ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND AND WALES

ANNUAL REPORT
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Contents

Association of Community Health Councils for England and Wales

There are 207 Community Health Councils 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 1974 in response to evidence that NHS care was not sufficiently patient-centred and to make a clear distinction between the mangagement and public functions of the NHS. CHCs were given the role of representing the community to managers of the Health Service.

The Association of Community Health Councils for England and Wales (ACHCEW) was established in 1977 to provide a forum for member CHCs, to provide information and advice to CHCs and to represent the user of health services at a national level. CHCs are not obliged to be members of ACHCEW but the vast majority are. Member 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.

DYING FROM DOGMA

The NHS has not been getting a good press. A few months ago successive days' newspapers featured the following headlines:

- "Consultants fear collapse of NHS"
- "Former Chief Scientist condemns internal market in NHS"
- "NHS changes harming medical research"
- "Doctors' leaders warn of patient-care cuts"
- "Market threatens London hospitals"

Then there have been the emergence of stories about the rationing of health care that have not always reflected well on those responsible for purchasing or providing the care concerned. Thus, a series of examples of care or treatment apparently being refused to patients simply on the grounds of their age was followed by the tragic case of child B and the unconvincing denial that money was a factor in the decision not to continue treatment.

Whatever the rights or wrongs of the individual cases, the perception has been allowed to grow that the NHS is no longer able to provide health care from the cradle to the grave and that the preoccupation with market forces has come between patients and the doctors and nurses who care for them.

This is not helped by the response to every criticism of the NHS appearing to be met by the repetition of the mantra "More money is being spent than ever before. More patients are being treated than ever before. Patients are being treated more quickly than ever before."

Such statistics are widely recognised as being flawed. For example, up until 1988 patients were counted each time they were discharged from hospital or died. This itself could lead to misleading conclusions because if a patient was discharged too early and had to be readmitted that counted as two people treated. Since 1988, patients have been counted each time they change consultant or speciality within a hospital. So instead of patient numbers, the figures are now expressed in de-personalised jargon as "finished consultant episodes". This means, as was reported in the British Medical Journal, someone could be admitted to the observation ward of an accident and emergency department, be transferred to an orthopaedic department for the treatment of a fracture, subsequently develop vascular problems and be referred to a cardiologist, and finally be transferred to a rehabilitation ward under the care of a geriatrician before being discharged. This single hospital stay by one person would then have contributed to the statistics as four finished consultant episodes.

Of course, the introduction of Patient's Charter standards has led to the production of new statistics which at least purport to be related to the NHS user's experience. But again things are not always what they seem. For example, the English Patient's Charter says that if you are admitted to hospital from an accident and emergency department this should happen within four hours. Hospitals are now keeping statistics to measure this. The time is meant to count from the point at which it is decided to admit the patient, but if hospitals only take that decision once they know a bed is available the Charter standard is easily met.

Similarly, a Charter standard which requires that a patient is seen within half an hour of their appointment time in an out-patient department says nothing about how long the patient may then spend sitting around after being seen initially before their visit is concluded.

The Patient's Charter does not in itself produce patient-centred care. However, it has required managers to focus on certain indicators and this focus has led to some improvements in the way in which patients have been treated.

The Patient's Charter only covers part of what matters to those who use the NHS. A key issue for service users is the quality of the treatment they receive and this is dealt with only in the most superficial way by the Charter. Moreover, there are other trends that are both

worrying for patients and also do nothing for the image of the service.

The operation of the market for health care is undeniably leading to a fragmentation of the service. It is becoming increasingly difficult to say with confidence that the NHS is a genuinely "national" service. There have always been inequalities in health status and in the care provided in different parts of the country. However, there is evidence that the gaps are now widening. The multiplicity of purchasing decisions is opening up differences in the care offered to neighbouring communities in an entirely new way. When this is brought together with the impact of GP fundholding, differential standards of care are clearly discernible.

This is undermining confidence in the service and, when the language of the market itself alienates many patients, this must be of serious concern to all who care about the NHS and its founding principles. This developing unease on the part of many patients is coupled with what can only be described as dangerously poor morale amongst many of those who work in the Health Service.

There now seems to be a danger that the market dogma, if taken too far, will lead to a terminal change in the culture of the NHS. Despite the new Code on Openness, we hear more and more about commercial confidentiality and the need for commercially sensitive matters to be discussed in secret. Instead of the ethos of public service, we now have decisions that are led by accountancy analyses and determined by the forces of the market. Patients are fearful that the soul is going out of the NHS to be replaced by the icy certainties of cost-benefit calculations.

Yet, it is not quite too late. The language of patient empowerment is increasingly being used by Health Service professionals (and even by NHS managers) almost as an antidote to the litany of market forces. If a spirit of partnership can be created between the people who provide the services and those who use the services, then that will be beneficial both for the individual patient and their care and it will also help recreate faith in the NHS itself.

CHCs are unequivocally on the side of such a partnership. This is not only because CHCs have always sought to support and help individual patients. But it is also because CHCs are quite clearly on the side of the NHS against those who are its detractors or would seek to undermine it.

The next few years may well determine the future of the NHS. Whatever debates may lie ahead, CHCs will be there defending the interests of the public and supporting the existence and role of a patient-centred NHS.

Better for some?.....
GP fundholding - what it means for patients.

The 1990 NHS reforms have provoked heated debate both within and outside the Health Service with one of the most controversial initiatives being the introduction of GP fundholding. The scheme allows practices which qualify to manage a budget to buy medical services for their patients from hospitals and community units.

Supporters of the system feel that this has the potential to make GPs more efficient and hospitals more responsive to what GPs and their patients want.

Opponents of the scheme fear that it gives GPs the opportunity to cut back on expensive forms of treatment to save money or even refuse to take "expensive" patients on to their lists. Also, there is concern that fundholders might be able to get their patients treated earlier than non- fundholders because they are dealing directly with the provider, creating "two tiers" of hospital care.

Last year the Government announced new steps to encourage more GPs to become fundholders as part of the move towards a "primary care led NHS"- a vision for the future of health care which involves more patient care being provided in a community setting. Moves to expand the system demand that attention be paid to the potential risks and benefits from making GPs responsible for purchasing treatment for their patients. ACHCEW's survey addresses this issue by finding out how the scheme is working in practice and whether the fears of its opponents and the enthusiasm of its supporters are justified.

ACHCEW sought CHCs' experiences of fundholding to date in order to assess its impact on the provision of health care from the patients' perspective. Over a hundred CHCs responded to the Association's survey with half reporting that between 21 per cent and 60 per cent of their local population are covered by fundholding practices. Two-thirds of CHCs say over a fifth of local people have fundholders as their GPs.

Gains at the Surgery

Nearly half the CHCs report that most or all fundholders have upgraded their premises. This creates improved facilities in patient waiting areas and has led to a wide range of services being developed at fundholders' surgeries. Physiotherapy services appear to be most common with almost half the CHCs reporting that they are provided at most or all surgeries. Slightly less common are counselling services and consultants providing out-patient sessions at GPs' surgeries. Other services developed at fundholders' surgeries include: chiropody; minor surgery such as the removal of cysts; homeopathy; osteopathy; psychotherapy; marriage guidance; welfare advice and dietary clinics.

Purchasing from Providers

Fundholders' patients have also benefited in terms of access to hospital care. Just under half the CHCs report that all or most fundholders have obtained shorter waiting times for hospital referral or admission for their patients. Almost as many CHCs report that most or all fundholders have achieved other types of quality improvement including: direct access to diagnostic procedures, some fundholders can arrange appointments for X-rays and other exploratory tests, with the hospital; faster return of laboratory results; patients being seen by more senior doctors.

Undermining Patient/Doctor Trust?

Some concern has been expressed that giving GPs financial incentives to take cost-effectiveness into account could compromise the services provided to "expensive" patients. Whether or not this actually happens, fundholding can raise suspicions in patients' minds and undermine the relationship between the doctor and the patient. Responses from a minority of CHCs suggest that this is indeed starting to happen.

Seventeen CHCs report that they are aware of patients who feel they have been removed from a fundholder's list, or not accepted on to a list, on cost grounds. Several of these patients may be unduly suspicious and it is not possible to establish what proportion of the allegations are justified. Responses worth noting include:

"We have received complaints about patients on long term courses of medication who have been struck off. We suspect the allegations are justified."

"Several examples, particularly older people with multiple health needs, but also families with several young children who it is felt by fundholders(s) are making "excessive demands" on the service. Other examples are people with mental health and substance abuse problems. Fundholders monitor use of their services regularly and invite "miscreants" in for interview."

"One patient was refused admission to GP list and was told that this was due to the cost of her treatment."

Nineteen CHCs report knowledge of patients who feel that they have been denied medicines or hospital referral by fundholding GPs on cost grounds. They report:

"Several people feeling medicines have been denied because of cost - with some justification. Also referrals for second opinion and out-of-county referrals have been difficult in some instances. Whether allegations are justified or not, it is of concern that patients should ***feel*** *they may not get the care they need because of cost..."*

"We have received complaints about GPs wanting the patient to call out ambulances themselves rather than the GP referring the patient to hospital for treatment which costs the practice money. One complainant who lived in a village was told by their GP to go back to the city centre hospital for drugs they needed as they were too expensive."

However, these suspicions are not restricted to fundholders' patients. One CHC has no examples of fundholders' patients being denied treatment on cost grounds: *"This has however happened with* ***non****-fundholding GPs who sometimes use finance as an excuse for non-referral rather than the truth".*

Equity and Impact on Health Authorities

In addition to the impact for the GPs' patients, the effect of fundholding on the NHS generally is an issue for debate. Do fundholders' patients enjoy quicker or better treatment? Do other patients benefit as hospitals improve their procedures?

More than one in four CHCs say that fundholders' patients get priority access to hospital services in their area but nearly half say they do not. Most CHCs have examples of fundholders placing contracts for acute care away from their traditional providers - often to speed up waiting times. On the other hand, there is less evidence of fundholders making contracts with different providers for community health services.

Twenty three CHCs are aware of health authority planning and purchasing being influenced by fundholders' contracting decisions. This influence appears to have been generally positive, with health authorities trying to improve services for patients of non-fundholding GPs. Meanwhile, 28 CHCs are aware of health authorities attempting to influence fundholders' decisions, for example in order to protect local providers. One CHC comments:

"'Partnership' between health authorities and fundholders is increasingly the name of the game, with health authorities using fundholders 'bite' to achieve change, and fundholders increasingly making use of the 'strategic overview' the health authority is formulating to give direction to their purchasing. At its best, this starts to give some real power to purchasing within the reformed NHS; at worst, they form an unholy alliance. My problem with it is that as the two power bases jostle around together, engaging in trade-offs et al, where is the voice of the patient?"

Fundholders and health authorities work together well in some areas, suggesting that the tension between the two systems of purchasing can have positive results for patients. Could this be put at risk if health authorities move away from direct involvement in purchasing?

Conclusions

Although the survey indicates that fundholders have secured significant improvements in the services provided for their patients at their surgeries and elsewhere, there is concern amongst some CHCs that the scheme has the potential to compromise the trust between patient and doctor. Claims by some patients that they have been refused admission or struck off a fundholder's list should not be dismissed even where there is no hard evidence that their fears are justified. This issue must be carefully monitored in order that any potential threat to the most vulnerable sections of society is not realised. A starting point could be that all GPs be required to provide a reason for refusing people admission to and for striking them off their list of patients. ACHCEW would like to see this requirement included in the GPs terms of service, so that patients receive an explanation for action that often causes great distress and confusion.

Mixed sex wards
- whatever happened to privacy and dignity?

If you have to go into hospital it is now more than likely that you will be nursed next to members of the opposite sex. Although this practice is widespread, its origin can not be traced back to any central policy decision. The Government has left it up to individual hospitals to decide whether and in what circumstances mixed sex wards should be used and the practice seems to have been adopted nation-wide as a means of reducing waiting lists.

However, this "backdoor" introduction has meant that the views of patients have not been fully taken into account. The original Patient's Charter for England stated that all health services should respect patients' privacy, dignity and religious and cultural beliefs, but Community Health Councils, amongst others, have become increasingly concerned that mixed sex wards contradict this promise. In response to this concern, the following resolution was passed at this Association's AGM in 1994:

"This AGM believes that all patients, with the exception of young children and patients in intensive care units, should be offered the choice of accommodation in a single sex area with segregrated toilet and bathroom facilities, without delaying their treatment or otherwise reducing its quality."

The revised Patient's Charter for England goes some way to addressing the issue by stating explicitly that "*If you would prefer to be cared for in single sex accommodation (either a single sex ward or 'bay' area within a larger ward which offers equal privacy), your wishes will be respected wherever possible*". However in a convenient let-out clause that weakens this response, the Charter states that choosing single sex accommodation may result in delays to treatment and does not indicate how long a patient will be expected to wait.

It is interesting to note that neither of the Welsh Patient's Charters contains this or similar provisions. CHCs in Wales are, however, seeking to have the rights of Welsh patients brought into line with those of their counterparts in England.

To find out the extent of the practice nationally and to consider the implications for patient care, ACHCEW surveyed CHCs about mixed sex care in their districts. The survey was carried out shortly before the revised Patient's Charter was issued in England. Just under half of the CHCs in England and Wales took part, covering approximately 190 units.

Policies

Almost half of the CHCs which responded said that their health authority did not have a specific policy concerning mixed sex areas. Only 17 per cent said that there were definite policies in place.

"Until recently the district health authority (DHA) did not perceive problems with mixed sex wards. This changed, however, at a public meeting where over 400 people made it abundantly clear that mixed sex wards were not acceptable."

"It [DHA] says it supports choice but there is no choice regarding mixed wards."

CHCs were asked whether units had mixed wards or bays for the care of general, psychiatric and elderly patients. For those units that did have mixed sex accommodation, mixed wards are by far the most common. Yet not all units have specific policies concerning mixed sex provision. It is, however, likely that the introduction of the new Charter Right will force the rest into developing policies. Many of those that already have policies state that they will only mix patients in the case of emergency admissions. This may be acceptable at face value but there have been reports that the number of emergency admissions is rising. Mixing patients in emergencies can be disruptive since it frequently leads to patients being moved if and when a place in a single sex area becomes available.

For or Against

More than half of the CHCs believe that local health service users are against mixed sex areas. Of these 16 per cent state that health service users are strongly against mixed wards or bays.

"At a recent CHC meeting the question of single sex wards was raised and the majority were opposed to mixed sex wards. Research into the needs of ethnic minority women and children showed great concern, particularly amongst Muslim women."

"Depends on age. Elderly are usually anti mixed wards. However even younger people can lose enthusiasm for mixed wards when they need to use a bedpan."

"Some patients are against but accept situation. A few strongly against and initiate complaint though seldom whilst still in hospital."

Information

The majority of patients assume that they will be treated in single sex accommodation. Since this is increasingly becoming the exception rather than the rule, it is essential that patients receive information about hospital practices and their rights concerning mixed sex provision. Evidence from this survey suggests that as a rule patients are not informed about or aware of their rights. When patients are informed this is generally done in an admission letter or general information booklet. Many CHCs are hoping that information to patients will improve as a result of the requirements of the new Patient's Charter Right.

It is not just inpatient areas that cause concern with regard to mixed sex provision. X-ray departments were frequently cited as being a problem area. In particular X-ray gowns which are short and open at the back are the cause of considerable embarrassment for many patients. Other areas that do not afford patients the privacy and dignity they might reasonably expect are A&E departments and day care units. There is an issue about whether the new Charter will apply to day surgery accommodation, as this form of treatment becomes more common.

Choice

A third (34 per cent) of CHCs believe that compared with five years ago patients are likely to have less choice about being placed in a mixed area. It has been suggested that the reduction in choice for patients is linked to the introduction of the internal market to the NHS. The priority of the providers now seems to be throughput or cost effectiveness and not, as it should be, the well-being of patients. Many would question whether mixed care is in fact conducive to the recovery of patients. There is a clear need for research in this area.

Complaints

A third of CHCs had received formal complaints from patients about mixed sex areas. It is likely that many more patients are unhappy about being treated in mixed areas but do not lodge formal complaints. One CHC noted:

"... people are so demoralised and grateful to be in [hospital] that they do not think they have grounds for complaint: assumption is that their dignity will be compromised when they go into hospital".

A number of CHCs noted that they generally learn about dissatisfaction with mixed areas during routine visits to hospitals and when people consult them on another issue.

Although only 23 per cent of respondents stated that patients had expressed their views about mixed sex areas in mental health facilities, their comments are particularly disturbing.

"We have handled complaints which indicate that female patients are worried about inappropriate sexual behaviour on the part of male patients. The risk would seem to be aggravated by the layout of mixed areas."

Conclusion

In addition to asking CHCs to report on specific issues relating to mixed sex provision, the survey also asked for their general comments on this system of hospital care. The vast majority are against, based on their experience of dealing with formal complaints and the informal comments made by individuals who prefer not to make their opposition official.

CHCs also express doubts about the effectiveness of the new Charter commitments. A major reservation is the Government's refusal to allocate major capital to adapt old buildings and build new single sex accommodation. The Government's plan to scrap mixed wards gradually, as part the normal programme of building maintenance, is an inadequate response to the problem. In addition, reductions in bed numbers and increasing rate of emergency admissions will continue to put pressure on hospitals, with the probable result that patients will have to wait longer to obtain the privacy and dignity promised in the Patient's Charter.

CHC Noticeboard

Over the last year CHCs have continued their efforts to make sure that local health services meet the needs of the whole community. The following projects represent just a fraction of the dedicated work going on throughout England and Wales to ensure that the patients' voice is heard by the Health Service.

Worcester District CHC has put a lot of work into developing a protocol for monitoring the Patient's Charter 'respect for privacy and dignity' standard. They interviewed patients on four wards over a one month period and have used these observations to establish a set of monitoring criteria, aimed at raising standards of privacy, dignity and respect. The resulting manual 'Monitoring Privacy, Dignity and Respect' is a very useful tool for continuing monitoring work in any hospital setting.

Islington CHC and the local family health services authority (FHSA) identified a lack of adequate family doctor and community care services in a deprived part of their community. The CHC helped to set up the 'Bath Street Patients Association' which is a community group campaigning to improve local services. The campaign has prompted the FHSA to purchase a new site for building an improved health centre, which will have space for up to four GPs, and will provide other services such as counselling and a chiropody clinic. The CHC and the Bath Street Association are now organising a public consultation exercise to ensure that the FHSA plans reflect the views and needs of the community.

Salford CHC has initiated a pioneering joint agency project on complaints handling. Following the CHC initiative, the local health authorities, NHS providers and social services met together to develop common standards and procedures for handling complaints. This work has been successful in promoting good practice in complaints handling, in particular where the complaint involves more than one organisation.

Airedale CHC members are participating in a Quality Audit scheme with the local trust. The intention is to monitor the activities of the various parts of the hospital and to measure performance using indicators of quality which include the expectations of patients. The reports that the CHC produces are more detailed than the 'normal' visiting reports and the members feel that the scheme allows them to make a valuable contribution to improving services for patients.

Rochdale CHC was concerned that people were experiencing difficulties with the supply of continence products. They decided to obtain the views of all users of the service by means of a survey and a forum of users. These methods revealed the variability of the service and particularly the lack of information available to users. Many people, particularly the elderly and the frail, had no information about who to contact for emergency or regular supplies of continence supplies. Feelings ran high - "We are fed up with being offered too few pads and having to have continual battles to keep supplies at an adequate level". As a result of these findings, the local purchaser and provider are meeting with the CHC to work out how the service can be improved.

Aberconwy, Arfon-Dwyfor, Meirionnydd, and Ynys Mon CHCs have set up a joint research project to monitor the quality of health care after patients have been discharged from hospital in Gwynedd. This project is based around visits to patients in their own home. CHC members have visited hospital wards, inviting patients to have their say about discharge arrangements and experiences. The CHCs are currently following up over 120 responses. Once the research is complete, the CHCs intend to use the findings to influence local policy planning in social services, as well as health provision.

Following the one year closure of a local health clinic for refurbishment, the previously popular family planning clinic sessions were not restored when the clinic re-opened. **Harrow CHC** was convinced that this service was required, but service managers maintained that 'nobody had complained' during the time the clinic was closed. The CHC knew that there had been a promise to re-open the family planning sessions and felt that this explained the lack of complaints. To confirm this, a survey of nearly 1,000 women who had previously used the family planning service at the clinic was organised. The overwhelming majority of respondents were furious that the service was not going to be restored. The CHC is using the 'patients' voice' to negotiate the re-opening of the clinic.

CHC Noticeboard

Ceredigion CHC has set up an Agricultural Injuries Response Group with local farming unions, the local trust and health and safety inspectorate. Amongst other initiatives, the group has produced map grid reference cards for farmers to keep by their telephones which can be used to guide emergency services to the site of an accident. The CHC intends to expand this idea and to distribute map grid cards to other isolated dwellings and rural communities.

Chorley and South Ribble CHC has been seeking the views of local residents on the future provision of maternity services in the Chorley area. In partnership with South Lancashire Health Authority, the CHC distributed 5,300 leaflets 'Seeking your views on Maternity Care' through libraries, health centres and other public places. The leaflets outlined different ideas on the provision of maternity services and asked for comments. The CHC received nearly 1,000 replies which were written up into a report. The findings of the public consultation were conclusive, with 97 per cent of responses in favour of one particular option, the establishment of a consultant led maternity service at Chorley General Hospital. The health authority is now planning to set up this service in the knowledge that it is responding to what the community wants.

Bristol and District CHC has employed a 'local voices' project co-ordinator, with funding from the health authority. The co-ordinator is working with individuals and groups from the local community to help them to influence purchasing decisions. The Director of Public Health has said "We know the project is successful because it is beginning to cause us problems".

Southend District CHC. For the past 12 months, Southend District CHC has been working with local GPs and patients to produce a model practice information leaflet. The leaflet includes information required by the Department of Health, but goes beyond that to provide information which patients find useful, including, for instance, whether the doctor speaks languages other than English. When the exercise is complete, the model leaflet will be distributed to all GPs (on paper and floppy disk), giving them the opportunity to adapt it, saving time and resources otherwise used on producing leaflets, whilst providing the sort of information patients want. The leaflet will be updated biannually as a service to GP practices. The CHC sees this as an important move towards establishing a co-operative relationship with GPs.

Liverpool Eastern CHC in collaboration with students from the Liverpool School of Tropical Medicine, has conducted a qualitative study to identify the Dovecot community's perception of local services, including health and social service issues. This survey allows the CHC to look at the full range of services and their impact on the health and well-being of the community. As a result of the research, the community has been able to see real improvements in a range of services. For example, the FHSA is to recruit a peripatetic female GP to provide well women services in GP surgeries The City Council has taken up other recommendations, including improving the distribution of refuse skips and funding youth work with drug users.

Herefordshire CHC was concerned about proposed changes to local mental health care provision which would reduce the number of elderly mentally infirm (EMI) beds and the occupational therapy (OT) provision. The CHC felt it had an important role as a bridge between the providers of the service and the community, and designed a consultation questionnaire which was distributed to local users, carers, staff and the public. Having obtained the views of local people, the CHC was able to successfully intervene in the planning process and to ensure that the views of the community were taken into account. As a result, the health authority and trust have improved the OT provision in the acute psychiatric unit and have ensured the future provision of day hospital places in the EMI unit.

Burnley, Pendle & Rossendale CHC recognised that the CHC had an important role to play in facilitating the public response to the Wilson Report 'Being Heard'. The CHC organised a conference for complainants last July, bringing together a cross-section of people who had contacted the CHC for assistance in making a complaint over the previous 12 months. The initiative was very successful. As well as the local trust reviewing its complaints procedure, the CHC, with trust funding, has started a six month pilot 'complaints, comments and suggestions' hotline based at the CHC offices.

Children's Services
- how well is the NHS looking after children ?

Children and adolescents represent around a quarter of the population of England and Wales yet, as evidence from CHCs shows, many NHS services still fail to take their specific needs into account.

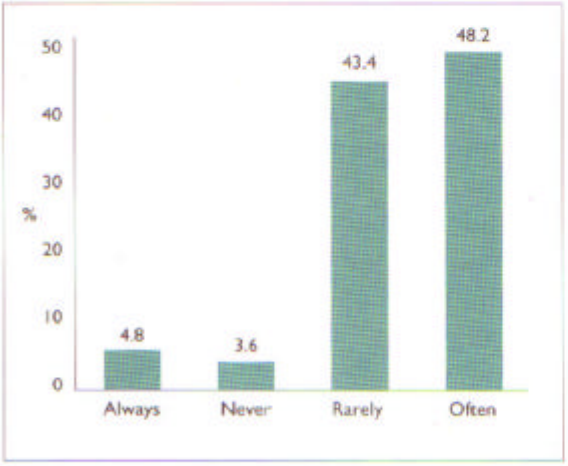
Although all health authorities should have a formal policy about the provision of child health services, this survey of CHCs suggests that around a quarter of the authorities in England and Wales have no such policy. This would seem to indicate a lack of commitment to providing co-ordinated child health services'; it may also explain many of the problems faced each year by children needing NHS care.

Children in hospital

There is little doubt that children continue to be placed inappropriately on adult wards - our survey suggests that less than two thirds of general hospital units offer separate facilities for children in all cases. Moreover, there are still occasions when children are placed on adult psychiatric wards - this clearly contravenes Department of Health guidance and the advice of Action for Sick Children and the Children's Society.

"Normally children are not placed on adult wards. Recent nursing staff shortages have meant closure of children's wards and children have been nursed in adult wards which we believe is not acceptable."

How regularly are children placed on adult psychiatric wards?

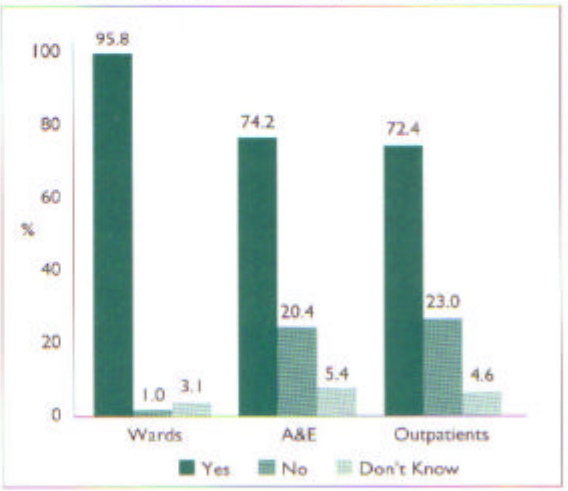


Facilities

Parents or guardians will of course want to stay overnight with their children in certain circumstances. Facilities for overnight stays range from none at all to the provision of a nearby self-contained flat; a laundry service; counselling; and permits providing free use of the hospital car-park. Nearly every hospital ensures that beds on or next to the ward are available to parents/guardians, and that 24 hour access to the ward is provided. Access to a telephone is almost always provided to parents staying overnight but a subsidised canteen or basic catering facilities (a kettle or microwave) are less common, and the provision of private rooms, television areas or showers is rare.

CHCs were generally satisfied with security arrangements for children in hospital - less than five per cent described local arrangements as "unsatisfactory". Efforts seem to have been made to update existing facilities and install electronic doors and video surveillance equipment. CHCs also gave their views on the sufficiency of play areas, including toys and equipment:

Are there sufficient play areas, toys and equipment in...



"The inpatient service provide a pre-admission club to help take away the fear of going into hospital ... there are special trolleys to take children to theatre ... attractive tabards for nurses so they do not look severe."

"The paediatric wards have their own kitchen for child oriented meals and snacks."

"On admission, a list of visitors is drawn up between staff and parents - anyone not on the list is not allowed in without the consent of parents."

Hospital staffing

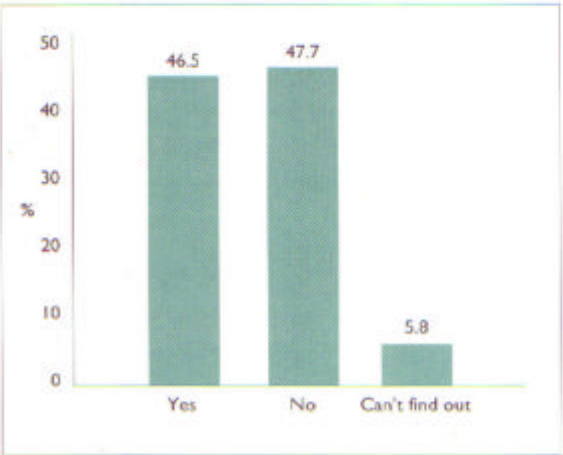
Perhaps the most disturbing finding of the survey is the number of hospitals which fail to meet basic requirements for staff cover. For example, the British Paediatric Association and the Royal College of Physicians recommend that all junior doctors responsible for providing cover in paediatric departments should have at least 12 months paediatric experience. This standard was not observed in over a quarter of the hospitals in our survey.

The Department of Health states that there should be "at least two Registered Sick Children's Nurses (RSCNs) - or equivalent Project 2000 Nurses - on duty 24 hours a day in children's hospital departments", and yet it appears that the NHS is only able to uphold this standard in a minority of hospitals. Around half the CHCs reporting problems in meeting this standard say that these were due to recruitment difficulties:

"The hospital has found it difficult to recruit RSCNs and has a programme to recruit more nurses."

"Not enough RSCNs or RSCNs with other training/qualifications in other specialties. But the children's services unit is confident that this issue will be addressed in the next two years."

Are at least 2 RSCNs on duty 24hrs a day?



Accident & Emergency

This year alone, around two million children will visit the A&E department of their local hospital[4]. Although the large majority of these visits will be made to units which have paediatric medical staff available on a 24 hour basis, 12 per cent of CHCs have indicated that their local hospital cannot guarantee this.

In theory, nearly all hospitals have systems to ensure that children requiring emergency care are seen as a priority. More than 70 per cent have some form of "fast-tracking" for children attending A&E and, although only a handful of hospitals have an exclusive children's A&E unit, many have dedicated areas which cater for the particular needs of children undergoing a traumatic experience.

"In theory, children should be seen first - according to the hospital policy ... in practice they frequently have to wait hours to be seen."

"Children's cubicles are available - decorated and with a range of toys."

"There is a separate playroom but no separate waiting area. There is one nursing bay for children but if used, children have to use adult facilities."

Primary Care

There are mixed views about how well community services meet children's needs. For example, positive views are expressed about recent health visiting initiatives, eg: greater focus on child surveillance and "at risk" families; introduction of Asian linkworker schemes; and the use of personal child health records. At the same time, one in ten CHCs report an overall reduction in health visiting services for young children; one in four report restrictions to the school health service. Most concerns about the latter relate to the trend away from universal screening of school children and a greater reliance on the potentially cheaper option of health promotion.

"Lack of funding for staffing the rubella vaccination programme in November 1994 resulted in the temporary withdrawal of the school nursing service."

"Health Visitors are able to do better and more skilled work due to better and more frequent training courses. The clerical side of their job has also been reduced enabling them to spend more time visiting young children."

"... domiciliary services have deteriorated due to lack of time allowed, [it] is a crisis service rather than a supportive service."

Community clinics

Although the overwhelming majority of patients still see clinics as providing a unique and valuable service, sites continue to be closed down as GP involvement in child health surveillance and immunisations increases. Many CHCs believe that the true value of the clinics is being overlooked in the name of efficiency and, although GP immunisation rates are generally high, the service is less accountable.

"Mothers gain mutual support from meeting in child health clinics. Facilities at clinics are more geared to children, and welfare foods are available."

"The reduction in numbers attending child health clinics since 1990 has been a direct result of GP involvement in child health immunisations and surveillance. The CHC is concerned that we are not able to monitor GP clinics as is the case with community service provision."

"Some parents resist immunisation and are dropped from [GP] lists."

Conclusion

The health needs of children are now recognised as being distinct from those of adults and important standards have been developed as a result. However, these standards have clearly not been applied uniformly throughout the NHS and, although many managers and clinicians are addressing the problems, the quality of care that children can expect remains a lottery.

[1] Dept of Health. *Welfare of Children and Young People in Hospital*. London: HMSO, 1991.

[2] Action for Sick Children Annual Report 1994

The establishing arrangements for CHCs

The period of this report was dominated for CHCs by the implications of the Health Authorities Bill. The Bill abolishes RHAs with effect from 1 April 1996.

In the early part of 1994, this had led to considerable debate about what would be the most appropriate form of establishing arrangements for CHCs once RHAs were abolished. The then Minister for Health, the Right Honourable Dr Brian Mawhinney MP, however, announced at the ACHCEW Conference in July 1994 that the NHS Executive acting through its regional offices would be the establishing body for CHCs.

There was some disappointment about this as ACHCEW had argued strongly that CHCs should be established by an agency independent of the rest of the NHS. Nevertheless, ACHCEW welcomed the Minister's clear commitment to full consultation with CHCs about the implementation of this decision and the offer that ACHCEW and the Society of CHC Staff could be represented on the NHS Executive Working Group considering the details.

The Working Group itself met four times and established four sub-groups. ACHCEW was represented on these by the Chair of the Association and the Director. The main issues considered by the Working Group were the arrangements for the employment of CHC staff (and, in particular, who should be their legal employer), the changes in the Regulations governing CHCs, the arrangement of contracts to be placed by the NHS Executive regional offices for the services to be provided to CHCs, and the financing of CHCs.

As far as the employment of CHC staff was concerned, the option whereby staff would have been employed directly by the NHS Executive regional offices was rejected. This option would have meant that CHC staff would have become civil servants and there was no enthusiasm for this. Instead, it was concluded that the employment function, currently carried out by RHAs, has three elements:

(i) the issuing and holding of contracts of employment (on the instruction of the establishing body);

(ii) a personnel service for CHC staff at an administrative level (eg organisation of recruitment, pay and service condition queries etc);

(iii) involvement in staff interviews, appointments and dismissals (in conjunction with the CHCs concerned), policy on employment (eg staff numbers and grades) and the grandparent role for IPR.

The Working Group recommended that the third element above be retained by the new regional offices and that the first two elements be carried out by one health authority in each region for all the CHCs in that region. (ACHCEW expressed concern about this and the potential implications for the independence of the CHCs in the area of the selected health authority, but the rest of the Working Group felt that this was the most viable option).

The Working Group also recommended a number of changes to the CHC Regulations. These were:

- to delete references to RHAs and, where appropriate, change these to the establishing body;
- to delete references to DHAs and FHSAs and change these to health authorities;
- to change references to the CHC Secretary to the CHC Chief Officer;
- to include a provision for consultation with CHCs about changes to the number of members of CHCs, the relevant health bodies and the area covered by the CHC and the provision of premises and resources;
- to reduce the period of non-attendance (without reasonable cause) at CHC meetings from six months to four months after which a member's place may be declared vacant;
- to change the categories of person disqualified from becoming members of a CHC (to include employees of local health authorities and trusts, local GPs and GDPs and their employees);
- to set the periods of disqualification from becoming a member for people guilty of misconduct and non-attendance at four years;

- to allow CHCs to have more than one Vice Chair;
- to set the reporting year for CHCs to coincide with the financial year.

The Working Group also considered the various services currently provided by RHAs to CHCs and divided them into groupings which could form the basis of delegation to other bodies or be carried out on a contractual basis for the regional office. These groupings are: estates; legal; personnel; paymaster; information technology; and arranging elections.

Finally, much time in the Working Group was spent discussing the resources for CHCs. The Working Group estimated that some £20 million is currently spent on CHCs in England - around £17.5 million is clearly identified (including the current allocations to CHCs) and another £2.5 million is the "hidden" cost of support services to CHCs provided by RHAs. These "hidden" costs are hard to estimate (particularly as RHA staff have dispersed) and fears were expressed by ACHCEW and others that these costs might have been under-estimated.

The allocation of resources to individual CHCs is also a complex question. Initially, the NHS Executive seemed keen to move to a new national formula for allocating money between CHCs. However, eventually it was accepted that addressing disparities between CHCs in the resources they receive will take some time, particularly if the real level of resources available for CHCs remains tightly restricted.

However, the Working Group accepted that any future system of resource allocation for individual CHCs would need to address variations in:

- the quality of CHC accommodation;
- the number of CHC staff;
- the level of CHC performance and the need for development work associated with this;
- the nature and size of the population serviced by CHCs;
- the geographical area served by CHCs; and
- the local patterns of NHS services.

In practice, this means that the NHS Executive needs to do further work on defining:

- a national standard for CHC accommodation;
- a national staffing standard for CHCs;
- the resource consequences of core CHC functions.

It is recognised that this work will need to be progressed over the next year or so and that only marginal adjustments will be possible in CHC budgets at least initially. The possibility is to be considered of targeting any "performance-based" or "developmental" funding at either local innovative projects or to those CHCs, who have identified areas where they need to improve in relation to the national framework of standards. It seemed to be accepted that the setting of a national framework of performance standards for CHCs and of the local objectives of individual CHCs should be very much under the control of CHCs themselves.

The Working Group's report was finally launched by Mr Gerald Malone MP, Minister for Health, on 7 April 1995 and is currently out for consultation. ACHCEW will be coordinating its detailed response in the light of the views expressed by individual CHCs.

Code of Conduct for CHC members

The Working Group has also produced a draft Code of Conduct for CHC members. This too has been issued for consultation. Many of the comments ACHCEW made on the earlier drafts have been accepted. ACHCEW has welcomed the principle of having such a Code, particularly as it was ACHCEW who first proposed that there should be such a Code and indeed drafted an earlier version some years ago for consideration.

Membership of the Association

Virtually all CHCs continue to be members of the Association. At 31 March 1995, there were 206 CHCs in England and Wales and 203 were members of ACHCEW. This represents 98.5%.

Membership of ACHCEW

1987 - 85%	**1988 - 86%**	**1989 - 88%**
1990 - 92%	**1991 - 93%**	**1992 - 94%**
1993 - 95%	**1994 - 97%**	**1995 - 99%**

With the formation of a new CHC in north west London, ACHCEW will have one new member, but the total membership is likely to remain constant as another CHC has decided to withdraw from membership.

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 is currently being reviewed.

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 some fifteen 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 other interested parties.

Much of the Information Team's time is spent on responding to requests for information and advice from member CHCs. Considerable use if made by member CHCs of this service and the number of enquiries from CHCs runs at about 300 per month. Other organisations and academics, some from overseas, also approach ACHCEW for information, particularly about the role and work of CHCs and ACHCEW.

HEALTH NEWS BRIEFINGS

As usual a number of "Health News Briefings" have been published during the year. These have focused on changes within the NHS and have been produced primarily 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:

Community Health Services

This briefing reviewed the wide range of community services which are a crucial part of primary care in the NHS, looking at their development and prospects, in the light of recent reforms. The briefing concluded that community health services are highly valued by patients and provide an element of NHS care which is unique, and tailored to meet individual needs. However, it also found that community health services are poorly resourced and are being run down to a level where they become ineffective, that there is likely to be further fragmentation and that they may be unable to cope with the additional workload imposed by community care without urgent additional funding.

Public Participation in Setting Priorities

This was the Association's evidence to the House of Commons Select Committee on Health. It looked at the whole debate and the official guidance on the subject, together with the different approaches taken by CHCs to the subject.

Outpatient Appointments - "Did Not Attends"

This responded to the challenge to CHCs from the Minister for Health to help persuade patients to be more considerate towards other patients by making sure that they contact outpatient departments in advance if they are unable to keep appointments. The paper reviewed the initiatives taken at local level on this subject and made a number of recommendations for action to reduce the number of "Did Not Attends".

Staffing and Resources for Community Health Councils

This reported on a survey conducted for ACHCEW by Christine Hogg looking at the staffing and resource needs of Community Health Councils. It was prepared so as to feed into the deliberations of the NHS Executive Working Group looking at the implementation of the decision that CHCs should be established by the

regional offices of the NHS Executive. The key conclusion of the survey was that each CHC requires a minimum of three full-time staff, regardless of local factors.

Other briefings for CHCs have included a report of the ACHCEW seminar held on **"The Future of NHS Complaints"**, on **"The Patient's Charter - the Patient's Perspective"**, and on **"Charity fundraising and the NHS"**.

A new type of ACHCEW publication was also produced during the year. These are called "Health Perspectives" and the first issue was published in April on the new Patient's Charter.

THE COMPLAINTS DATABASE

With the support of funding from the NHS Executive, the Association commissioned AMS Ltd to produce special software for CHCs to record and manage their complaints work. Following extensive testing, this was made available to CHCs in July 1994 and in the succeeding months more and more CHCs have gone on-line with it. The database enables CHCs to keep a systematic record of the complaints they are handling, to generate reports and statistics easily, and to generate letters and actions as the complaint progresses.

An additional feature is that the software can generate a statistical report on a common basis for ACHCEW. An initial report of the data so collected is being prepared and when the system has been running for longer, it will provide an invaluable record of the extent and nature of CHC complaints work.

SEMINARS AND TRAINING

A wide range of training events have been organised for CHCs during the year. These have included sessions organised in conjunction with the Industrial Society for those representing complainants at meetings and working with AMS to ensure that computer training sessions were provided to CHCs on the use of the new complaints database. A cycle of training workshops in May and June has been organised covering the following topics:

Tackling research
Understanding the changing role of the health service and the role of the CHC
A guide to contracting in the NHS
Giving the public and users an effective voice in the shaping of health services
Setting performance standards for CHCs
Understanding and working with the community
Complaints - monitoring, setting standards, measuring the quality
Using the media effectively
Working with the media

New cycles are being planned for the autumn and winter.

ACHCEW staff have also contributed to a variety of training events and seminars organised during the year by individual CHCs and by regional groupings of CHCs. An input is also usually made into the Basic Training Course run for CHC Chief Officers by the Society of CHC Staff.

The Association has produced a "Handbook for CHC Members" in the form of a small ring binder with loose-leaf entries to facilitate periodic updating and to enable CHCs to insert locally relevant material. Also in preparation are a series of open learning packs for CHC members and, in particular, CHC Chairs.

RESPONSES TO CONSULTATION DOCUMENTS AND REPRESENTATION 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 few years the volume of such consultation exercises seems to have risen sharply. In 1994/5 the Association responded to more than 60 documents, compared with 40 in 1993/4, 16 in 1991/2 and 11 in 1989/90. Over the last year the consultation exercises to which the Association has submitted responses have included:

Consumer representation in the public sector (Consumer Congress)

Training for dental specialists in the future (DoH)

A patient's guide to doctors in hospital (BMA)

Priorities in R&D relating to Health Technology Assessment (DoH)

NHS priorities in research and development relating to mother and child (NHS Executive/DoH)

Clinical negligence: proposed creation of a central fund in England (NHS Executive)

GP fundholding - evidence towards the Department of Health review (Health Visitors' Association)

A national academy of medicine/structured training (BMA)

Confidentiality policies for drug and alcohol agencies (SCODA)

Review group on priorities in nutrition research (Northern & Yorkshire RHA)

NHS R&D programme - physical and complex disabilities (South & West RHA)

National standards in community care (BMA)

Implications of local government re-organisation for health boundaries (Welsh Office)

Revision of the Patient's Charter (NHS Executive)

Draft report on mental health services (Audit Commission)

Being Heard: Report of the NHS complaints review committee (DoH)

Nurse prescribing implementation (Medicines Control Agency)

Probity in the NHS (Audit Commission)

GDC response to Nuffield report on dental auxiliaries (General Dental Council)

Medical negligence claims: Application for medical records (Law Society)

Hospital Medical staffing (Audit Commission)

Access to complaints systems (discussion paper 1) (Cabinet Office)

Improving your image: How to manage radiology services (Audit Commission)

Simplicity and Speed: Discussion Paper No 2 (Citizen's Charter Complaints Task Force)

Continuing Education for Doctors and Dentists (Chief Medical Officer)

A Policy Framework for Commissioning Cancer Services (DoH)

A Framework for Local Community Care Charters (DoH)

Guidance to Health Authorities on Clarifying Responsibilities for Long-term Health Care (NHS Executive)

Draft Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the application of Biology and Medicines (DoH)

Improving NHS Dentistry (DoH)

Draft Confidentiality Bill (BMA)

Regulation of Residential Care and Nursing Homes (DoH)

NHS R&D Priorities: Asthma Management (NHS Executive)

Research priorities for SCOPME (SCOPME)

Openness in the NHS (NHS Executive)

Proposals for the Future National Blood Service (National Blood Authority)

Discussion Paper No 3: Fairness (Citizen's Charter Complaints Task Force)

Patient Records (Audit Commission)

Draft Guidance for the NHS on the Confidentiality, Use and Disclosure of Personal Health Information (DoH)

Nutrition Guidelines for Hospital Catering (DoH)

Discussion Paper No 4: Attitude and Motivation (Citizen's Charter Complaints Task Force)

Identifying R&D Priorities for the NHS into Methods of Implementation (NHS Executive)

Priorities and Planning Guidance (NHS Executive)

Arrangements for Inter-Agency Working for the Care and Protection of Severely Mentally Ill People (DoH)

Tackling Drugs Together (Central Drugs Coordination Unit)

Draft Joint Commissioning Guidance (NHS Executive)

Rehabilitation of people with severe head injuries (House of Commons Welsh Affairs Committee)

Mental Health Act Guardianship (DoH)

Discussion Paper No 5: Information (Citizen's Charter Complaints Task Force)

Towards a Primary Care led NHS: An Accountability Framework for GP Fundholding (NHS Executive)

Scrutiny into Bureaucracy in General Practice (NHS Executive)

Revised Code of Practice on Openness (NHS Executive)

Report of the Working Party on the Unified Training Grade (NHS Executive)

Professional Involvement in Health Authority Work (NHS Executive)

Applying Citizen's Charter principles to the Registration and Inspection of Independent Nursing Homes (NHS Executive)

Anonymous HIV Surveys (DoH)

Discussion Paper No 6: Redress (Citizen's Charter Complaints Task Force)

Agenda for Change: Management Development for Primary Care (Institute of Health Services Management)

Publication of Success Rates (Human Fertilisation and Embryology Authority)

Review of Ambulance Response Time Standards (DoH)

The composition of the GMC: Proposals for Change (GMC)

A Guide to the National Health Service (NHS Executive)

Health in the Inner City (Royal Society of Health)

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 Department of Health, the NHS Executive or other bodies as appropriate.

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. Various 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". It has recently been completely revised, and is available in English, Urdu, Bengali, Punjabi, Gujerati, Hindi, Cantonese, Vietnamese, Turkish, Greek, Somali, and Arabic. Discussions have also been taking place with the Welsh CHCs Support Unit about producing a version in Welsh. The leaflet is widely used by CHCs, but also by many other advice organisations. There is a multi-lingual poster promoting this leaflet, and a version of the leaflet is also available on tape. In addition, factsheets derived from the leaflet have been produced on the following subjects: "Making Choices", "Going into Hospital", "Family Doctor", "On the Record", "Care in the Community", and "Making a Complaint". These too are available in minority languages.

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 and these run at 60-70 per month.

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, the Consumers' Association, and Action for Victims of Medical Accidents.

There are also good working relationships with a variety of organisations working in the health field. For example, meetings have been held with the General Medical Council, Pharmaceutical Services Negotiating Committee, Health Visitors' Association, United Kingdom Central Council for Nursing, Midwifery and Health Visiting, the Audit Commission and MIND. There are also good working links with the National Association of Health Authorities and Trusts, the Institution of Health Services Management, 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. Mention should also be made about the special seminar organised for CHCs by the Royal Pharmaceutical Society in March 1995.

Finally, there is regular contact between the Association and the Department of Health and the National Health Service Executive. ACHCEW has been pleased to have had constructive discussions with Mr Gerald Malone MP, Minister for Health and with his predecessor the Right Hon Dr Brian Mawhinney MP. Regular discussions take place with the division of the NHS Executive 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, the Openness in the NHS Task Force and other working parties.

STANDING COMMITTEE AND WORKING GROUPS

Since the AGM in 1994, the Standing Committee has met on four occasions. Meetings have focused 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 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.

From the Chair.....

This is the last time I will have to sit down and write 'From the Chair...' and I think it is probably traditional that I should review my last five years with ACHCEW, (in case anyone is getting worried, two years as Vice Chair, three as Chair). However, looking back into the mists of time is not my strong point and it would be nice for once to be able to look forward. I honestly believe that CHCs have never before had such a positive future.

Things are obviously still not all that we would wish, but we have had the opportunity, through the meetings of the 'Working Group on the Implications of the Change in the Establishing Arrangements for CHCs' at Quarry House in Leeds, to put our case to NHS Executive officials. We made the most of the chance to let them know what life can really be like in a CHC with an inadequate budget, just two permanent staff and inaccessible premises. As the only member of that group who was 'unsalaried', I also had the responsibility to make sure that the members' view was taken into account, or at least listened to sympathetically. An added difficulty was keeping up with the paperwork, or indeed even obtaining it in time in some cases. (Members will not be surprised to hear that there are people who do not know how to communicate with you if you are one of the underclass without a personal fax!). I would, however, like to thank Pat Lewis and Ray Hill for all their help, particularly Ray, who has given valuable advice at Standing Committee meetings, (sometimes just by raising an eyebrow!) and has been very fair in all his dealings with us. I wish him all the best for a long and happy retirement.

The result of many hours of what I can only describe as hard slog has now emerged into the harsh light of day, and is now (at the time of writing) out for consultation. This is certainly worth noting, as firstly, CHCs are being consulted, secondly, there is a reasonable time span for consultation, and lastly the period for consultation does not span either the Christmas or summer holidays. Things are looking up!

Those CHCs who were present at the start of last year's AGM will remember the rather chaotic start, as the Minister, Dr Brian Mawhinney was marooned on a train in a siding. He was subsequently appointed Minister of Transport, (an appointment prophesied by our Director, Toby Harris during a rather irate conversation with BR whilst trying to establish the whereabouts of the Minister - strange but true!). All being well, we expect John Redwood, Secretary of State for Wales to be our ministerial speaker in Cardiff, which again demonstrates that CHCs are now recognised as an important force to be reckoned with.

ACHCEW itself has grown this year. We have taken on additional staff, to expand our service to all members, but particularly to give a better service to the Welsh CHCs, improve our training courses and, at last, in response to the perennial cry, raise our media profile. As always I would like to thank the staff for their hard work on our behalf over the past year.

This year was the first year in which we elected two Vice Chairs. Jennifer Elliott was re-elected and Joyce Struthers joined the 'team'. I have enjoyed working with them very much, they have always been helpful and supportive and I appreciate that.

The Honorary Officers and I have between us, represented the Association at a wide range of events and occasions and we have done our best to put the CHC point of view wherever and whenever we can. It is beneficial to have two Vice Chairs, to spread the load, and with a revised role for the Treasurer, ACHCEW will have a good, strong, broad based 'executive', if that is the right term. We also welcomed many new members to Standing Committee in September, they have not had an easy year, but the meetings have been cordial, have finished in reasonable time and got through all the business satisfactorily. That seems to be everything a Chair has a right to expect so thanks to all members of Standing Committee.

As I said at the beginning, this is my last year as your Chair, and although I will miss everyone I have worked so closely with over the last few years, I have to admit I will not be sorry to 'retire'. Three years is quite long enough for anyone and it is time for a new face and fresh ideas. It is too easy to listen to people and think 'Yes, we did that and it didn't work' or 'We have already discussed that' and write it off. I hope whoever does take over the reins will have more success in dealing with issues such as GP fundholders, all the knotty problems associated with Community Care, and will have to spend less time on the 'processes', than I did.

Forward to the next Century!

Chair

Ms Eleanor Young *(Northern and Yorkshire Region)*

Vice Chair

Mrs Jennifer Elliott *(Northern and Yorkshire Region)*
Mrs Joyce Struthers *(Anglia and Oxford Region)*

Honorary Treasurer

Mr Ross Thomson *(till April 1995)*
Mr Graham Girvan *(Acting Honorary Treasurer, from April 1995)*

Members of the Standing Committee

Mr Norman Roper	Northern and Yorkshire Region
Mr Harry Davis	Northern and Yorkshire Region
Mr John Laurent	Trent Region
Mr Charles Espin	Trent Region
Mr Fred Evans	Anglia and Oxford Region
Mrs Eileen Pulham	Anglia and Oxford Region
Mrs Janet Skipworth	North Thames Region
Mrs Alison Cook	South Thames Region
Sir Frank Mills	South Thames Region
Mr David Cook	South and West Region
Mrs Christine Dore	South and West Region
Mrs Elaine Taylor	West Midlands Region
Mr John Pearson	West Midlands Region
Mr Mark Winstanley	North West Region
Mrs Eileen Scott	North West Region
Mr Grenville Darby	Wales
Cllr R I Thomas	Wales

Chief Officer/Secretary Observers

Mr John Godward	Northern and Yorkshire Region
Ms Jackie Gladden	Trent Region
Mrs Joy Bennett	Anglia and Oxford Region
Mr Dave Lee	North Thames Region
Mr Nicholas Buchanan	South Thames Region
Mrs Jacqueline Salter	South and West Region
Mrs Barbara Collins	West Midlands Region
Ms Cath Arnold	North West Region
Mrs Sandra Taylor	Wales

NHS Executive Observer

Mr Ray Hill *(till February 1995)*

Society of CHC Staff Observers

Mr Richard Edwards Mrs Wendy Lockwood

Staff

Toby Harris	Director
Chye Choo	Chief Administrative Officer
Angeline Burke	Development Officer
Nigel Ellis	Research/Information Officer
Ben Griffith	Information Officer (Health Policy)
Roselyn Wilkinson	Information Officer
Liz Rickarby	Training Organiser
Helen Richardson	Publicity Officer
Anne Hamilton	Secretary to the Director (p/t)
Estelle Kiss	Administrative Assistant (p/t)
Vera Beswick	Administrative Assistant (p/t)
Nicola Bennett-Jones	Newsletter Editor (p/t)

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