role and 17 per cent of CHCs not involved at all. Mr Dorrell also said CHCs should be able to *'contribute to the process of setting quality standards'*. The reality is similar to the involvement in 'target setting' — 23 per cent of CHCs have a major role, 63 per cent some role and 14 per cent no role. So some CHCs *'are, in fact, asked to be involved in more than we can cope with'*. Others can see *'no evidence yet that DHA prepared to allow CHC/public/users actually to influence decisions!'*.

CHCs are generally satisfied with their relations with Health Authorities. Just 6 per cent say relations are poor or very poor. 38 per cent of relations are good and 32 per cent are described as very good. Some CHCs are even worried that the Health Authority appears too friendly: *'We are wary of being manipulated by the DHA and future Trust — we have never been so popular'; 'DHA seeks cosy relationship, CHC seeks formal relationship'.*

> 'DHA has actively sought to involve CHC in the setting of local health targets, the development of the local patients' charter, the development of locality commissioning and of quality standards within contracts. The CHC Chair and Chief Officer are routinely invited to seminars on areas such as the corporate contract, joint commissioning and community care.'

Family Health Services Authorities

Sadly, relations between CHCs and FHSAs have deteriorated sharply since the reforms. While the number of CHCs reporting poor or very poor relations remains low (five per cent), very good relations now make up just 18 per cent of the total, compared to 45 per cent before the reforms. Relations are now described as good by 49 per cent of CHCs and merely as satisfactory by 28 per cent. CHCs call their FHSAs 'stuffy', 'secretive and defensive', 'useless and powerless'. But one CHC boasts of a 'very open relationship — CHC recognised as constructive in helping plan and develop services'.

Certainly, access to FHSA meetings is less satisfactory than access to DHA meetings. 98 per cent of CHCs are invited to FHSA meetings but only 80 per cent have speaking rights and only 76 per cent always receive the papers. 67 per cent of CHC representatives are never allowed to stay for private sessions.

However, relations with individual FHSA officers are often fine, for example in relation to complaints work. Also, some FHSAs have financed projects and provided practical support including statistical and mailing back-up.

> 'The relationship between the CHC and FHSA is satisfactory on the surface — but lacking in real depth. The FHSA does not involve the CHC in key decision-making over issues such as the development of GP Consortia...On the other hand the CHC and FHSA have recently begun to hold more productive joint meetings. The CHC has contributed to training for practice staff. The FHSA has supported the CHC's work on developing user participation and focus groups. The FHSA has begun to consult the CHC more often of late on proposed developments.'

> 'Our...FHSA is committed to working closely with CHCs but in practice does not always appear to respond to CHCs views...regular informal contacts are difficult to maintain. They are working towards stronger commissioning role with GPFHs and appear to be less available to be part of local issues, debates etc.'

CHCs IN ACTION

As always CHCs are having to cope with the demands of an ever increasing workload in order to fulfil their statutory duties. This, however, has not prevented them from undertaking a number of projects. The projects illustrated here are just the *tip of the iceberg* but give some examples of the wide variety of CHC initiatives and involvement with local health services.

The Next Generations

Concerned about rapidly rising abortion rates and the District Health Authority's (DHA) rationalisation of family planning clinics **Newham CHC** conducted a survey amongst people who attended family planning clinics in the area. Following publication of the results of the survey the DHA set up a working party to review family planning provision. The CHC was invited to take part in the review and recommendations are being prepared for early implementation. The CHC hopes that its work will result in a much-improved family planning service for Newham. In conjunction with statutory and voluntary agencies **Ynys Mon-Anglesey CHC** has been involved with setting up drop-in premises where young people can get advice and information on a number of subjects including family planning, safer sex, AIDS/HIV, drugs, alcohol and healthy eating. CHC members help to give out the information.

Involving Users

Aylesbury Vale and **Wycombe and District CHCs** have developed a project — *Patient's Agenda* — with the FHSA to assess public opinion on general medical services. The project involves interviewing a random sample of people from across the District and selected from the FHSA registration computer. The interviews are conducted by CHC members trained in interviewing skills — skills that they will be able to use for future surveys. Up to 20 members of the public take part in one-to-one recorded interviews at each session and at the end of each session there is a forum for open discussion. Participants are paid £10 to cover their expenses. Generally the public are pleased to be given the opportunity to air their views and some useful information has been gathered. The FHSA has given an undertaking that the information will be used in its planning process. **West Cumbria CHC** is the lead agency in local health forums set up to encourage a group of people recruited from a GP list to discuss issues that they feel have an impact on their health. Involved in the forums are paid professionals within the District from the FHSA, DHA, hospital provider unit, social services, health promotion and the CHC. The project is considered to be of great importance in assessing local health needs and more specifically *Health of the Nation* issues. The FHSA is the major funder of the project.

Lobbying by **Kingston and Esher CHC** brought about a change of plans for a new maternity unit in a local Trust hospital. Prior to CHC involvement the Trust intended to establish the unit on the 7th floor of the hospital. The CHC asked local women what they wanted and found, amongst other things, that there was a preference for a purpose-built unit. In light of the CHC's findings the Trust re-drafted its plans to incorporate all of the CHC's suggestions and is providing a two-storey purpose-built unit.

Sandwell CHC has taken the lead in developing user participation in local health and community care services. Locality-based user groups link directly into joint planning groups, locality needs assessment and commissioning and quality assurance systems of providers and purchasers. **Merton and Sutton CHC** supports two user groups for mental health users. The groups have been helped to obtain grant funding and representatives from the groups attend various planning meetings with the support of the CHC.

Raising Awareness

Walsall CHC is spearheading a multi-disciplinary group looking at respite care throughout the District. The group is actively encouraging care organisations such as Crossroads Care to set up respite care schemes to support carers in their homes. The aim of the group is to secure the provision of a comprehensive range of respite care services in Walsall.

Llanelli-Dinefwr CHC partnered the Health Authority, the FHSA and social services in a review of community and social services for elderly people. The review took the form of a series of public meetings and used questionnaires to GPs, patients and carers. The review has identified service deficiencies and unmet need.

A working party from **Shropshire CHC** visited all acute and community hospitals in the District to assess their accessibility for people with disabilities, both physical and sensory. The basis of the survey was the criteria established by the Access Committee for England. The DHA accepted the CHC's recommendations for improvements and is currently working on a programme for implementation. The CHC working party is currently working with users to identify specific standards to improve the quality of service offered to people with a sensory impairment.

Hastings CHC ran a health day for women. The aims of the day, which had a wide-ranging programme, included establishing women's concerns about their health care, providing women with information to promote good health and enabling women to influence the type and quality of health care provided. Creche and catering facilities were provided allowing women to attend for part of or the whole day.

Preston CHC was successful in a campaign to get the DHA to provide meals that meet the dietary requirements of people from minority ethnic groups, for example, Halal food. Five West Yorkshire CHCs — **Calderdale, Dewsbury, Huddersfield, Leeds and Wakefield** — have each employed a linkworker to work one day a week to develop links with local minority ethnic communities. It is hoped that the workers, four of whom are Gujerati speaking and the other Chinese speaking, will encourage the communities to express their views about health services and their health needs. Considerable interest has been shown in the project which is scheduled to run for one year. **Salford CHC** initiated a joint project with the DHA to investigate the needs of minority ethnic groups. This was the first survey of its kind in Salford and resulted in the gathering of much information and new links being made with the communities. The survey also highlighted a need for interpreting services. As a result the DHA is negotiating for interpreting services to be provided in hospitals and in the community.

Out and About

Islington CHC held the first in a series of *Community Access to Health* days. The aim of the days is to inform communities of NHS services available to them. Instead of waiting for people to come to the NHS the information is taken to them. The first day was aimed at the Turkish community and was attended by over 120 members of the community, together with health staff including advocates, dietitians, physiotherapists, psychiatrists and health promotion nurses. Over 80% of the people attending found the day to be 'very useful'. Further days are planned for the Somali and Cypriot communities. **Chester CHC** has use of a mobile telephone and a notebook computer with database and printer and has developed an outpost office scheme whereby the CHC can take full office services, such as Regional health information, to the community.

THE WORK OF ACHCEW 1992/3

The Role of CHCs

At the beginning of 1992 a much more positive attitude toward CHCs became apparent as far as the Department of Health and the NHS Management Executive were concerned. The publication of 'Local Voices' and the issuing of guidance (ML(92)1 and EL(92)11) highlighted the following key points:

- the purchasing activities of health authorities must be rooted in the needs and wishes of local people.
- a good working relationship with local CHCs is important in this (and presumably health authorities should be expected to strive to achieve this).
- CHCs should focus increasingly on purchasing issues.
- there is a recognitiion of CHC involvement in individual casework.
- CHCs should have reasonable access to the information on which health authorities base their judgements, and also to the contracts placed by GP fund-holders.
- CHCs should have the opportunity to contribute to the process of:
  - local target setting (in the context of the Health of the Nation document).
  - monitoring performance against the targets set.
  - setting quality standards (as part of the purchasing/contractual process).
  - monitoring performance against standards.
  - assessing relative service priorities.
- health authorities should recognise the role given by Parliament to CHCs and should ensure that the opportunity exists for them to make a proper contribution to the purchasing function. (This means that CHCs should be properly resourced and adequate arrangements should be made for the development of CHC staff).

ACHCEW has a key role in supporting CHCs in their work. Indeed, one of its main objectives is to provide information and advisory services to CHCs and to promote good practice in their work. Much of the effort of the Association in the last year has therefore been to make sure that CHCs are in a position to respond to this more positive approach.

In addition, every opportunity has been taken to make sure that the role of CHCs has been promoted at meetings with Ministers, the NHSME and other bodies. The background for this has been the paper 'The Developing Role of CHCs' (see below) that was launched at the 1992 ACHCEW AGM/Conference.

In November 1992, the House of Commons Health Committee published its report on NHS Trusts. Earlier in the year, ACHCEW had submitted both written and oral evidence to the Committee on this subject. The report recommended that the Department of Health 'undertake a thorough review of the statutory basis of CHCs in relation to the reformed NHS.'

In February 1993, the Government published its response to the report and this pointed out that:

> *'A particular feature of successful relationships between the NHS and the public is the involvement of CHCs.'*

and goes on to say:

> *'As part of the Government's commitment to a National Health Service which is responsive to people's views and needs, the NHSME will be issuing guidance later this year on how the relationships between purchasers and providers and CHCs can help to enable public involvement and encourage high quality service.'*

At around the same time, the Honourable Thomas Sackville MP, Parliamentary Under Secretary of State for Health, wrote to the Chair of the Association, following earlier meetings and correspondence. This letter reiterates the Government's view that RHAs and DHAs should discuss with CHCs how CHCs can play a full part in monitoring the Patient's Charter, that CHCs should have access to data about local health needs and services, that health authorities should make GP fund-holders' contracts available to CHCs, and that GP fund-holders should send to CHCs a copy of their annual statement on the contracts they place with providers. In addition, the letter indicated that consideration will be given to clarifying guidance in respect of CHCs' relationships with purchasing consortia. The Association welcomes the continuation of the positive tone set at the beginning of 1992 and looks forward to the chance to feed into the proposed new guidance.

Membership of the Association

The proportion of CHCs who are members of the Association has continued to increase. At 31 March 1993, there were 211 CHCs in England and Wales and 201 were members of ACHCEW. This represents 95.3%. The trend over the last few years has been as follows:

1986	82%
1987	85%
1988	86%
1989	88%
1990	92%
1991	93%
1992	94%
1993	95%

The number of CHCs in membership will fall slightly during 1993 when a number of CHCs are being merged. The position of a couple of CHCs that have given notice of withdrawal is also not yet clear, but it is also known that several non-member CHCs are considering joining ACHCEW.

There remains concern about CHC mergers. Regional Health Authorities seem to be pursuing rather different policies. In a number of cases the value of locally-based CHCs has clearly been recognised and even where DHAs merge the CHCs remain independent. However, some Regions are seeking to merge CHCs often creating bodies covering very large areas and populations. ACHCEW has made representations in a number of cases and has also raised the issue with Department of Health Ministers.

The Government's position is set out formally in the circular ML(91)2 which made the following points:

- The Department of Health no longer requires RHAs to merge the relevant CHCs if their matching DHAs are merged.
- RHAs should not consider merging CHCs without first consulting the relevant CHCs and 'other local community interests.'
- RHAs must be satisfied that CHCs are organised to carry out their duty to represent the Health Service interests of the public in their own areas effectively.
- RHAs should consider whether maintaining the existing CHCs would help promote better accountability, local sensitivity and local responsiveness and so outweigh any advantages to be gained from merging.
- RHAs should take the CHCs' views fully into account before taking a final decision on a CHC merger.

ACHCEW's view on CHC mergers is clear. In cases where District Health Authorities merge, the presumption should be that the Community Health Councils involved will not merge. The first priority of the establishing authority should be to ensure that the local communities involved are effectively represented. This will usually be best achieved by having more than one Community Health Council in the new District, each one covering a manageable local area or a defined community. Such an arrangement would permit more ready access to a CHC office and will allow there to be enough CHC members to cover the population and to have a wide range of local community links. The Community Health Councils that remained in such a District would need to establish effective liaison arrangements with each other, perhaps by means of a Joint Committee, so that their activities in making representations to the new DHA could be coordinated. CHCs should only be merged where it is clear that local communities would be more effectively represented by merged CHCs and where the CHCs concerned agree that this is appropriate.

Even where CHC mergers have not gone ahead, the RHAs have indicated that the matter will be reviewed in due course. It remains a concern therefore that the service users' input may be further diluted then.

Community Health Council News

'Community Health Council News' is the newsletter produced by the Association. It is edited for ACHCEW by Nicola Bennett-Jones and is intended to be a mixture of news and comment, plus reports on the major activities of CHCs, publications received, contents of medical journals and conferences and meetings. 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, and the format and presentation has recently been revised.

THE WORK of ACHCEW 1992/3 continued

Seminars and Training

A special day seminar is taking place on 25 May 1993 on 'Rationing Health Care: Should CHCs Help?'. The day is being facilitated by Frank Honigsbaum (author of 'Who Shall Live? Who Shall Die?') and the speakers include Geoffrey Carroll and Sir Raymond Hoffenburg. The Association, with the support of the NHSME, has organised a number of training seminars for CHC members and staff during the year. Sessions have been run as follows:

Skills for CHC Chairs (three sessions)

Facilitation Skills (three sessions)

Media-handling Skills (eleven sessions)

HIV/AIDS Awareness for CHCs (two sessions)

The feedback from participants on all of these has been extremely positive and virtually all sessions have been over-subscribed.

ACHCEW has also provided training to CHC members for South Western Regional Health Authority and has contributed to a variety of training events organised by amongst others the South and East Wales CHC Training Consortium, South West Thames Regional Association of CHCs, and the Yorkshire Regional Association of CHCs.

The support provided by the NHSME has been part of a wider project they have sponsored. The other objectives of this project have been to:

(1) identify and assess the training needs of CHCs (with particular reference to CHC members);

(2) develop a range of training seminars/study days with suitable trainers/facilitators; and

(3) develop a handbook for CHC members.

Discussions are still proceeding as to how this work will be taken forward. However, it is anticipated that training and development of CHCs will become an increasing part of the work of ACHCEW.

Information Service

The Information Service maintains a data base 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 some thirteen hundred 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 a rate of about 120 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.

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. It has been translated into a variety of community languages. Three publicity posters are also produced to go with this leaflet, together with a poster-sized statement on equal opportunities for display by CHCs. Also available is a poster simply saying 'Community Health Council', which is intended to be displayed on the door or window of CHC offices. It can be sealed in transparent plastic to make it more durable for those CHCs who find this useful.

For a number of years, ACHCEW has also produced a leaflet on 'Patients' Rights'. This has been available in English, Welsh, Urdu, Bengali, Panjabi, Gujerati, Hindi, Cantonese, Vietnamese, Turkish, Greek, Armenian, and Somali. The leaflet is widely used by CHCs, but also by many other advice organisations. There is a multi-lingual poster promoting this leaflet. The leaflet is currently being revised and up-dated and the new version will be available shortly.

ACHCEW also produces a 'Directory of Community Health Councils' and an annual bibliography of CHC publications.

External Relations

The Association continues to try to 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 has 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, in particular with our sister Associations of Health Councils in Scotland and Wales. There is frequent contact and joint working with the National Consumer Council, the Patients' Association, the College of Health and the Consumers' Association.

ACHCEW and Action for Victims of Medical Accidents continue to work together on a variety of matters. This has included the major project on the case for a Health Service Inspectorate and a unified complaints system.

There are also good working relationships with a variety of organisations working in the health field. For example, meetings have been held with the British Medical Association, Pharmaceutical Services Negotiating Committee, Health Visitors Association, United Kingdom Central Council for Nursing, Midwifery and Health Visiting, Long-term Medical Conditions Alliance and the Bloomfield Inquiry. There are also good working links with the National Association of Health Authorities and Trusts, the Association of Directors of Social Services, the Royal Colleges, and the various parts of the King's Fund. ACHCEW is also an active participant in the Standing Conference on Public Health.

Finally, there is regular contact between the Association and the Department of Health and the National Health Service Management Executive. ACHCEW has been pleased to have constructive discussions on several occasions with the Hon Thomas Sackville MP, Parliamentary Under Secretary of State for Health. Regular discussions take place with the division of the NHSME with responsibility for CHCs and there are increasing links with other parts of the Department. For example, ACHCEW is represented on the Mental Health Task Force Support Group and is consulted regularly about initiatives arising from the Patient's Charter.

Standing Committee and Working Groups

Since the AGM in 1992, 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 and other staff have 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.

THE WORK of ACHCEW 1992/3 continued

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:

- Regulation of practitioners of non-conventional medicine (Consumers' Association)
- A new Health Authority for North Yorkshire/Commissioning Health in Bradford and Airedale (Yorkshire RHA)
- GP Complaints Procedure (General Medical Services Committee)
- The Education and Training of Personnel Auxiliary to Dentistry (Nuffield Foundation)
- Standing Medical Advisory Committee on Sickle Cell (DoH)
- Caring for Sick Children (Audit Commission)
- Inter Agency Liaison on Tackling Drug Misuse (DoH)
- Amendments to Professional Conduct Rules (United Kingdom Central Council for Nursing, Midwifery & Health Visiting)
- Complaints Review Working Party Draft Report (General Medical Services Committee)
- Proposals to amend Medicines Act (Medicines Control Agency)
- Arbitration for medical negligence in the NHS (Institute of Arbitrators)
- Medicines Information Bill (National Consumer Council)
- Cigarettes (Maximum Tar Yield) Regulations 1992 (DoH)
- Regulations to Implement Part of Second Labelling Directive Banning Tobacco for Oral Use (DoH)
- The Protection from Tobacco (Display of Warning Statements) Regulations 1992 (DoH)
- Repeat Prescribing (National Audit Office)
- Proposal for new Performance Procedures (General Medical Council)
- NHS (Service Committees and Tribunal) Regulations 1992 (DoH)
- Working Group on UK Specialist Training (DoH)
- Freedom of Speech for NHS Staff (NHSME)
- Implementation of EC Directive on the Advertising of Medicinal Products for Human Use (Medicines Control Agency)
- Advisory Group on Setting Priorities in Research and Development in the Field of Physical and Complex Disabilities (NHSME)
- NHS Hospital Catering (National Audit Office)

Health News Briefings

As usual a number of 'Health News Briefings' have been published during the year. These have focussed on the changes within the NHS and have been primarily produced for the information of member CHCs. However, they have also been circulated more widely, as a contribution to debate and discussion on current health topics, and have attracted considerable press and media attention. The principal 'Health News Briefings' issued during the year have been' ...

The Developing Role of CHCs

A briefing setting out how the role of CHCs has developed since the 1991 NHS reorganisation and putting forward proposals for the future.

A Fairer Way of Funding the NHS?

A Closer Look at Weighted Capitation Funding

A briefing looking at the impact of the new formula for distributing NHS resources and considering whether other factors should be included in the formula.

Making Changes in Maternity Services:

The Health Committee Report and CHCs

A briefing, jointly prepared with the Royal College of Midwives, that summarised the Health Committee's report on maternity services and the issues that CHCs might wish to address.

- Effect of Tobacco Advertising on Tobacco Consumption (DoH)
- Issues of Race and Culture — Review of Services for Mentally Disordered Offenders (DoH)
- Pathology Services (Audit Commission)
- Services for People with Learning Disabilities or Autism - Review of Services for Mentally Disordered Offenders (DoH)
- Inspecting Social Services (DoH)
- Expert Maternity Group (DoH)
- Mental Health Nursing Review (DoH)
- Proposed Amendments to the Dentists Act 1984 (General Dental Council)
- NHS Day Care for Elderly People (National Audit Office)
- Medical Staffing (Audit Commission)
- Medical Records (Audit Commission)
- Information and IT (Audit Commission)
- Complaints About Private Dental Treatment (General Dental Council)
- Review of Mental Health Services (Audit Commission)
- The Role of FHSAs (Audit Commission)
- Revision to Mental Health Act Code of Practice (DoH)
- Changes to the Legal Aid System (Lord Chancellor)
- The Medicines (Products other than Veterinary Drugs) (Prescriptions Only) Order 1983 (Medicines Control Agency)
- Structured Settlements and Interim and Provisional Damages (Law Commission)
- The Association also gave written and oral evidence to the House of Commons Health Committee on the subject of NHS Dentistry and to the Bloomfield Inquiry
- London Speciality Review on Plastic Surgery (NHSME)
- General Practitioner Fundholders (National Audit Office)

In addition, both the Audit Commission and the National Audit Office routinely consult ACHCEW about their respective work programmes and individual studies concerning the NHS.

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

User Involvement in Mental Health Services:
The Role of Advocacy

A briefing for CHCs on how users of mental health services should be more involved in the planning and provision of these services.

Self Reviews in Community Health Councils

A summary of a pilot study to develop a yearly planning process for use by CHCs through a model of 'self review'.

Rationing Health Care:
Should Community Health Councils Help?

A briefing setting out the arguments on both sides of the rationing/priority-setting debate within the NHS and discussing the role of CHCs in respect of the issues raised.

Care in the Community:
Policy Development, Implementation and Community Health Councils

A briefing looking at the Community Care changes coming into force in April 1993 and looking at how CHCs should respond to them and monitor developments.

Response to the Government's White Paper:
'The Health of the Nation'

ACHCEW's response to 'The Health of the Nation' White Paper, reiterating concerns expressed when the original Green Paper was published.

FROM the CHAIR

If you had asked me during my first year as Vice-Chair of ACHCEW in 1990 where CHCs would be in 1993 I would have said the future was at best uncertain.

I think it is a tribute to the largely unacknowledged hard work, solid research and years of experience and expertise of CHCs throughout England and Wales that not only are we still here and have not been sidelined, but that also the important role of CHCs within the NHS is increasingly being recognised.

CHCs are now back in vogue and the consumer, patient, user, or whatever, is now supposed to be king. Terms such as 'customer focus', 'patient empowerment', and the 'Local Voices' documents are being tossed about like confetti. Information points are springing up like mushrooms and Patient's Charters are blossoming everywhere. In Darlington — my home CHC — we currently have four Patient's Charters and I am reliably informed that the best way to use them is to turn up for your appointment clutching all four with your appointment card.

Nationally, responsibility for ACHCEW has switched from the Department of Health to the NHS Management Executive. This has been a good move, and the discussions that have been held so far have been much more constructive with far less emphasis on what I always felt were minor housekeeping issues.

We are now holding many more training days, on various topics such as AIDS/HIV, media skills and chairing skills. These have been mostly oversubscribed and from what I hear they are very successful. A new handbook for CHC members is being produced and work is being done on standard setting for CHCs.

One of the most difficult areas for CHCs in the future will be rationing of health care. How far we get involved, considering all the different pressures and influences that bear on CHC members is going to be a major area for debate, potentially as important as the implementation of the NHS and Community Care Act. ACHCEW will be holding a one day conference on this issue, and has published a Health News Briefing on the subject.

During the year I have visited various individual CHCs and Regional Associations, as well as the Welsh Association, and I do welcome these invitations and enjoy the visits. I have made a real nuisance of myself with my colleagues in the Northern Region by continually carping that they should meet in venues which are easily accessible

by public transport — I know it is not always easy, but I feel it is a matter which should always be considered. If we wish to make our active membership base as broad as possible we should not make it more difficult to attend meetings than it already is.

Over the year I have attended various meetings, conferences and functions, either on my own or with various combinations of fellow officers, ACHCEW staff and representatives from individual CHCs. We have had meetings with Ministers, professional and other bodies, all of which are very useful and informative — for both sides hopefully. The subjects were varied, from dentistry to CHC mergers, information points to 'whistle blowing'.

During the year, my Vice-Chair, Heather Wood resigned as she turned from poacher to gamekeeper, and took up a post with the Isle of Wight Commissioning Authority. She has assured me that she will carry the CHC torch forward and we all wish her the very best for the future. I would like to thank her for all the valuable work she did in her relatively short time as Vice-Chair.

Jennifer Elliot was appointed by Standing Committee in her place and has coped extremely well with being thrown in at the deep end. Ross Thompson was re-appointed Treasurer on becoming eligible for a further term during the year. I must admit I am very relieved to have the support of Ross and Jennifer — I had visions of sitting on the platform at Manchester on my own.

One of the most important functions of the Chair of ACHCEW is to chair the Standing Committee meetings held four times a year. These are all day meetings with a lot of people around the table. I would like to say thank you to all the members of that Committee for making the task so relatively easy. We might not always agree with each other but the meetings are always friendly and courteous.

Last, but by no means least, I would like to thank all the staff at ACHCEW. They seem to get through mountains of work with very little fuss. When I give talks about ACHCEW and its work people are invariably surprised at how few staff we have, which I always take as a great compliment to their dedication.

I have enjoyed this year as Chair. I am now an expert on train timetables and my children know the opening times of the local take-aways by heart, but I would not have missed the experience for the world. Thank you for giving me this opportunity.

Eleanor Young
Chair

There are 211 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 inprovements. 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 community to managers of the health service.

The budgets and staffing of CHCs are 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 and other bodies supplement ACHCEW's income.

ASSOCIATION of COMMUNITY HEALTH COUNCILS for ENGLAND and WALES 1992/3

Chair

Ms Eleanor Young *(Northern Region)*

Vice Chair

Dr Heather Wood *(Wessex Region)*

Mrs Jennifer Elliott *(Northern Region)* from February 1993

Honorary Treasurer

Mr Ross Thomson

Members of the Standing Committee

Cllr JB Colebrook	*Yorkshire Region*
Mr John Laurent	*Trent Region*
Mrs Carole Myer	*East Anglia Region*
Mr Colin Barry	*North West Thames Region*
Mr Ron Codington	*North East Thames Region*
Mrs Alison Cook	*South East Thames Region*
Mr Bill Williams	*South West Thames Region*
Mrs Mary Judge	*Oxford Region*
Mr Allan Storey	*South West Region*
Mrs Margaret Hayes	*West Midlands Region*
Mr Frank Hardwick	*Mersey Region*
Mrs Eileen Scott	*North West Region*
Mr M Hughes	*Wales*
Mr J Lewis	*Wales*

Secretary/Chief Officer Observers

Mr Ian Webb	*Northern, Yorkshire*
Mr Tony Richards	*Mersey, North West*
Ms Jackie Gladden	*Trent, East Anglia*
Mr Tom Richardson	*Oxford, West Midlands*
Mr Richard Edwards	*North West, North East Thames*
Mr Graham Girvan	*South East, South West Thames*
Mrs Jacqueline Salter	*Wessex, South West*
Mr Bryn Williams	*Wales*

DoH Observer

Mr Neil Paterson

Society of CHC Staff Observer

Mr Chris Hogg

Staff

Toby Harris	*Director*
Chye Choo	*Chief Administrative Officer*
Ben Griffith	*Information Officer (Health Policy)*
Clare Collins	*Research/Information Officer*
Nigel Ellis	*R/I Officer from November 1993*
Angeline Burke	*Development Officer*
Anne Hamilton	*Secretary to the Director (p/t)*
Estelle Kiss	*Administrative Assistant (p/t)*
Rose Walter	*Administrative Assistant (p/t)*
Nicola Bennett-Jones	*Newsletter Editor (p/t)*
Susan Bonici	*Training and Development Assistant (p/t)*