Association of Community Health Councils

for England and Wales

Annual Report

1995/96

Contents

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for England and Wales 1995/6

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 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 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.

Review of the Year
1995/96

According to the old joke, every year is an average one for the British economy - worse than last year and better than next. For the Health Service there is no such year as an average year. Virtually every recent year has seen enormous changes - either in structure or culture. 1995/96 was no exception. For example, the last 12 months have seen:

- the onward march of the Private Finance Initiative, hailed by the Government as the panacea for the NHS's capital requirements, but perceived by many CHCs as causing delays to capital projects and feared by some as a Trojan Horse ready to undermine the very ethos of the NHS as a public service;
- the replacement of one set of NHS buzz words with another as "patient empowerment" disappears in favour of "patient partnership", at the same time as large newspaper advertisements were placed in the name of "Doctor-Patient Partnerships", apparently with the aim of discouraging some people from using the Service at all;
- increasingly overt rationing of treatment - or priority-setting as it is more euphemistically called by NHS managers - as a response to continued pressure on health authority budgets and as an alternative to more traditional responses such as ward/bed closures and postponed admissions;
- the wider prevalence of GP fundholding leading to a greater blurring of the accountability for purchasing decisions and a variety of standards of service being offered by providers;
- the negotiations leading to the introduction of a new complaints system, which promised much, but during the lead in period managed to shed many of the hoped for benefits for patients; and
- the preparations for the merger of the old district health authorities and family health services authorities and for the abolition of regional health authorities.

This last had major implications for CHCs, as RHAs had previously fulfilled the role of being their establishing body. Further details are set out in a separate section in this report. The following section looks at some of the issues covered by ACHCEW in the past year.

Complaints

The year has at long last seen the introduction of a new system for handling patients' complaints about the NHS. The procedure, which has been in operation since 1 April 1996, is aimed at speeding up and simplifying the bureaucratic tangle that frustrated complainants in the past. Although ACHCEW was involved in detailed discussions about the new system, as these progressed we were disappointed that many of the main concerns of patients were not being taken into account. We still believe the system lacks independence from the NHS and that its six month time limit will unnecessarily prevent many genuine complaints from ever being heard. We are also extremely concerned that it lacks any power to discipline doctors and others who are found to be at fault - this crucial aspect of public accountability has been completely disregarded within the complaints procedure.

It is still too early to consider the reaction of patients to the new system but CHCs will have an important role in ensuring any problems are brought to public attention. ACHCEW has tried to support CHC complaints work at this busy time by arranging training on the procedure throughout England and Wales, publishing a Health Perspective briefing, arranging a national seminar for 200 CHC delegates and issuing CHCs with an updated complaints leaflet aimed at members of the public. In addition, we have gained funding for and co-ordinated the development of an upgrade to the CHC complaints database to take account of the procedural changes. The database is widely used throughout the country as a tool to manage CHCs' increasing workloads, and can for the first time provide comparable statistics on complaints.

Continuing Care

The dramatic reduction in the number of NHS continuing care beds has long been an issue of concern for CHCs. The Government issued guidance aimed at clarifying the situation, which was welcomed by the Association because it clearly stated that health authorities do have a responsibility for continuing care. This responsibility is, however, limited because health authorities only have to pay for long term care if people requiring care fulfil a number of eligibility criteria. In addition, these criteria are drawn up on a local rather than a national basis and will vary according to the availability of local resources. This concern is shared by the House of Commons Health Committee and by other patient representatives and professional organisations. As a result, the National Consumer Council (NCC) organised a series of meetings so that organisations with an interest in long term care, including ACHCEW, could discuss the guidance and work out a plan of action. As a result of these meetings the NCC has produced a leaflet about the guidance and the implications of the changes so that groups can share the information with members of the public. The implementation of the guidance on 1 April 1996 has not been without its problems, as predicted by ACHCEW, and there is a clear need for careful monitoring to ensure that

the situation is not allowed to deteriorate.

Private Finance Initiative

The NHS certainly needs new investment. Whether it needs the Private Finance Initiative is another question. In September 1995, ACHCEW issued *Private Finance and National Health*, a Health News Briefing on the implications of private investment in NHS services. We were concerned that the requirement to consider private finance options was delaying capital projects. More fundamentally, would managers of hospitals financed by the PFI try to cut costs in undesirable ways? Could private companies be trusted to respect the public service values of accountability and openness? Would private finance genuinely add to public sector investment in the NHS? The Budget subsequently confirmed ACHCEW's fear that in practice the PFI would be used to justify cuts in public sector investment. On a more optimistic note, the Health Secretary, Stephen Dorrell, has stressed that the PFI would not usually involve NHS doctors and nurses being directly employed by private companies. ACHCEW agrees that there is a fundamental distinction between clinical services and supporting facilities. But we remain concerned about private companies investing in NHS hospitals and clinics with a view to profit maximisation.

Confidentiality

Despite the right set out in the Patient's Charter, ACHCEW is concerned about the need to protect the confidentiality of personal information held by the NHS about individual patients. Our Health News Briefing, *Keeping Information Confidential*, called for statutory protection, guidelines to extend patient choice about how information is used and effective controls to prevent unintended disclosures of personal details. The Government's guidance, finally issued in March 1996, clarified the official position and was a definite improvement on the draft version sent out for consultation. ACHCEW, however, has lent support to the British Medical Association's promotion of a Private Member's Bill to protect confidentiality. We also share the BMA's concern about the development of Information Technology, in particular the introduction of electronic patient records (EPR), without prior agreement on firm security standards. Patients give personal information to doctors, nurses and other professionals expecting it to be used within the NHS for their own health care. Administrative convenience is not sufficient justification for disclosing personal information without patients' consent.

GP Removals

ACHCEW first highlighted the problem of patients being removed from their GP's list, without explanation, in the Annual Report for 1993/4. Because doctors can strike off a patient without giving a reason, patients are left feeling distressed and often angry and there is nothing they can do to challenge the doctor's decision.

The Association has received assurances from the profession that no GP would strike off a patient without a very good reason. The Department of Health continues to stress that conciliation between doctors and patients can solve this problem. However, ACHCEW maintains that the only way to protect patients' rights and to preserve accountability in the NHS is to make GPs legally obliged to inform the patient exactly why they are being removed from the list. This is the only way to convince patients that they will not be removed because their treatment is "expensive" or because the level of care they need is a burden on the doctor. It is also vital in ensuring that patients can exercise their right to complain without worrying about being victimised.

ACHCEW continues to call for a change in GPs' Terms of Service, taking every opportunity to publicise the issue. In the past year, with help from individual CHCs, we have contributed to TV and radio documentaries, feature articles in the national press and various magazines. As a result, public awareness of the issue has been raised and we hope that this will add force to the Association's campaign for change.

The year ahead

1996/7 shows all the signs of being as full of change for the Health Service and, in particular CHCs, as was this last year. The new structures of governance within the Health Service came into being on 1 April, at the same time as the new complaints system came into force. Meanwhile, CHCs are having to adjust to the new establishing arrangements.

The year will see a General Election, the outcome of which will have potentially profound implications for the direction of the NHS. Whilst this will undoubtedly herald a further period of uncertainty and possibly another round of major changes, the crucial role for CHCs of protecting and promoting the interests of the local user of the Health Service will remain just as vital as before. As the NHS prepares for its fiftieth birthday, its future and purpose is debated as never before. CHCs and this Association will need to ensure that the service users' viewpoint is not neglected in the sound and fury of Party political discourse.

In all of this, our vision of the Health Service is a clear one - a vision articulated by the Royal Commission on the National Health Service in 1979, whose report stated:

We believe that the NHS should:

- **encourage and assist individuals to remain healthy;**
- **provide equality of entitlement to health services;**
- **provide a broad range of services to a high standard;**
- **provide equality of access to these services;**
- **provide a service free at the time of use;**
- **satisfy the reasonable expectations of its users;**
- **remain a national service responsive to local needs.**

That vision has sometimes seemed a tarnished one in the past, but as a vision for the future its allure is as strong now as it ever was.

Counting the Cost

NHS fees and charges

The practice of charging patients varies widely throughout the NHS and Community Health Councils regularly receive complaints from patients who believe they have been charged inappropriately for health services. In this article, we aim to find out more about where and why this is happening.

THE OPENING WORDS of the 1977 NHS Act state that: "It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service ... The services so provided shall be free of charge except in so far as the making and recovery of charges is expressly provided for..." . In some cases, such charges are discretionary, in other cases they apply to all NHS patients other than those who are deemed to be exempt.

What is clearly evident from a survey of 103 CHCs (50 per cent of CHCs in England and Wales), is that the amount patients have to pay - and whether they are asked to pay at all - is often a matter of pure chance. If you live in Maidstone, ante-natal special screening tests are charged for but in neighbouring Tunbridge Wells they are free; in Manchester, charges for incontinence aids vary in different parts of the city; and in Aylesbury Vale, patients may or may not be charged for immunisations for travel abroad depending on which GP they are registered with. Some of the problem areas are discussed below in more detail.

Prescription charges

The most common complaint about the level of NHS charges is the cost of prescriptions. This has risen from 20 pence in 1979 to the current charge of £5.50 per item. Although the exemption arrangements are intended to ensure that this charge will only apply to those who can afford to pay, the majority (58 per cent) of CHCs are aware of patients who have neglected to get their prescriptions dispensed (or not visited their doctor in the first place) because they considered the prescription charge to be too high. This has obvious implications for the health of the population and undermines the philosophy of health care irrespective of ability to pay.

Hospital services

The charges most commonly made by hospital trusts are for car-parking (77 per cent of hospitals charge some level of fee) and for treatment in casualty resulting from a road traffic accident (72 per cent). Although the latter is a statutory charge under the Road Traffic Act 1988, the level of charge to vehicle users for immediate treatment or examination still varies up to the maximum of £21.30, as does the hospital's policy on the methods of collecting the fee or whether a charge is made at all.

It is the more recently introduced charges which seem to be of most concern to CHCs. For example, 27 per cent of hospitals now charge inpatients for TV or radio facilities (typically around £2.00 - £3.00 per day) and, although there is still no charge for hospital meals, 12 per cent charge for "additional" drinks or snacks. There are also cases of deposits being charged for the loan of seemingly essential equipment such as walking sticks and crutches. The legality of these deposits, which range from £5.00 to £50.00, has been jointly challenged by ACHCEW and Hastings and Rother CHC, and the NHS has conceded that "if the item is medically required, it must be supplied without charge under the NHS, and such charge would include the taking of a deposit". The only exception to this is where the patient gives a deposit on a voluntary basis.

Dentistry

Nowhere else in the Health Service is there such a high level of dissatisfaction with NHS charges than in relation to dentistry: Non-exempt patients pay 80 per cent of the cost of dental work and dentists can charge up to £325.00 for a single course of treatment. A lack of clear information and excessively high fees cause confusion amongst patients. Many people who contact CHCs are often unclear whether they are paying for private or NHS treatment. Around half the CHCs we questioned knew of instances where the estimated cost of NHS treatment prevented patients from having necessary dental work carried out. Seventy-two per cent reported problems with the system through which patients should be informed whether their treatment is NHS or private, and how much they will have to pay.

> *"Dentists are often supposed to provide treatment plans detailing treatment and cost. We rarely find a patient who has had sight of this or who knows exactly what the cost will be beforehand."*

> *"A patient opted to have all their teeth removed and dentures made simply because they felt they could not afford restoration at the prices quoted."*

Many patients no longer even consider visiting a dentist unless they are suffering pain or discomfort; 77 per cent of CHCs say the examination fee discourages patients from finding out whether they need dental treatment. Oxfordshire CHC reported that: "Oxfordshire FHSA conducted research which indicated that fear of the potential fee put many people off going to the dentist. A survey conducted by Warrington CHC in 1994 found that "The cost of services discourages 40 per cent of respondents from having a dental check up". Apart from seriously

damaging the nation's dental health, this hesitancy to attend regular check ups may actually be more costly to the NHS; clearly the longer a problem is left the worse it becomes.

Eye tests

Most of the population are not eligible for free NHS sight tests and have to pay to have their eyes checked privately. Although this may not present a problem for those with high incomes, a disturbing 26 per cent of CHCs knew of instances where the required fee has prevented people whose eyes needed testing from having a sight test. This suggests that certain optical conditions may go unnoticed causing more serious problems for patients in later life.

> *Many clients have indicated that they have tests less regularly, if at all. Even some of those on low incomes avoid tests believing or knowing that they will be charged.*

> *Patients have kept their current spectacles fully knowing that they are not now suitable.*

Travel costs

Although the NHS provides limited help with travel costs, 59 per cent of CHCs knew of patients who had difficulty paying the travel costs relating to NHS treatment, and nearly a third had examples of relatives or close friends of inpatients who had been unable to make hospital visits due to financial hardship. Where they *are* paid, travel reimbursement rates vary because the NHS Executive believes it is inappropriate for them to be set nationally. It is interesting that this argument does not apply to other NHS reimbursements - such as the payment of health authority members' travel expenses.

There are likely to be further problems as an increased number of services are provided in primary care settings - and therefore cease to be covered by the Hospital Travel Costs Scheme.

> *A pensioner had to use a taxi, at £3.50 per trip, to a GP surgery to have a bone infection dressed for three months before being admitted to hospital.*

> *There are problems for people needing regular treatment, eg chemotherapy at a specialist cancer centre, who feel too ill to use the bus and yet a taxi is too expensive.*

> *When a premature baby was treated in a Special Care Baby Unit in Birmingham, the £60.00 round trip meant that the mother could visit only occasionally and was very distressed.*

Variations in other charges

Many CHCs reported problems with unpredictable variations in charges, and the inequity this caused between patients living in different parts of the country. For example, some health authorities ensure that supplies of incontinence pads are available free of charge on the NHS to residents of private nursing homes, yet some do not provide them at all. This means that in some areas residents do not pay for the pads but in, for example, South Warwickshire, they are faced with a £12.00 charge for a weekly supply.

Under the Access to Health Records Act, patients can ask for copies of their own records. However, the fee which the Act says may be charged for photocopying patients' health records seems to be interpreted unreasonably in many cases. In Leeds you might pay £1.00 for an A4 sheet which would cost only six pence in parts of Kidderminster - a major difference for patients with lengthy records. The length of the records themselves are less relevant to some residents of Warrington who are charged 25 pence per copy plus a £75.00 "administrative fee". An even higher charge of £104.50 per hour has been suggested by the British Medical Association for the interpretation of medical records. ACHCEW believes this charge may contravene the Access to Health Records Act and has raised the matter with both the Department of Health and the British Medical Association.

To charge or not to charge?

It is not only the level of NHS fees which is of concern to patients but the seemingly inappropriate circumstances under which they are sometimes charged. For example, one CHC reported a charge made - via the undertaker - for the removal of a pacemaker after the death of a patient. Another referred to the case of a woman who, after suffering injuries from a road accident, was insensitively threatened with legal action if she did not pay a hospital bill to cover her treatment and that of her two young sons and her brother.

Perhaps the most disturbing charging policy was discovered by Wigan and Leigh CHC which discovered that the local trust was charging outpatients for life-saving chemotherapy, causing additional anxiety at an already stressful time. At first the trust claimed it was merely following Government guidelines but after the CHC achieved national press coverage on the issue, the trust was persuaded to review its guidelines and to stop charging.

Certain NHS charges prevent patients from obtaining the care or treatment that they require; where this happens we can only conclude that the charges are inappropriate. Clearly the process of bringing public pressure to bear on inappropriate charging in the NHS can be effective, but we would question whether CHCs should be forced into this sort of action. If charges are to be made at all, it seems only fair that three basic criteria are satisfied:

- decisions made about NHS charges should be brought into the public arena
- charging policies should be more firmly regulated at a national level
- patients should know well in advance about anything for which they have to pay.

CHC Round Up

The following projects represent some of the work carried out by Community Health Councils in the past year to make sure that the patients' voice is heard by the NHS.

LEEDS CHC has set up an Information Roadshow to go out to minority ethnic groups in the Leeds area. The Roadshow aims to establish a two-way exchange of information and ideas between the CHC and currently under-represented minority groups in the community. The first meeting with the Chinese community was well received. The CHC was able to share information about local health services with the group, and to identify areas of specific concern to the community. For example, parents were concerned that they could not understand information given out by schools about health checks for their children. The meeting has encouraged a member of a local Chinese voluntary services group to put themselves forward as a CHC member. A meeting with the Vietnamese community was also a success. Gaps in services for the elderly, and maternity services were identified and the CHC has since taken up these issues with the health authority.

MID ESSEX CHC has taken the lead in setting up local 'cluster groups', involving the public in decisions about local health services. Each group represents a small geographic area covering a cluster of neighbouring parishes, and is made up of three CHC members and seven residents. The groups meet quarterly to discuss local health issues, but the real discussion takes place between meetings - at home, in social gatherings and at work. Positive benefits include direct contact with health authority policy makers as the groups feed into the health authority's purchasing planning. This direct link to the health purchasing plan allows the community to have a genuine influence on health decisions.

NORTH DERBYSHIRE CHC has set up the 'High Peak Health Panel', to seek views and opinions about major changes to the High Peak health services. The CHC wrote to one in fifteen of the electoral roll (2,750 people), asking if they would like to be involved in consultation about local health services. Over 600 people responded positively. The High Peak, a remote rural area, is served by Buxton hospital or by hospitals outside the area. The first consultation exercise involving the 'panel' concerned proposed changes to hospital services, including the withdrawal of some specialist services from Buxton Hospital. The CHC sent out a summary of the consultation document, a health authority factsheet and a questionnaire compiled by the CHC to the 'panel'. The CHC intends to use the information collected to influence health authority planning.

NORTHALLERTON AND DISTRICT CHC covers a vast, sparsely populated rural area with limited public transport, so the CHC felt it important to go out to the public to help them get involved in local health issues. This initiative is called Health and your Rights, based on the panel discussion format of the TV programme Question Time. At the first meeting the 'expert panel' consisted of the CHC Chief Officer, a senior person from the local trust and health authority and a representative from the Citizens Advice Bureau. This and two subsequent meetings were very well attended, with lively debate. Many highly pertinent questions were asked which revealed the issues of concern to local people. Common themes emerging from the debates include: concerns about paying for community care, accessing NHS dentistry and the cost of prescriptions. The CHC says that the major learning point is to involve social services in future meetings. The most valuable benefit is the opportunity to hear directly from service users about their concerns, as well as promoting awareness of the CHC and building links with the community.

WARRINGTON CHC has also developed a panel discussion format for involving the community in health debates. The CHC has organised a series of four Any NHS Questions? evenings.

GLOUCESTERSHIRE CHC used a move to new offices to raise the profile of the CHC locally by holding an Open Day. Tom Sackville MP, Parliamentary Under Secretary of State for Health, officially opened the office, and local NHS managers also attended. Members of the public, including students from local schools, came along to find out more about the work of the CHC. The event was broadcast live on BBC Radio Gloucestershire and has raised community awareness of health issues and the CHC role.

WANDSWORTH CHC has produced the Men's Health Book aimed at helping people to get better information and knowledge about health services and to provide contact details for organisations involved in men's health issues. The booklet was produced in response to men requesting information that was unavailable from other sources. The CHC found that even leaflets on smoking, alcohol and exercise were geared towards women. The booklet has been distributed to local health centres and libraries and there has been a large demand for it nationally. The CHC has received lots of positive feedback, some new ideas for inclusion in the next edition and offers to help with the production of an updated version.

CLWYD NORTH CHC AND CLWYD SOUTH CHC have appointed two part-time complaints advocates (funded by the Clwyd Voluntary Services Council) to advise and support people who have complaints about NHS treatment. The advocates mediate on behalf of the patient to solve problems quickly and effectively, wherever possible. The project is felt to be a great success and the Chief Officers say "we could not imagine re-absorbing the caseloads built up by our advocates!".

MERTHYR & CYNON VALLEY CHC has set up a Diabetic Advisory Services Group to improve services for the estimated three per cent of the local population with diabetes. The group was formed by the CHC and includes diabetic service users, health professionals and health authority managers. The group has also conducted a survey of local diabetics to find out about their service needs and the take-up of current services, and is compiling a report of the findings. In the meantime, the group has already achieved marked improvements in local services. A major success has been the introduction of monthly visits by a consultant to the diabetes clinic in Aberdare for the first time in 17 years.

ARFON-DWYFOR CHC has responded to the local shortage of NHS dentists. In Gwynedd most of the dentists have transferred to the private sector, and by November 1994, less than three per cent of Dwyfor residents were registered with dentists for NHS dental treatment. The CHC campaigned vigorously to highlight this issue and met Rod Richards MP, the Under Secretary of State at the Welsh Office to discuss this crisis. By late 1995, the Welsh Office agreed to set aside £5 million to be allocated as grants to attract NHS dentists into the area. In areas where the lack of NHS dentistry was most acute, grants of £50,000 were available to relocating dentists willing to commit to providing at least five years of NHS treatment. In Gwynedd, four new dentists are about to set up practices. Many more have shown interest and are likely to be taking up the offer in the near future.

SCUNTHORPE CHC'S Acute Services Special Interest Group set up a study to monitor the local trust response to the Patient's Charter standard on accident and emergency, that "all patients attending the accident and emergency department will receive an assessment of the severity of their injury and the need for nursing/medical intervention within five minutes of arrival, and the level of priority will be discussed with the patient". The CHC survey, however, found that only 58 per cent of people were assessed by the triage nurse within the 5 minute specified time limit, compared to the official hospital figure of 90 per cent. The hospital challenged the CHC findings, but when the CHC discussed this with hospital managers, it was found that the computerised logging system used to produce the A&E statistics was at fault. The managers have promised to investigate, and the staff in A&E are pleased that their staffing shortages are at last being highlighted.

MANCHESTER NORTH CHC has had a hectic year responding to threatened changes in the provision of children's services which included the closure of Booth Hall Children's Hospital. Both the CHC and the local council opposed the closure of the hospital. The CHC argued that there had been inadequate consultation over the proposals, and that the health authority was failing to take local opinion into account. Both the CHC and the City Council were granted leave for a judicial review, but before that took place, they reached agreement that the health authority would carry out a full consultation and would meet the legal costs of the CHC and the City Council.

ISLINGTON CHC'S Mental Health Working Party, on a routine visit to a local psychiatry unit, were very concerned to find patients living in cold, grimy and totally unacceptable conditions. The issues raised with the Chief Executive of the trust received considerable press coverage, and the Chair of the trust apologised personally to every patient. More practically, £300,000 was found in their estates budget to refurbish the unit. The Mental Health Act Commission inspected the unit in January to monitor improvements.

KIDDERMINSTER CHC followed up concerns that people were not taking up their prescriptions because they could not afford to pay. The survey involving local pharmacies and the public found that the cost of prescriptions does deter some people from getting their medicines dispensed, and that some people who are entitled to free prescriptions were in fact paying for them. The survey received wide media coverage both regionally and nationally. Acting on one of the survey findings, the CHC has undertaken a joint campaign with the family health services authority to print and distribute 100,000 leaflets and posters to inform the public about entitlement to free prescriptions and help with prescription costs.

PONTEFRACT AND DISTRICT CHC were awarded a Charter Mark, 'the people's mark of approval', in 1995. Any public sector organisation that deals directly with the public can apply for the Charter Mark, which lays down a rigorous set of nine criteria aimed to assess the performance of public sector bodies. The CHC gained the award after two years hard work to develop their services in response to the views and needs of local people. Initiatives included the establishment of the Health Information Centre in the new CHC town centre office. The Health Information Centre holds over 380 leaflet titles and has computerised links to three health information databases. From July to December 1994 the centre was visited by 2,205 people, compared to 43 within the same time period in 1992.

SALISBURY CHC was highly commended by the judging panel of the Charter Mark award scheme for "providing a high quality public service".

Behind Closed Doors?

the accountability of NHS trusts

The NHS Executive states: "Because the NHS is a public service, it should be open about its activities and plans[1]". This is particularly important during a period of dramatic change including debates over 'rationing' health care, a nation-wide increase in people receiving emergency treatment and private sector involvement in building and running NHS hospitals and clinics. We all need and deserve to know what decisions are being made in our name and the opportunity to influence those decisions and hold those responsible to account.

BEFORE THE CREATION of the NHS internal market, hospitals and community health services were run by district health authorities (DHAs). The DHAs included members appointed by local authorities and observers appointed by Community Health Councils (CHCs), as the statutory representatives of the interests of the public. DHAs typically met most months in the year and did so in public so that staff, local residents and the media knew about the decisions being made.

Now, hospitals and community health services are run by self governing trusts each with its own board of directors who are expected to pursue the corporate financial interests of their own trust (with the health authorities left to act as "champions of the people"). Yet at the same time trust boards remain part of the NHS and the Government insists that they respect the "public service values" of probity, openness and accountability. This survey of CHCs was designed to assess how trusts balance the demands of being both self-governing and accountable to the public.

Over a hundred CHCs responded to the survey, half the total. They submitted 232 returns on the main hospitals in their area. Altogether, information was received about 191 separate trusts (not including trusts set up to run ambulance services). Forty-five per cent of the trusts run acute hospitals and 32 per cent run community health services or "priority" services (often in the mental health field).

Meetings

Self governing trusts are required to hold an annual general meeting in public but otherwise are free to hold board meetings in private and to exclude CHCs. Just over half the trusts never invite the CHC to attend board meetings, never give the CHC speaking rights and never send the CHC the agenda and background papers. These findings are remarkably consistent with those of a survey three years ago, indicating no improvement in the openness of trust board meetings. Two thirds of trusts do not allow CHCs to put items on the agenda of their meetings. This means that CHCs are often unable to monitor the decision making of trusts or to speak up for patients' interests at crucial meetings. Meetings where boards may decide how to cut spending to balance the trust's books or how to win contracts from GP fundholders.

For four out of five trusts, the chief executive or other directors meet with the CHC's chief officer or members at least three times a year. Half the trusts always or usually send a representative to attend CHC meetings - which are held in public. As a result, they can hear the concerns of CHC members and are often invited to contribute to discussions and explain the background to the trust's decisions.

Visits and complaints

CHCs are legally entitled to visit NHS hospitals in their area in order to assess the quality of the care delivered and report any concerns. This remains a major area of work for CHCs. Nearly half the trusts in the survey are visited and inspected by the CHC at least ten times a year. Another one in four trusts are visited by CHCs five to nine times a year. For nearly 70 per cent of trusts, the management is "very helpful" in relation to CHC visits. Unhelpful managers are reported for just two trusts.

CHCs are "very satisfied" by the response of three out of ten trusts to the issues raised following visits. Another two-thirds of trusts respond in ways which leave the CHC "quite satisfied". CHCs report a wide range of improvements made by trusts following CHC visits, involving:

- information leaflets for patients
- sign posting within hospitals
- redecoration and refurbishment
- tackling mixed gender wards
- support for people who have been bereaved
- staffing levels
- access for people with disabilities
- security.

In recent years, CHCs have helped an ever-increasing number of people pursue complaints about NHS treatment. For 58 per cent of trusts, a "very good" working relationship has been established between the CHC staff assisting complainants and

[1] *Code of Practice on Openness in the NHS*

the trust's staff responsible for handling complaints. CHCs describe the relationship as "poor" for just five per cent of trusts. A good working relationship can make it more likely that complaints are handled speedily and sensitively and that justice is seen to be done.

What a difference CHCs can make

One CHC submitted a critical report after visiting a community health services trust. The chief executive was so concerned he made a personal unannounced visit to a unit. All the CHC's concerns were then addressed.

Another CHC visited a children's ward for ENT patients. This resulted in the trust agreeing to review security arrangements and signposting. Bed screens would be used to separate pre- and post-operative children.

Following concerns expressed by a third CHC, a trust introduced a new policy to cut down the waiting times for maternity cases. Also, additional staff were recruited to the audiology service after the CHC drew attention to complaints from people waiting for hearing aids to be fitted.

Information and consultation

Each trust is legally obliged to publish an annual report on their work. This is a valuable opportunity to show their commitment to openness and accountability. Three-quarters of trusts do include some statistics on the quality of their services in their annual report. However, less than half give statistics on quality for the different specialties or compare the results with any targets they had set for the year or with the achievement in the previous year. Only just over half include statistics on complaints made by patients, which should be seen as a basic measure of trusts' commitment to accountability and quality assurance.

The Department of Health has issued a Code of Practice on Openness in the NHS which says it is "good practice" for trusts to publish various documents. Nearly three-quarters of trusts do publish information comparing their performance with the national targets set by the Patient's Charter. Also, three out of four trusts publish information about changes to the services they provide. However, less than half publish quarterly reports to their board including financial, activity, quality and contract information; and less than half publish the agenda and papers for board meetings held in public (apart from the AGM). So the overall picture could be worse. But a fully accountable NHS would require trusts to publish such basic information.

Trusts are not obliged to consult CHCs or other interested parties when significant changes are proposed in their services. The local health authority is supposed to consult which makes some sense when the changes at the trust are the direct result of health authority strategies. It makes less sense when the trusts are responding to demands from other health authorities or from GP fundholders which are not controlled by the health authority in charge of the consultation. If the health authority cannot determine what the trust does, it cannot meaningfully consult about the trust's proposals. The duty to consult should lie with the body which decides.

In fact, the survey reveals that 60 per cent of trusts always or usually consult the CHC formally when considering making substantial changes in services. CHCs report that 14 per cent of trusts never consult the CHC. This suggests an improvement over the situation three years ago when one in four CHCs said they were not consulted by trusts. One in four trusts always involve the CHC in discussions at an early stage when changes are being considered and another 45 per cent of trusts usually do so.

Conclusion

CHCs rate their relationship with 42 per cent of trusts as "very good" and another 33 per cent of relationships are described as "good". Just four per cent of relationships are "poor" and none are "very poor". In 1993 it was reported that 62 per cent of CHCs said their relations with local trusts were good or very good and eight per cent said they were poor. This suggests that trusts are now more committed to openness and accountability, less liable to push through decisions in a 'macho' fashion and more happy to acknowledge the skills, experience and concerns of CHCs.

The findings of this survey are encouraging in relation to trusts' help with, and responsiveness to, CHCs' visits and their work with complainants. On the other hand, there is still plenty of room for improvement in relation to the openness of board meetings and the publication of meaningful information. Perhaps trusts are better at responding to problems raised by CHCs than they are at admitting to problems of which CHCs are not yet aware.

CHCs were asked what requirements should be laid down to make trusts more open and accountable. Some felt that trust status inherently makes hospitals unaccountable. Others called for the publication of more information in relation to board meetings, plans under consideration and decisions being made and the results of financial and quality monitoring. Some CHCs suggested changes in the membership of trust boards including a role for elections or local authority representation or CHCs nominating individuals.

The most common suggestions were that CHCs should be able to send observers to trust board meetings and that these meetings should be held in public. Until these requirements are laid down, the fear will remain that allowing boards to meet in secret provides cover for those trusts which have something to hide.

Changes in the Establishing Arrangements for CHCs

The Government announced in July 1994 at the ACHCEW conference that when regional health authorities (RHAs) disappear the Secretary of State will establish CHCs through the NHS Executive regional offices. Detailed guidance on how this was to happen was contained in Guidance issued at the end of December 1995, under cover of EL(95)142. CHCs had originally said that they wanted the future establishing body to be an independent agency. Once it was clear that the key role would be played by the new NHS Executive regional offices, the Seven Key Principles (see box) that should govern the relationship between regional offices and CHCs were agreed. CHCs will be watching closely to see whether this is the way in which the relationship works in practice.

EL(95)142 says that the relationship between the NHS Executive regional offices and CHCs should be based on seven key principles:

1. **Understanding and respect** for the functions and independence of CHCs from health authorities, trusts and other providers.
2. Broad **consistency** in the handling of CHCs by regional offices throughout England.
3. Visible, open and **clear lines of communication** between regional offices and CHCs.
4. Recognition that CHCs are **responsible for managing their own day-to-day affairs**, overall workplan, workload and resources and also that CHCs need to **demonstrate that they are accountable for the work that they do** by having in place a framework of performance, business and financial planning and monitoring processes that is acceptable to the regional offices.
5. **"Light touch" management** of CHCs by regional offices in the context of the provision of co-ordinated support to CHCs and the monitoring of their performance.
6. Willingness of **CHCs to offer constructive criticism and comment on the Health Service** and of the regional offices to consider it, and to encourage the relevant health authority and trust also to consider it.
7. The regional offices' responsibility for and commitment to ensuring provision of access to **support and training for CHC members and staff.**

Other points from EL(95)142 include the following:

- Policy on CHCs will be co-ordinated by a new NHS Executive "CHC Policy and Liaison Group" comprising representatives of each regional office, but not involving ACHCEW or any other representatives of CHCs themselves.
- The NHS Executive will encourage the development of strong regional associations of CHCs and will fully fund subscriptions of CHCs to ACHCEW.
- Health authorities, trusts, local authorities and other bodies will be encouraged to take part in and fund joint projects with CHCs.
- Changes to health authority boundaries should not automatically lead to changes in CHC boundaries and regional offices must consider whether maintaining the existing CHCs will better serve the local communities' interests.

In addition, up-dated CHC Regulations were laid before Parliament and included the following changes:

- the title of CHC Secretary was changed to Chief Officer;
- CHCs were allowed to appoint two Vice-Chairmen;
- the rules governing eligibility for appointment as a CHC member were changed;
- the CHC reporting year was changed to end on 31 March; and
- CHCs must be consulted about changes in the area they cover, the number of their members, and the provision of premises and resources.

Subsequently, the NHS Executive issued more new guidance, superseding EL(94)4, and this clarified a number of remaining issues on the operation of CHCs following the change in establishing arrangements. The main features of this revised guidance - EL(96)17 were as follows:

- purchasers should involve CHCs in the purchasing process, in particular in respect of:
  - needs assessment and priority setting
  - overall contract strategy
  - development of quality standards
  - monitoring services
  - matching services to community needs
- purchasers and providers should involve CHCs in:
  - monitoring Patient's Charter activity
  - developing local standards
- purchasers should make available information necessary for CHCs to fulfil their role
- CHCs should give information to NHS bodies about their findings from monitoring exercises and surveys
- GP fundholders should publish key documents (e.g. annual practice plans, major shifts in purchasing plans, performance reports) and these should be sent to CHCs
- NHS trusts should recognise the statutory role of CHCs and should seek the advice and support of CHCs when seeking patients' views
- NHS trusts should offer regular liaison opportunities for CHCs - perhaps through attendance at Board meetings
- health authorities will continue to be required to consult on substantial variations in service
- if a CHC contests a health authority's proposal and the health authority still wishes to proceed with it, having considered the CHC's objections, the proposal will be referred to the relevant regional office who will put the proposal to the Secretary of State for final decision
- the Code of Practice on Openness in the NHS applies to CHC work and also to information requests made by CHCs
- CHCs have no statutory powers in respect of local authority social services but "can discuss" such matters as hospital discharge arrangements, complaints, user feedback and community care plans
- an important aspect of the role of CHCs is in relation to individuals who wish to make a complaint about the Health Service
- CHCs should operate the ACHCEW guidelines for handling complaints about CHCs and regional offices will handle complaints about CHCs that it is not possible to resolve by internal investigation
- CHC members are advised to act in accordance with the Code of Conduct for CHC members
- a CHC is "an unincorporated body established under statute" - a CHC cannot therefore sue or be sued as a separate legal entity and any liabilities arising from action taken by members will attach to those members severally
- CHC members should refer members of the public asking for advice to CHC staff
- CHCs continue to have a statutory responsibility to meet once a year with the relevant health authority, but this should be only one element of a continuing dialogue
- regional offices will require CHCs to develop annual plans (to cover agreed priorities, objectives, targets and work programme), following discussion with the regional office and local purchasers and providers
- progress against these plans should be reviewed each year and the outcome of the review should be made known to the regional office
- CHCs should produce an annual report reviewing achievements against the previous year's plan and indicating the priorities and targets for the year ahead.

Work of ACHCEW

1995/96

Virtually all CHCs continue to be members of the Association. At 1 April 1996, there were 207 CHCs in England and Wales and 205 were members of ACHCEW. This represents over 99 per cent.

Membership of ACHCEW

1988 - 86%	*1993 - 95%*
1989 - 88%	*1994 - 97%*
1990 - 92%	*1995 - 99%*
1991 - 93%	*1996 - 99%*
1992 - 94%	

Information Service

The Information Service maintains a data base of information on reports produced and surveys conducted by CHCs, and information on other reports and publications that may be of interest to CHCs. All CHCs are encouraged to send reports and surveys to ACHCEW and there are over fifteen hundred of these held by the Association. This source of information is of increasing interest to academics and other organisations. An annual bibliography 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 responding to requests for information and advice from member CHCs. Considerable use is made of this service and the number of enquiries from CHCs runs at about 350 per month. Other organisations and academics, some from overseas, also approach ACHCEW for information, particularly about the role and work of ACHCEW and CHCs.

Training

With the many changes occurring in the NHS and the effects on the role of the CHC there has never been a more crucial need for training. ACHCEW has continued to expand its provision of training aimed primarily at CHC members and we have now organised summer and winter training programmes consisting of 40 training days.

We offer a wide range of courses presented around the work of the CHC (our core programme) and the following topics have been offered:

Tackling research

Understanding the changing Health Service and the role of the CHC

A guide to contracting in the NHS

Local voices

Setting performance standards for CHCs

Understanding and working with the community

Complaints - monitoring, setting standards, measuring quality

Using the media effectively

Working with the media

Using broadcast media effectively

Consultation procedures

Giving strength to patient feedback - understanding consumer audit techniques

Developing skills for CHC chairs and vice chairs

Developing your links with local communities

Continuing care - an overview

GP fundholders - in whose best interest?

Understanding how the CHC works.

In March 1996, in conjunction with the Society of CHC Staff, we organised a one day training day for CHC Officers on the Wilson Complaints System and CHCs. This training initiative was supported by the NHS Executive and was offered in 24 locations throughout England and Wales. Attendance was high, with over 400 participants benefiting from this training.

All participants on our training days are encouraged to complete an evaluation form and the feedback for all our courses has been very positive. A further summer cycle has been planned and we aim to continue to expand our training programme.

Further Training Initiatives

In line with our commitment to provide high quality training and educational material for CHCs, we have produced an innovative series of distance learning packs for CHC members and chairs. The packs provide members with an effective learning programme to help them develop the skills that are essential for their role in the CHC. They will provide each individual with an invaluable source of information that they can refer to throughout their time with the CHC. The packs available are:

Skills for new CHC Members

Developing Skills as a CHC Member

Skills for CHC Chairs.

Publications

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 for review, contents of medical journals and conferences and meetings. Although primarily for member CHCs, there are an increasing number of subscriptions from other organisations and the press. It has been published ten times during the course of the year.

A new format will be launched in May 1996, and from then, an individual copy of the newsletter will be circulated to all CHC members.

Health News Briefings

Over the past year ACHCEW has published a number of ***Health News Briefings***, in-depth reports focusing on Health Service issues. These concentrate on the changing NHS and are produced primarily for the information of member CHCs. However, they are circulated widely as a contribution to debate and discussion on current health topics and have attracted considerable media attention. ***Health News Briefings*** published in the last year are detailed below:

The Future Establishing Arrangements For CHCs - response from ACHCEW to the NHS Executive Working Group report- June 1995.

Keeping Information Confidential- June 1995

This briefing looks at the risks to confidentiality in the new NHS. Although in theory patients can expect details of their medical status to be confidential this report highlights the circumstances when this private information is disclosed without patients giving informed, explicit consent. It also sets out ACHCEW's view that there should be statutory protection for patients' confidentiality.

Private Finance And National Health - August 1995

This briefing highlights the implications of using private investment to cut public spending on the NHS. It reports that the Government's Private Finance Initiative has held up essential improvements to NHS facilities because NHS trusts are forced to seek private finance for all major building developments. The briefing warns that PFI must not be used as a substitute for adequate public investment in the NHS.

Fit to Practise? - the rights and responsibilities of impaired health care workers, prepared for ACHCEW by Ken Howse - October 1995

The briefing calls for greater co-operation between health professionals, their employers and the Government to identify health care workers whose physical or mental condition could put patients at risk.

The Accountability of Fundholding - November 1995

Based on a survey of CHCs, this briefing assesses the openness of GP fundholders and their willingness to work closely with CHCs. It concludes by making national policy recommendations in line with resolutions passed at the 1995 ACHCEW AGM to strengthen the rights of CHCs in relation to fundholding and in the context of the primary care led NHS.

Quality Contracts - improving standards of patient care - December 1995

This briefing illustrates examples of current good practice and considers how CHCs can intervene in the health commissioning process to help to ensure that the public are being provided health care of the best possible standard.

The Financial Health of the NHS - March 1996

Based on a survey of CHCs, this report assesses the state of the NHS finances five years after the introduction of the internal market.

In addition to the above briefings, ACHCEW and the Institute of Health Services Management (IHSM) commissioned a discussion paper, ***Back From the Margins***, which considered the future of CHCs in the new NHS. The paper, prepared by Christine Hogg, concludes that future arrangements for CHCs must ensure that they are: independent of NHS management; effective, with clear rights and responsibilities that can be enforced; accountable for their actions and use of funds and have adequate resources for the duties expected of them.

Health Perspectives

Health Perspectives is a series of briefing papers which examines emerging themes and issues within the NHS and considers the implications for patients. These are published ten times a year and every CHC member is provided with an individual copy. The following issues have been published:

Continuing Care- June 1995

Investing in Children's Health - August 1995

NHS Changes and the Role of Community Health Councils - September 1995

NHS Dentistry - October 1995

GPs' Responsibilities for 24 Hour Care - November 1995

Ambulance Services- Towards Three Tiers?- January 1996

Future Establishing Arrangements for Community Health Councils - February 1996

Quality in the NHS - Improving Standards of Patient Care - March 1996

The New NHS Complaints Procedure - March 1996

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. For a number of years, ACHCEW has also produced a leaflet on patients' rights. It has recently been updated. The leaflet is widely used by CHCs, but also by other advice organisations. There is a multi-lingual poster promoting this leaflet and a version of the leaflet is available on tape. In addition, ACHCEW has produced a series of factsheets derived from the leaflet. These cover the following subjects: ***Making Choices - finding out about an illness and consenting to treatment, Going into Hospital, Family Doctors, On the Record - confidentiality and access to medical notes, Care in the Community, Making a Complaint.*** These are available in the following minority ethnic languages: Arabic, Bengali, Cantonese, Greek, Gujarati, Hindi, Punjabi, Somali, Turkish, Urdu and Vietnamese. This range of

languages will ensure that as many people as possible have access to information about NHS services.

To help CHCs with publicity work the Association has prepared and circulated ***Communications Guidelines for CHCs***. This pack offers practical advice on publicity issues such as dealing with the media and publications.

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 the concerns of patients. Regular contact is maintained with the specialist press, with health correspondents on national newspapers and with relevant programmes on radio and television. Regular news releases have been issued over the year both highlighting ACHCEW publications and activities and in response to Government announcements. This has led to substantial coverage for the Association. There have also been an increasing number of requests for comment on current health issues.

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

There are also good working relationships with a variety of organisations working in the health field. For example, regular contact is maintained with the General Medical Council, the British Medical Association, the Health Visitors' Association, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, the Audit Commission and the Health Service Commissioner. There are also good working links with the National Association of Health Authorities and Trusts, the Institute of Health Services Management, the National Association of Fundholding Practices, 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 and the Public Health Alliance. Finally, there is regular contact between the Association and the Department of Health and the NHS Executive. ACHCEW has been pleased to have had constructive discussions with Mr Gerald Malone MP, Minister for Health and Mr John Horam MP, Parliamentary Under Secretary of State for Health who has the responsibility for links with CHCs. Regular discussions take place between the division of the NHS Executive with responsibility for CHCs and there are increasing links with other parts of the Department.

Responses to consultation documents and representation on behalf of CHCs

A significant amount of the Information Team's time is devoted to considering consultation documents, issued by the Department of Health, other Government departments and other external agencies and, where appropriate, submitting responses in line with the Association's policy. Over the last year the Association has submitted responses to the following consultation exercises:

NHS R&D Priorities
DoH
7/4/95

Dear to our hearts? - Commissioning for cardiac health
Audit Commission
12/4/95

Inquiry into long-term care
Health Committee
17/4/95

Who knows? A study of information management and systems in the acute hospital
Audit Commission
18/4/95

Community Health Council boundaries
South Thames RHA
24/4/95

Community care plans for 1996/7 in England - draft guidance for consultation
DoH
28/4/95

Hospital doctors: training for the future - proposals for implementing legislation: the specialist medical order
NHS Executive
25/5/95

Audit Commission study programme. Suggested topics for future studies
Audit Commission
24/5/95

Joint Reviews of Social Services Authorities
Social Services Inspectorate, Department of Health
26/5/95

Proposed study of maternity services
Audit Commission
31/5/95

Child health in the community: A guide to good practice
DoH
12/6/95

A strategy for security of the electronic patient record
Institute for Health Informatics
22/6/95

Review of the role, functions and responsibilities of the General Optical Council
General Optical Council
28/6/95

Hospital Waiting Times
NHS Executive
17/7/95

Nurse practitioner (Professional Briefing VIII (1995))
Health Visitors' Association
18/7/95

Acting on Complaints Implementation Advisory Group: Monitoring Complaints - Data Collection
NHS Executive
19/7/95

NHS responsibilities for meeting continuing health care needs: review procedure
NHS Executive
20/7/95

SIFT into the future
DoH
24/7/95

Core values for the medical profession in the 21st century. Report of conference held on 3/4 November 1994
British Medical Association
25/7/95

Care of older people with hip fracture
Audit Commission
27/7/95

Nutrition Task Force - Guidelines on Educational Materials
DoH
9/8/95

Accidents and the Management of Health and Safety in the NHS
National Audit Office
10/8/95

Hospital doctors: training for the future - supplementary reports
NHS Executive
15/8/95

Study of the disposal of waste in the NHS
Audit Commission
15/8/95

Core standards on information and psychosocial support for people affected by cancer (draft)
BACUP -British Association of Cancer United Patients
25/8/95

More people, more active, more often. Physical activity in England. A consultation paper.
DoH
30/8/95

Community care development programme
DoH
8/9/95

Health Committee: Inquiry into Children's Health
Health Select Committee
18/9/95

Inquiry into long-term care
Health Select Committee
27/9/95

Whistleblower protection bill
Campaign for Freedom of Information
27/9/95

Review of ambulance performance standards
DoH
13/10/95

Patient's Charter and services for children and young people
DoH
13/10/95

Guidance for the involvement of patients and service users in developing and using national clinical guidelines
Royal College of Nursing
2/11/95

Proposed Changes to Social Security Benefits for Asylum Seekers
Refugee Council
10/11/95

Review of Professions Supplementary to Medicine Act (1960)
JM Consulting, DoH
23/11/95

Childrens' Community Nursing
Royal College of Nursing
23/11/95

By accident or design: Improving emergency care in acute hospitals - consultation draft
Audit Commission
5/12/95

Priorities and planning guidance for the NHS: 1996/97
DoH
7/12/95

Practice based complaints procedure: draft guidance pack for general medical practices
NHS Executive
13/12/95

Investigation into the Adequacy of Service Provision and Treatment for Patients with Skin Diseases in the UK
All Party Parliamentary Group on Skin
13/12/95

Health Service Commissioner - Public information leaflet
Health Service Commissioner
15/12/95

Maintaining medical excellence. The review of guidance on doctors' performance
DoH
15/12/95

General Dental Council: Registration of Dental Auxiliaries; Composition of the Council; Amendments to the Dentists Act, 1984
General Dental Council
20/12/95

SCOPME's work programme for 1996/97
SCOPME
22/12/95

Supervised discharge: consultation on draft guidance
DoH
9/1/96

Inquiry into long-term care
DoH
10/1/96

Election of voluntary sector members
NHS Executive
11/1/96

Review of the role, functions and responsibilities of the General Optical Council. The rules on publicity 1985
General Optical Council
25/1/96

Responsibilities of the Health Service Commissioner
Office of the Health Service Commissioner
29/1/96

New procedure for the Preliminary Proceedings Committee and Health Committee, Introduced by the Medical (Professional Performance) Act 1995
General Medical Council
29/1/96

Continuing care information leaflet
NHS Executive
12/2/96

Future use of forms currently used to register for General Medical Services
DoH
12/2/96

Community Care (Direct Payments) Bill - consultation paper
DoH
15/2/96

Career redevelopment framework
General Dental Council
26/2/96

Health Service Commissioner - Public Information Leaflet
Health Service Commissioner
29/2/96

Draft Health Service Guideline - NHS Indemnity
DoH
29/2/96

National report on GP fundholding
Audit Commission
11/3/96

Health Service Commissioner - New Powers: Explanatory Leaflet
Health Service Commissioner
14/3/96

GMC booklet on Advertising
General Medical Council
19/3/96

Standing committee and working groups

Since the 1995 AGM in Cardiff, the Standing Committee has met on four occasions. The meetings have focused on current NHS issues, ACHCEW initiatives and publications and policy issues raised by member CHCs.

The Honorary Offficers of the Association have also met on a regular basis throughout the year. In addition, they have 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 is 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 substantial contact with regional groupings of CHCs. This has helped 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

ALTHOUGH I have been a member of Standing Committee since 1990 and was Vice Chair for two and a half years, I still felt a little nervous when taking over as Chair of ACHCEW last July. My regular journeys from Durham to London, courtesy of East Coast Railways, have not been too traumatic, but I will never get used to six o'clock starts however often I travel.

It has been a busy year, and a year of change for Community Health Councils.

This year, the arduous task of the Working Party Group on the Future Establishing Arrangements for CHCs was finally completed. The long awaited updated guidance was finally produced in mid March. The ACHCEW bid for the legal service level agreement was successful and I am sure will provide a much needed more direct service to all CHCs.

A team of consultants has been appointed by the NHS Executive to examine the resourcing and performance management of CHCs and is due to report at any time. Members of the Society of CHC Staff, Regional Co-ordinators and ACHCEW (via myself and Toby Harris) have been involved as members of a steering group to oversee the consultation process. We hope to have identified the basic principles of CHC areas of work, to enable the identification, as fairly as possible, of the "notional" CHC.

I am looking forward to this year's conference. In what is perceived to be a possible election year (or at least the last ACHCEW AGM before a General Election) we have, as is normal practice, invited Ministerial speakers from the two main political parties, and at the time of writing are expecting Harriet Harman MP, Shadow Secretary of State for Health and John Horam MP, Parliamentary Under Secretary of State for Health, to speak. This high level of interest demonstrates the enhanced status of CHCs.

This year I have also been involved in a project to consider joint working between health authorities and social services departments, and the role of CHCs in this process. The working party, as agreed at the last AGM, has worked hard to produce a paper which will be presented for discussion and debate at this year's conference. I would like to thank those involved in the working group for their efforts, particularly Angeline Burke, one of our Information Team, who has managed to turn our deliberations into a lucid and relevant document.

I would also like to thank all the staff at ACHCEW, who continue to provide us all with a high calibre of support. We have a truly professional team doing an excellent job on your behalf. The increased and improved training programmes, the regular flow of highly topical Health News Briefings and the invaluable introduction of Health Perspectives briefing papers, have found favour with staff and members alike.

With two Vice Chairs, Joyce Struthers and Mark Winstanley and our Honorary Treasurer Graham Girvan, we have a strong Honorary Officers team, which has worked well together over the last year representing the Association at national level, and promoting the CHC role at every opportunity and I thank them for their efforts and support.

A feature of the Standing Committee meetings this year has been the volume and complexity of the agendas, and a huge burden has been placed on individual members to disseminate the relevant information. I thank them for this and for all the help they have given to me in my first year as Chair.

CHCs are going from strength to strength and it has been an honour to have been Chair for this last year. I anticipate with confidence that ACHCEW will continue to grow in influence as the patients' voice in the NHS.

Jennifer Elliott
Chair

Association of Community Health Councils
for England and Wales 1995/6

Chair

Mrs Jennifer Elliott
(Northern and Yorkshire Region)

Vice Chair

Mrs Joyce Struthers
(Anglia and Oxford Region)

Mr Mark Winstanley
(North West Region)

Honorary Treasurer

Mr Graham Girvan

Members of the Standing Committee

Mr Norman Roper	*Northern and Yorkshire Region*
Mr Bernard Graham	*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*
Mr Ciaran Farrell	*North Thames Region*
Mr Reg Pyne	*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 Ann Raschke	*West Midlands Region*
Mr John Pearson	*West Midlands Region*
Mr Eric Trew	*North West Region*
Mrs Eileen Scott	*North West Region*
Cllr Dewi Pritchard	*Wales (South)*
Cllr R I Thomas	*Wales (North)*

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*
Mr Tony Richards	*North West Region*
Mrs Sandra Taylor	*Wales*

NHS Executive Observer

Mr Steven Jolliffe

Society of CHC Staff Observer

Mr Chris Sweeney

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 (Development)*
Liz Rickarby	*Training Organiser*
Helen Richardson	*Publicity Officer*
Estelle Kiss	*Administrative Assistant (p/t)*
Vera Beswick	*Administrative Assistant (p/t)*
Anne Hamilton	*Secretary to the Director (p/t)*
Nicola Bennett-Jones	*Newsletter Editor (p/t)*

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