Association of Community Health Councils

for England and Wales

Annual Report 1996/97

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for England and Wales 1996/7

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 role and public representation within 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.

Spicing up Patient Partnership -

Give the NHS Patient Power

In the recent General Election, the state of the Health Service was a key element in the political debate. Without exception, the main parties pledged their support for the NHS or at least their version of it. And all of them expressed pious sentiments about how the interests of patients must be central to the Health Service.

Such sentiments are not new, usually every Government White Paper on the NHS - whatever the Party of Government - has begun with a ringing statement about how the interests of patients are paramount within the Health Service.

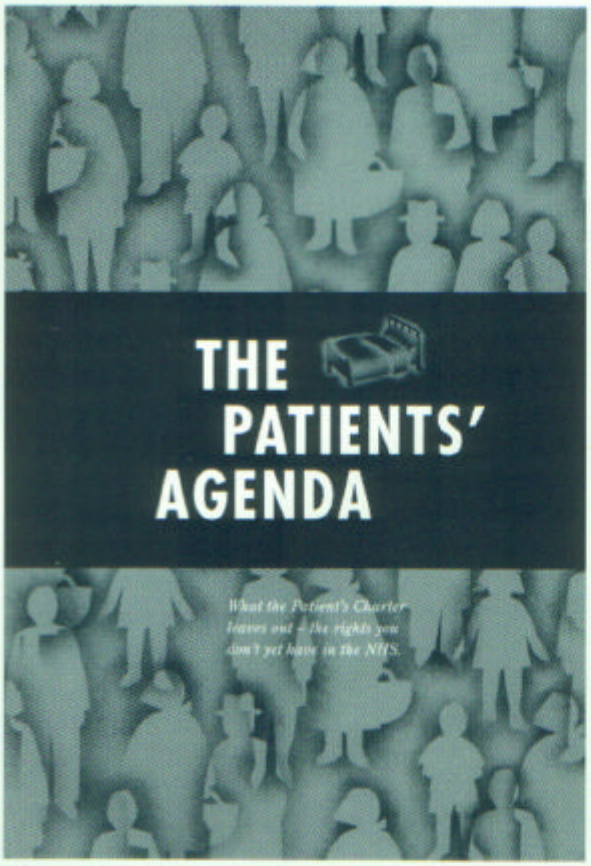
However, these ringing statements are almost oxymoronic: any health care system - whether it is run well or badly, whether its organisation is sensitive to service users' needs and wishes or not - is about delivery of patient care. Without patients, all the efforts of doctors, nurses and other professionals are pretty pointless. Without patients, even managers become redundant.

Yet, there is a point in reiterating the centrality of patients to the system: too often in the past it has felt to the users of the service that it was organised for the convenience of the professionals and those who worked in the NHS rather than those for whom the care was being provided.

That is why in 1986, ACHCEW produced the first **'Patients Charter'** - a concept adopted by the then Secretary of State for Health five years later. And whilst, over the last ten years, most has been done to make the NHS more responsive to the needs and wishes of its users, there is still a long way to go.

And that is why - ten years after ACHCEW produced its Charter - we produced **'The Patients' Agenda'**. This sets out the rights left out of the official Patient's Charter and highlights those areas where patients find their present rights are poor or non-existent and where their reasonable expectations are not met.

Most of **'The Patients' Agenda'** is about the individual service user and how they should be able to interact with their doctor and with the other professionals they will encounter within the NHS. This involves both



formal rights and the increasing understanding that patients are genuine partners in their own care. Many professionals already recognise the importance of this and realise that not only is such partnership good clinical practice but also leads to better outcomes of treatment. Moreover, this trend is irreversible. Patient's are becoming better informed and are accessing the wider variety of sources of information about health, about care and about treatment more and more readily. Patients are also becoming more confident, if not assertive, and this too is a trend that will continue.

All of this is recognised in the Patient Partnership Strategy currently being pursued by the NHS Executive. There is, however, another key element of Partnership and that is involving patients collectively in the decisions about the direction of the service both at local and national level.

There is, of course, a statutory requirement on Health Authorities to consult CHCs on their plans for local health service developments and changes. Indeed, the best managers will always agree that their plans are improved by discussion with, and the views, of a lively and effective CHC. This relationship nonetheless needs to be strengthened which is why ACHCEW's response to the ***Insight*** report highlighted ways in which this could be done.

But if the Patient Partnership Strategy means anything it must also be about the NHS as a whole setting its policies and priorities in the light of the views of those who use or potentially use the service. If the NHS wishes to be sensitive - as a national service - to patient and public wishes, then it needs to make sure that national mechanisms are in place to establish those wishes. Only then, can those responsible for setting priorities at national level or for designing the policies to be adopted throughout the country obtain adequate feedback from those affected by their decisions.

Clearly, ACHCEW acts as a conduit for the views of CHCs throughout England and Wales as part of this process. Similarly, other organisations focusing on individual diseases or conditions have a key role in informing policy in respect of the management of these diseases or conditions. However, no group is funded to provide this role systematically - ACHCEW for example, is resourced primarily to provide support to its member CHCs, and the single disease organisations are established to provide services to those with the diseases in question.

Yet in other countries major surveys are carried out of health service users on a regular basis to track opinions and views and help policy makers in their decisions. In other countries, substantial programmes are supported to encourage and facilitate patient feedback, and mechanisms are in place to collate the work done locally. By contrast, our Health Service does little to make Patient Partnership a reality at national level. The opportunity is there and now is the time to turn that rhetoric into reality and demonstrate that the NHS really wants to listen to the people who use its services.

'The Patients' Agenda'

New Complaints System

For many years the system for handling patients' complaints about NHS services was criticised for being complex for patients and staff and for failing to meet the needs of complainants. The majority of complainants quite simply want to know what happened, why it happened, was anyone to blame and what action will be taken. Constant criticism eventually led the Government to set up a review of the system in 1993. The resulting report *Being Heard*, and the Government's response to it, *Acting on Complaints*, provided the basis for a new system of handling complaints. This was introduced in April 1996. The key objectives for introducing the new procedure were:

- *ease of access for patients and complainants*
- *a simplified procedure, with common features for complaints about any of the services provided as part of the NHS*
- *separation of complaints from disciplinary procedures*
- *making it easier to extract lessons on quality from complaints to improve services for patients*
- *fairness for staff and complainants alike*
- *a more rapid, open process*
- *an approach that is honest and thorough, with the prime aim of resolving the problems and satisfying the concerns of the complainant*

Community Health Councils in England and Wales have, for many years, supported complainants and guided them through the system so CHCs were asked to give their impressions of the first few months of the operation of the new procedures. Sixty-five per cent (134) took part in the survey. In general, there was no clear consensus as to whether the new system is better or worse than the old one: forty-two per cent thought it neither better nor worse, 23 per cent thought it better and 25 per cent thought it worse. Some aspects of the procedures are discussed below.

Local Resolution

Great emphasis has been placed on Local Resolution which is seen as being the key to the success of the new procedures. The aim of Local Resolution is to try and sort out problems where and when they occur. In theory this could work well but a number of CHCs expressed concerns about the actual practice including the need for complainants to 'face' practitioners with their complaints. The following comments were made: *"Patients are discouraged from complaining if they have to face the GP or other medical practitioner they are complaining about"*, and: *"In terms of practice based complaints patients are put off by having to complain to the practice itself - they are left feeling very vulnerable"*. Some patients also fear being removed from their GP's list if they pursue a complaint. Indeed, one CHC wrote that one GP's version of 'Local Resolution' was to phone the complainant and ask them to withdraw the complaint or be removed from the GP's list.

Only 27 per cent of CHCs felt that the Local Resolution procedures for family health services were operating satisfactorily in their area. This is probably a reflection on the fact that few CHCs are involved in these procedures. CHCs would like the Local Resolution procedures of primary care practitioners to be monitored. At the present time family health services practitioners, GP fundholders and independent providers are exempt from the obligation to provide quarterly monitoring reports on complaints.

The procedures of trusts appear to be more open and 80 per cent of CHCs felt that they were operating satisfactorily: *"Trusts generally are responding within the time scales and are willing to discuss issues of discontent and act upon them"*.

Independent Review

If complainants are not satisfied with the outcome of Local Resolution they can ask the trust or health authority to set up an 'independent' Panel to investigate the complaint. This stage of the procedure is known as Independent Review.

Almost half of CHCs (49 per cent) did not know if the Independent Review Procedures were operating satisfactorily in their area. There could be a number of reasons for this: complaints have not succeeded in reaching the Independent Review stage so CHCs have not had experience of the procedures; complainants have been re-referred to Local Resolution; or

"One of the difficulties of the revised system is that some complainants may access practice based systems without recourse to the health authority or CHC and therefore neither agency is involved in monitoring progress of the complaint - patients question the impartiality of practice based systems. [There is] concern that the health authority's monitoring role has been seriously diminished and practices can thereby exert pressure (albeit unconsciously) on patients not to take their complaint further. Does local resolution really work or are patients simply deterred from progressing to the next stage?"

problems with establishing the Panels resulting in delays. One CHC commented:

"Independent reviews are very costly - very difficult to set up, and get the correct panel of experts etc, within extremely tight deadlines. Because of this, patients are being pushed to go back again and again for further local resolution in the hope that this will eliminate the need for independent review".

The decision about whether or not an Independent Review Panel should be established is the responsibility of conveners appointed by the trusts and health authorities. Whilst some conveners are working to the official guidelines, a number of CHCs have concerns: *"Conveners attempting to resolve Independent Review requests personally"; "Suspicion as to the role of the convener and his/her independence".*

Disciplinary issues

CHCs were asked whether in relation to family health services, the separation of disciplinary issues from complaints had resulted in problems. Respondents were evenly split between believing that the separation had caused problems (32 per cent) and believing it had not (33 per cent): *"One complainant [was] very aggrieved that he had no way of knowing whether disciplinary action would result from [the] complaint. Made him perceive [the] whole process as a way of protecting doctors"; "So far complainants generally satisfied with explanations of further action to be/likely to be taken".*

Unacceptable responses

The NHS Executive's complaints leaflet states that the aim of an investigation into a complaint *"will be to give you a quick, but thorough, response which answers your concerns properly".* Unfortunately some CHCs are aware of cases where the responses received by complainants have been unacceptably poor. One CHC stated that a complainant received *"a one line reply from a GP saying 'I am sorry you are not happy with your care. I have always tried to do my best'".* Another made the more general comment that the *"Standard of written responses suggest that insufficient time or resources are directed at investigation".*

CHC involvement

Seventy seven per cent of CHCs were involved in monitoring the new procedures to varying degrees. Some CHCs have regular meetings with trusts and health authorities to discuss developments whilst others are only able to monitor cases where they are supporting the complainant.

When asked about the impact of the new procedures on the CHC workload almost half stated that it had increased, 37 per cent felt that their workload had remained the same and only 15 per cent felt that the workload had decreased. *"All complaints now dealt with are much more complex and time consuming in every aspect - paperwork, meetings etc". "Increased numbers but emphasis has changed. More hospital complaints less GP and dental"*

Conclusion

Although it is early days most CHCs would agree that in theory the new system for NHS complaints has a number of advantages over the old system. However, as a number of CHCs pointed out, whether or not the system is able to achieve its stated aims relies too heavily on the 'personalities' involved: *"Procedures fine in principle - implementation leaves much to be desired. Hinges on staff attitude...".*

Clearly, it is unacceptable that this should be the case and steps must be taken to ensure a consistent and fair approach to the handling of complaints by everyone involved. In particular, the Local Resolution stage of family health services complaints will need to be monitored. Without proper monitoring it will be difficult to gauge just how effective the new procedures are.

Out of Hours Care

Access to emergency medical treatment from GPs (a right under the Patient's Charter) is under increasing strain. ACHCEW has become increasingly concerned with the development of out of hours care in recent years and the 1996 Annual Conference passed the following resolution:

"This AGM notes with concern the absence of consultation by Health Authorities on the proposals to establish GPs' out of hours treatment centres.

This AGM believes that the establishment of such centres is a substantial development and therefore requires consultation.

This AGM therefore calls upon the Secretary of State to ensure that Health Authorities consult CHCs on all such proposals."

ACHCEW has pursued this issue with the Department of Health. But we have not yet received a response that meets the requirements of the resolution.

An extensive survey of CHCs about out of hours service provision was conducted. In view of the survey findings ACHCEW will continue to press for both improvement in service provision and increased powers of CHCs to be consulted over changes to out of hours services.

The development of out of hours care

By 1993, with growing demand for out of hours visits, GPs called for an abandonment of the commitment to provide 24 hour care as laid down in their Terms of Service. The following April conditions of service were changed with GPs now responsible for their own actions when deputising for others. In February 1995 further changes were made so that

"..outside normal hours the doctor shall consider, in the light of the patient's medical condition, whether a consultation is needed, and if so, when".

GPs now have considerably more power in deciding whether to make a home visit.

Furthermore these amended Terms of Service make no specific reference to social conditions; this could make it harder to establish if a GP was in breach of contract if they failed to make a home visit, even when social circumstances dictated that a visit would be appropriate.

Alongside the changes in GPs' Terms of Service, ACHCEW has closely watched the developments in the way out of hours services are organised. Many GPs are forming co-operatives sharing the work with partners or neighbouring practitioners, while others are turning to commercial deputising services.

Arguably the most radical change has been the development of primary care emergency centres (also known as an out-of-hours emergency centres) where patients are asked to come in to special out of hours surgeries. Proponents of the centres argue that they cut down the time GPs spend travelling to patients and can provide modern facilities in an appropriate setting.

Out of hours survey

In February 1997 ACHCEW conducted an extensive survey of CHCs on out of hours care. 104 of the 206 member CHCs (50.5%) responded.

The survey found around a half of CHCs had GP co-operatives and/or deputising services in their area compared with a third of CHCs that had primary care emergency centres.

CHCs often identified the strength of co-operative and deputising services as their ability to give GPs time off in the evenings and hence more responsive to patients in the morning surgery. However many CHCs felt that the lack of access to patients' health records was a weakness and some CHCs questioned the standards of doctors employed by the deputising service, with comments such as *"some very poor doctors employed"*; and *"the standard of the deputising doctors varies greatly"*.

One third of the CHCs in the survey have at least one primary care emergency centre in their area. It was noticeable that the centres were quite prevalent in rural areas. This is of particular concern to ACHCEW as one criticism of the centres is that the patient rather than the GP has to travel. This is often difficult in rural areas due to the distances involved and the lack of public transport.

Accessibility was regularly identified in the survey as being a weakness of the centres. Some of the comments received were: *"the geographical area is very large so the centre is quite a distance from some patients"*; *"patients have to travel up to 20 miles"*; and *"GPs feel much more reluctant to visit generally. Travel is putting some people off visiting when they need to but cannot get a home visit."*

Clearly for some, access to the centres is a problem. Certain groups find it particularly difficult: the elderly or disabled who may rely on public transport or single parents who may have to transport not only a sick child to the centre but other children too. Many CHCs felt that transport to the centres should be improved.

Public reaction to these centres would appear somewhat mixed. Of the CHCs that indicated they had primary care centres in their area only just under half felt the public reaction was generally favourable. Only 54% of CHCs said that they had been adequately consulted about the development of the centre. In view of ACHCEW's resolution at our 1996 conference we feel that there is some way to go before the public views are adequately taken into account when such services are developed.

A consistent message throughout the findings of the survey was the need for greater information to be made available to the public on out of hours care. The public appear not to be fully aware of the services available. Comments as to how the services could be improved typically included: *"more information to patients as to out of hours service provided"*; *"better information to the public on why out of hours centres have been developed and what to do in an emergency"*; and *"practice leaflets should clearly show what the out of hours service is"*.

The next twelve months

The provision of out of hours care will continue to change with the development of GP co-operatives, deputising services and primary care emergency centres. ACHCEW has carefully watched the developments thus far and called for CHCs to be consulted on the establishment of such centres. We have pursued this issue with the Secretary of State arguing that Health Authorities should consult CHCs on all such proposals.

Whilst out of hours calls can place stress and demands on individual GPs any system to reduce the workload on doctors must be balanced with the needs of patients. ACHCEW believe that patients generally prefer to see their own GP or one of their GP's partners in an emergency. If people are distressed they are more likely to be reassured by a doctor who knows them and their history. If it is not possible for a patient to see their own GP then they would be somewhat reassured if they could be confident in the replacement doctor. CHCs could play a useful role in helping patient confidence if they were given more powers to monitor this service provision.

As the patients' representatives in the NHS, Community Health Councils would like to see developments closely monitored on a nationally agreed basis to ensure that the interests of patients are protected. ACHCEW, as the national voice of CHCs, will continue to call upon the Secretary of State to ensure that CHCs are fully able to represent their communities' views. We will continue to argue that CHCs should be consulted over such changes as they clearly represent a major service development.

CHCs Making the NHS Better

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

Salford CHC:

"A range of suggestions from Salford CHC was previously included as local Patients' Charter standards in the contracts of Salford and Trafford Health Authority. This change has already led to the development of provision such as play facilities for children in NHS facilities that would not otherwise have occurred. Following discussions in 1996 between the CHC, the health authority and local GP fundholders, the CHC was asked to develop a common annex for all contracts held by the health authority and local GP fundholding practices with providers. This has now been produced and is being recommended for use by all purchasers and has been accepted by all the local NHS trusts. This should ensure that all Salford and Trafford people can expect the same standards of service, whoever purchases services for them and wherever they go in Salford and Trafford. It has also meant that the CHC, together with GP fundholding practices, the health authority and local NHS trusts, have been able to begin to plan a common and more coordinated approach to the monitoring of the quality of services."

West Essex & District CHC:

"Our primary care project, which aims to stimulate patient participation groups in GP practices is progressing on target. We are currently involved with three local groups. We have devised a training programme and an information pack for GPs and practice managers. We have established links with local practices and many are keen to work with us. We have worked in partnership with North Essex Health Authority, who funded this project to ensure that local people have an opportunity to air their views in the primary care setting."

Huntingdon CHC:

"Huntingdon CHC have established a Public Consultation Panel which currently stands at 140 representatives of groups in the Huntingdon end of the Authority's District. In addition to our own contacts with the panel, the HA have now asked to use this group on three occasions since May 1996 as they consider that they are a very useful contact with 'The Public'. We maintain ownership of the Panel addresses even if it is a large additional postage cost for us."

St Helens & Knowsley CHC:

"As a result of a decision that the CHC should not only be associated with complaints, surveys, etc, seen by the Hospital and Community Trusts as highlighting faults, the decision was taken in January 1996 to launch a Patient's Commendation Scheme. This scheme gives patients or their relatives a chance to nominate a member of NHS staff who has given an exceptional level of service, felt to be above that normally expected. Each patient/relative can nominate only one member of staff and the decision as to the winner is made by a panel consisting of representatives of the Hospitals Trust, the Community Trust and the local health authority as well as the CHC. The award will be made twice yearly - June and December. The June award was very well received and the winners were featured in the ***Healthwatch Journal.***"

Tunbridge Wells CHC:

"The CHC were concerned at the security on the children's ward, Jacoby, in Pembury Hospital. The smaller babies were accommodated out of sight of the main nursing station and the doors at either end of the ward could be opened from the outside without the knowledge of the nurses. After ***much*** *pressure from the CHC the end doors were secured, entry to the ward was controlled by a switch card and the babies were tagged. The CHC was very relieved at the introduction of these security measures."*

Ceredigion CHC:

"For the rheumatology service, patients always had to travel out of county for even outpatient appointments involving long painful journeys. The CHC with others campaigned for a more local service. GP fundholders began buying consultant time at their surgeries - this led initially to lack of equity but continual pressure led health authority also to buy outpatient appointments at the local DGH for the patients of non-fundholders."

Bolton CHC:

"The CHC, together with the HA and a local voluntary group, got funding from the NHS Ethnic Health Unit for a development officer to set up an Ethnic Minorities Health Forum, in order to get a greater voice for ethnic minorities in health planning. The Forum is now established and has had a useful meeting on coronary heart disease and topics of interest. Already input is helping to develop role of linkworkers in hospital and highlight the need for Asian staff and translated materials."

Pontefract & District CHC:

*"We have an ongoing project of **Working with General Practitioners** and over the last two years we have developed positive working relationships with fifteen practices covered by the CHC. In one part of the district three practices barely spoke to each other but with the CHC acting as a catalyst we were able to set up and staff a market stall in the centre of Pontefract promoting Asthma Awareness. Throughout the day staff from each of the three surgeries including General Practitioners attended the stall and they all agreed that it was a very worthwhile event and encouraged the CHC to do something similar as soon as possible. Having promoted the existence of the CHC to local General Practitioners we have now reached the stage where the bandwagon is rolling and practices with whom we do not have specific working relationships are contacting us directly in order to climb aboard. We have made dramatic moves forward in terms of establishing complaints procedures within practices, setting up patient participation groups and being involved in the various Health Plans of the practices."*

Dewsbury District CHC:

"Two widows contacted the CHC (quite independently) to complain that their husbands had died unnecessarily due to two different hospitals failing to prevent the development of diabetes following steroid treatment for brain tumours. The drug-induced diabetes then caused both men to have heart attacks, after which they were no longer candidates for surgery and died after fairly short intervals from brain tumours. As a result, Dewsbury District Hospital has instituted routine urine testing for all patients on steroids, so any increase in blood sugar levels will be picked up immediately and appropriate action taken. Brain tumours are not always fatal - it depends on their location - so this is a potentially life-saving measure."

Blackburn, Hyndburn & Ribble Valley CHC:

*"Throughout 1996, this CHC has been carrying out a study on the **Discharge of Patients**. Phases I and II of the project, completed in May, comprised a postal survey of people recently discharged from hospital and interviews with hospital staff. As a result of recommendations made, a Discharge Lounge is about to be introduced at Queen's Park Hospital, Blackburn. This will be supervised by trained staff, allowing patients to wait in a relaxed and comfortable environment, whilst at the same time freeing beds for incoming patients. 'Time windows' for those requiring ambulance transfers are also being investigated as are improvements in the speed at which 'take-home' drugs can be made available."*

Milton Keynes CHC:

"Our catering project was affectionately known as 'follow the trolley'. Teams of two members were designated a ward and had to follow the food trolley from the Cook Chill rooms to the ward and observe obstacles in the corridors and operation of doors, the heating-up process, temperature testing, presentation of food, help with feeding, wastage etc. All their findings were noted on a questionnaire. A patient's questionnaire was put on each food tray, which asked them about the meal they had just eaten and the hospital food in general. Our findings will be published in a report to be available to the general public and presented to the Hospital Executive."

Kidderminster & District CHC:

"The CHC was successful in campaigning for an Out of Hours Emergency NHS Dental Service being provided. Following a survey by the CHC of local dental practices, it became apparent the situation was getting worse. Over 40 per cent of the public could not register with an NHS dentist and only two dental practices were taking NHS patients. (This has now been reduced to one from a total of eight dental practices within the area.) This Service became operational on 14 October 1996 and is open two evenings during the week and at weekends. On average 5-6 patients are being treated at each session. The CHC advertised the Service in its Newsletter which was delivered to 40,000 homes."

West Surrey & North East Hampshire CHC:

"West Surrey & North East Hampshire CHC has been concerned for some time that a significant number of people who may require assistance on aspects of the health service seem relatively unaware of the CHC and the services it can provide. To redress this situation, we launched a CHC awareness project in Spring 1996. An A6 postcard was designed, printed and distributed to all households in our area. The postcard briefly outlined the services the CHC can provide and details of our full address and telephone/fax number. We chose to use a postcard as we felt this was a manageable size which could be pinned on a noticeboard or left by the telephone for future use. Since the publicity project the number of telephone enquiries, letters and visitors to the CHC has increased considerably and based on current trends we estimate the figure may increase from 375 per year to 600 per year."

The *Insight* Review... and the *Real* CHC Agenda

In England, until April 1996, Regional Health Authorities (RHAs) used to act as the establishing bodies for CHCs. When RHAs were abolished a number of matters were left unresolved in transferring the responsibility for establishing CHCs from RHAs to the NHS Executive Regional Offices. One of these was the need to develop a mechanism for allocating resources to CHCs. As a result the NHS Executive agreed to appoint the management consultants, *Insight*, to conduct a review of CHC resourcing and performance management.

ACHCEW's response to the ***Insight*** report set out seven key principles for CHCs. Effective CHCs need to:

- be independent of local NHS management;
- work in partnership with all purchasers, providers and the community;
- listen and consult with users and potential users;
- be proactive in seeking views of people who are not normally represented;
- be open to public scrutiny in their discussion and activities;
- be visible in and participate in relevant community activities; and
- provide user-responsive information and advice.

In addition, the Association reaffirmed its view that CHCs are under-resourced for the work that they currently do, that the minimum staffing requirement of any CHC is three whole-time equivalent staff, and that the expectations now being placed on CHCs require new resources. This conclusion applies to CHCs in England (and reflects the guidance issued by the NHS Executive), but even more so to those in Wales where staffing levels fall a long way short of those identified as being necessary in the ACHCEW study.

In the Association's view, the methodology followed by ***Insight*** was seriously flawed and the consultants never properly understood the nature of CHCs and their work. The report's approach was derived from a narrow interpretation of the statutory responsibilities of CHCs.

Advising the public

Because ***Insight*** argued that there is no statutory requirement for CHCs to provide an information and advice service to the public, nor to provide support to individual complainants (even though these are major activities for most CHCs), they concluded that CHCs should consider:

- phasing out the provision of information and advice to the public and instead support other information/advice providers;
- scaling down their support to complainants and instead advise those within the NHS who are trying to implement the new NHS complaints system; and
- moving away from accessible and visible shopfront premises which - they argue - are mainly needed to support these information and advice services.

However, this argument was based on a misinterpretation of the statutory basis of CHC work. The National Health Service Act 1977 defines the duty of a CHC as:

"to represent the interests in the health service of the people in its district."

It was not possible, therefore, for ***Insight*** to draw the conclusions that CHCs have no statutory function, for example, to assist complainants - such activities clearly do fall within the general definition of representing the interests in the health service of the people in their districts.

Certainly, following the comments made by ACHCEW on the draft report and the vigorous reaction of CHCs, Ministers and the NHS Executive moved quickly to distance themselves from the more controversial ***Insight*** conclusions. The NHS Executive stressed that they remained "firmly committed to the continued statutory independence of CHCs" and promised that there was "no intention to impose a particular model of operation on CHCs, nor to prescribe in detail how they should discharge their role".

Ministers also made it clear that they did not support the ***Insight*** conclusions on the role of CHCs in helping people with complaints and in providing information and advice to the public. They recognised the value of CHC work in these areas and did not wish to encourage a general trend away from such activities. The NHS Executive also committed themselves to "visible and accessible" CHCs and to continued progress towards the national accommodation standard for CHC offices and its emphasis on shopfront premises.

CHCs have led the way in providing advice and support to complainants. They continue to do so and are the only service that by statute is available throughout England and Wales. Despite ***Insight's*** belief that other advice agencies could fulfil this role, in practice most other agencies refer people to CHCs if they need detailed advice on complaints procedures. CHCs have substantial experience of guiding and supporting people through the labyrinth of NHS procedures and hearings together with detailed knowledge of the way in which the local NHS operates. This is invaluable to complainants and is not readily available elsewhere.

Moreover, CHC complaints work is informed and supported by the other activities of the CHC.

In any event, it would totally undermine the credibility of CHCs if they tried to tell people in trouble that, although CHCs have the task of representing the interests of the public as a whole, they had no function to represent an individual person with a particular problem.

In addition, the intelligence that CHCs obtain from handling complaints - and indeed from providing information services to the public - is invaluable in informing and assisting CHCs to carry out their functions. CHCs are better able to carry out their role in monitoring services and in commenting on plans for them in the light of comments they hear and the insight into services they gain as a by-product of working with a complainant. This in turn has benefits for all patients and should be seen as an essential element of NHS quality assurance.

The Guidance issued on the introduction of the new NHS complaints system stresses that CHC staff have a very important role in assisting complainants at each stage of the complaints process - both in the hospital and community services as well as the family health services.

The Association, therefore, believes that the work that CHCs do in supporting and assisting individual complainants is central to the role of CHCs. To avoid any doubt about this, any redefinition or re-statement of the role of CHCs should refer to this explicitly. It is the Association's view that:

- CHCs should have an explicit statutory duty to assist complainants (including support, advice and advocacy) and should be adequately resourced and staffed to do so.
- GPs' patients should be entitled to bring CHC staff with them to any meetings convened to discuss complaints.
- NHS staff should be entitled to bring to the attention of CHCs their concerns about services and patient care without the threat of disciplinary action.

Performance Review

As far as performance review is concerned ***Insight*** recommends:

- an annual internal review of activities and performance;
- a biennial Peer Review process with an external review team, which would seek the views of local groups and the health authority on the impact of CHC activity and which would report to the CHC, the NHS Executive Regional Office and the local media.

The ***Insight*** report also draws a distinction between financial accountability to the establishing authority and the CHC's need to be accountable to the local community for its work.

CHCs recognise the importance of there being a proper system for CHCs to review their own activities and to demonstrate their effectiveness. However, as bodies established to represent the interests of the public and the users of the local health service, it is essential that the work of CHCs is not controlled by, nor should the agenda be set by, either the NHS locally or nationally or by the Government of the day.

ACHCEW has, therefore, identified three key principles that should underpin the relationship between CHCs and the Regional Office in relation to any CHC review process.

These are as follows:

Principle 1:

Local CHC members should determine the policies, priorities and direction of the local CHC.

Principle 2:

CHCs should be required to review their activities annually and to meet overall national performance standards, but this process should be under the control of CHCs collectively.

Principle 3:

The role of the NHS Executive Regional Office should be confined to making sure that the processes to fulfil Principles 1 and 2 are in place and are being followed, but should have no role in determining the policies and priorities of the ***individual*** CHC. The Regional Office will also want to be satisfied that the outcome of the review is consistent with statute and the CHC

NHS Trusts

As far as the relationship between CHCs and NHS Trusts and providers is concerned, the Association proposes that:

- CHCs should have a statutory right to participate, but not vote, at meetings of NHS Trust Boards which should be held in public. Observers should be asked to withdraw only where named members of staff are being discussed or where other exceptional circumstances apply. The Secretary of State should adjudicate where disputes arise.
- Trusts should be legally obliged to consult formally with CHCs and other interested bodies about proposals which they initiate for substantial development or substantial variation.
- NHS Trusts should be obliged to publish more detailed information in relation to board meetings, plans under consideration, decisions being made and the results of financial and quality monitoring.
- It should be the legal duty of each NHS Trust to provide a CHC with such information about the planning and operations of health services in its area as the CHC may reasonably require in order to discharge its functions.
- Planned changes should be set out in Trusts' business plans and full business plans should be published.
- CHCs should have the statutory right of representation at contract monitoring meetings between purchasers and providers.

GP Fundholders

The Association proposes in respect of CHCs and GP fundholders that:

- Fundholders should be subject to rigorous requirements to hold meetings in public, consult on purchasing intentions and submit contracts to quality monitoring.
- Meetings of fundholding consortia should be held in public and CHC representatives should be invited to participate as observers with speaking rights.
- Fundholding practices should be required to arrange meetings with CHCs at least once a year.
- CHCs should have the right to attend the regular review meetings between fundholders and health authorities.
- The results of any health authority audit or review of fundholding practices should be made available to CHCs.
- Fundholding status should be withdrawn from practices which fail to comply with the *Accountability Framework*, the *Code of Practice on Openness in the NHS* and other requirements to ensure accountability, openness and consultation.

Consultation

The Association recommends that the Department of Health review of consultation arrangements should take on board the following key principles:

- Any consultation process should involve a stay on any proposed change for a period of at least 3 months, excluding major holidays, with provision for varying this period with the agreement of local interested bodies.
- The results of public consultation exercises should be published including summarised views and reasons for decisions contrary to the views expressed.
- Where a CHC is opposed to a substantial change, in the absence of a right to appeal to a genuinely independent arbiter, a clear distinction should be drawn between the personnel involved in managing the internal market and the civil servants in the NHS Executive involved in advising Ministers on appeals. Advice to Ministers on these matters should be in the public domain. Ministers' decisions should give full reasons for accepting or rejecting the arguments put forward.
- Regulations should provide for:

  a) appeals where a CHC is not satisfied with decisions made following a consultation (which is now covered by guidance)

  b) appeals on all consultations on service specifications and other purchasing decisions (in addition to consultations on substantial variations)

WORK OF ACHCEW 1996/97

Membership of ACHCEW

Virtually all CHCs continue to be members of the Association. At 1 April 1997, there were 207 CHCs in England and Wales and 206 were members of ACHCEW. This represents over 99%.

1988 - 86%	1993 - 95%
1989 - 88%	1994 - 97%
1990 - 92%	1995 - 99%
1991 - 93%	1996 - 99%
1992 - 94%	1997 - 99%

Standing Committee and working groups

Since the 1996 AGM in Harrogate, 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 Officers 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.

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. Due to further funding by the NHS Executive ACHCEW has continued to expand its provision of training aimed primarily at CHC members. We are able to offer two training programmes per year autumn/winter and spring/summer consisting of 50 training days. We hope to continue with these programmes as CHCs now regard them as a regular feature and take up is always high.

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

Understanding the changing health service and the role of the CHC

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

The new NHS complaints system and CHCs

CHCs and primary care

Health, race, ethnicity and the CHC

Improving your writing skills

If any CHC or group of CHCs are interested in a particular course, ACHCEW is always happy to discuss the possibility of arranging a training day at a more convenient location and this is always mentioned in the promotional information for the courses. Courses can also be customised to the CHCs' own specifications.

All participants on training days are encouraged to complete an evaluation form and the feedback for all courses has been positive.

Further Training Initiatives

In line with ACHCEW's commitment to provide and inform CHCs of high quality training we are developing a database of training resources. By gathering together up-to-date information about training events, their value, and the course supplier, it is hoped to establish a central source of information about training initiatives available to CHCs. This will be updated regularly.

ACHCEW's innovative series of distance learning packs for CHC members and chairs continued to be well used by CHCs. 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 provide each individual with an invaluable source of information that they can refer to throughout their time with the CHC. The following packs continue to be available:

Skills for new CHC Members

Developing Skills as a CHC Member

Skills for CHC Chairs

Legal Services

ACHCEW was awarded the contract for the provision of legal services to CHCs and this service has been available to CHCs from early September 1996.

The demand for advice has been substantial with 245 new enquiries in the first seven months. This prompts the question, where did CHCs turn for advice before the service was available?

The range of types of enquiry is wide, even within the groupings shown above right. For example, a question relating to access to information, may concern the rights of an absent parent to see a child's medical records, or whether records of complaints can be accessed as medical records, or even whether a CHC has the right to access information which their local trust or health authority has decided is commercially sensitive.

When the same question is asked by a number of different CHCs, it is apparent that information needs to be made more widely available. All CHCs were advised about confidentiality issues in January 1997.

It is particularly interesting that so many enquiries have concerned CHCs' rights to be consulted. It is not clear whether this reflects an increase in health authorities failing to consult or consult properly, or just a growing awareness amongst CHCs of their right to be consulted. Again the questions range from whether a proposal does amount to a substantial variation/development, to the circumstances in which it is appropriate to make a referral to the Secretary of State, whether a CHC can be itself challenged in the courts for failure to insist upon its rights to be consulted, and upon what grounds a CHC can mount a judicial review of a consultation exercise or resulting health authority decision. A briefing on the legal requirements relating to consultation practices is planned.

Some issues have required a significant amount of research. Periodically, this involves seeking external advice from specialist solicitors, or an opinion from a barrister, for example where a CHC is contemplating mounting a legal challenge.

The Service Level Agreement between ACHCEW and the NHS

Type of enquiry - Legal Service	
Access to information	26
Charges for NHS Services	2
CHC Autonomy	12
CHC Functions	6
Community Care	4
Complaints Procedure	36
Complaints against CHC	5
Confidentiality	24
Consent	2
Consultation	45
Coroners Courts	6
Data Protection issues	17
Defamation	6
Dispute with Health Authority or Trust	6
Eligibility Criteria for care	5
Failure to treat	4
GPs	4
Health Services Ombudsman	1
Legal Aid/Referral	4
Members' Liability	7
Membership issues	10
Mental Health	2
Misc./other	11
TOTAL	**245**

Work of ACHCEW

Executive does not cover either, the costs to a CHC in bringing or defending proceedings, or any award of damages which might be made against a CHC or individual member. Such costs can be substantial, and as CHCs are not corporate bodies, CHC members are legally personally liable for these and for any costs order made against a CHC, in the event a case is lost. This issue has been vigorously pursued with the DoH. As a result, guidance has now been sent to the NHS Executive regional offices confirming that CHC members should be indemnified against claims against them arising from the proper exercise of their functions. However, the issue of payment of legal costs, is yet to be resolved.

Notwithstanding, there is a steady stream of enquiries from CHCs, wondering if they have the grounds to challenge decisions of their local Health Authority, or sometimes, decisions of the Secretary of State. In the period up to April 1997, the legal officer supported applications from CHCs who sought help from the Department with the costs of bringing judicial review proceedings. Only one of these was granted, and then only in part. Barnet CHC was paid the costs of seeking an opinion from a QC, who advised that the CHC had grounds and a good case for seeking judicial review. However, Barnet were not able to fund the application when the Secretary of State declined to do so and had to compromise the action.

ACHCEW itself applied for support with the cost of making an application for leave for judicial review on behalf of CHCs, after complaints about the manner in which the Secretaries of States for Health and Wales consulted over their proposals to extend NHS Trust powers. Support with costs was not forthcoming, but the continued threat that ACHCEW would apply anyway, had the effect of persuading the Secretaries of State to consult instead with individual CHCs on specific proposals in relation to trusts seeking extended powers. Those CHCs have received detailed advice and will continue to do so.

Information Service

The Information Service maintains a database 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 approaching nineteen 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 run at about 200 per month. Other organisations and academics, some from overseas, also approach ACHCEW for information, particularly about the role and work of ACHCEW and CHCs.

Publications

CHC News

CHC 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 and other matters of interest to CHC members. 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, and a special "Election Supplement" was published in April 1997. Every CHC member is provided with a copy.

Health Perspectives

Health Perspectives is a series of briefing papers that examine 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:

Confidentiality in the NHS
- June 1996

Developments in Purchasing
- July 1996

The Private Finance Initiative and the NHS
- August 1996

Citizen's Juries
- September 1996

Accident and Emergency Services
- October 1996

The Safety of Medicines
- November 1996

Choice and Opportunity in Primary Care?
- December 1996

CHCs and the Future: Insight or blind spot?
- February 1997

Health - The General Election Debate
- March 1997

NHS Charges - Do they matter?
- April 1997

CHC Listings

CHC Listings is produced ten times a year and sent to CHC Offices.

It contains listings of new CHC reports, forthcoming events and other recent publications. It is also a medium for the exchange of information about the activities of member CHCs, providing space for those CHCs seeking information from other CHCs.

Health News Briefings

Each year, ACHCEW publishes 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:

CHCs, Health Authorities and Social Service Departments - Accountability and Joint Working
- April 1996

This briefing looked at accountability in the NHS and considered whether accountability and service provision could be improved by placing responsibility for commissioning health and social services with a single agency - a united health commissioner. It also considered how the remit of CHCs might be extended to cover care in the community and how links with social service departments might be strengthened.

Guidelines on CHC Surveys and Research
- May 1996

This briefing aimed to provide CHCs with basic information needed to conduct consumer research, highlighting areas of good practice and some of the pitfalls to avoid.

An analysis of the complaints work of CHCs
- September 1996

This briefing was based on the annual complaints reports of 89 CHCs and covered a total of 7,916 NHS complaints. Its aim was to provide more information about the people who made complaints during 1995 and the reasons for these complaints.

How reformed is the NHS?
- October 1996

This briefing discussed the extent to which purchasers have shifted contracts from one provider to another and the development of rationing or priority-setting by purchasers. It also set out CHC concerns about the operation of the weighted capitation formula and the increased reliance on the Private Finance Initiative for capital development.

Rural Dispensing: The Concerns of CHCs
- November 1996

This briefing looked at the experience of CHCs in respect of rural dispensing and the need for amendments to the NHS (Pharmaceutical Services) Regulations to strengthen the requirements for local consultation.

Hungry in Hospital?
- February 1997

This briefing looked at why some patients do not eat and drink enough when they are in hospital, based on the experience of CHCs and correspondence received from relatives of patients. It examined who should be responsible for ensuring that patients do eat and drink enough and what should be done to address the problems highlighted.

A Stronger Voice for Patients in the New Millennium
- April 1997

This briefing was the Association's response to the ***Insight*** report on CHC resourcing and performance management.

The Patients' Agenda

A major initiative during the year was the publication of *The Patients' Agenda*. This was drawn up by the Association after wide consultation with CHCs and patients' organisations and the Association is grateful to the King's Fund for providing a grant to cover the costs of this exercise.

The Patients' Agenda sets out a series of rights not included in the NHS Patient's Charter. It focuses on:

- Access to Care and Treatment
- Health Care Regardless of the Ability to Pay
- Choice and Information
- Advocacy, Support and Appropriate Care
- Good Quality Care in Matter of Life and Death
- Confidentiality and Control over Personal Information
- Redress

The intention of setting out the proposals outlined in *The Patients' Agenda* was to help to promote fresh debate about the kind of health service that patients want and to set a new agenda for improving patient care throughout the NHS. As part of this process, a special seminar was organised by Neil Stewart Associates, on behalf of ACHCEW, on Tuesday, 25 February 1997, to discuss *The Patients' Agenda*. This was attended by some 200 people from CHCs, health authorities, trusts, the voluntary sector and local and current government and addressed by both the Right Honourable Stephen Dorrell MP, the then Secretary of State for Health, and Chris Smith MP, the former Shadow Secretary of State for Health.

Work of ACHCEW

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. This was updated during the year. This leaflet is widely used by CHCs, but also by other advice organisations. 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

In August 1996, the ACHCEW Handbook for CHC Members was updated and re-issued to all CHC members. The Handbook continues to be available in convenient loose-leaf format to go in special ring binders available from the Association.

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 Forum.

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 NHS Confederation, 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 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 John Horam MP, then Parliamentary Under Secretary of State for Health, who had the responsibility for links with CHCs until the Election. Discussions have also taken place over the year with the main Opposition Parties. Regular discussions take place between the division of the NHS Executive with responsibility for CHCs and there are increasing links with different parts of the Department.

Responses to consultation documents and representations 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:

Ambulance services study specification
Audit Commission

Moving Forward: Consultation Document on the Regulation and Inspection of Social Services
Department of Health

Prescription charges system
Royal Pharmaceutical Society

Patient's Charter & Mental Health Services
NHS Executive

Constitution of Fitness to Practise Committees: Proposals for Change
GMC

Damages for Personal Injury: Non pecuniary loss
Law Commission

Audit Commission Strategy
Audit Commission

Maternity Services Liaison Committees (MSLCs): guidelines for working effectively
NHS Executive/Changing Childbirth Implementation Team

Accountability Checklist
Consumer Congress

Value for money studies - Anaesthetic services
Audit Commission

Ethics Committee review of multi centre research
Department of Health

A better place to work: Retaining staff in NHS trusts
Audit Commission

A new partnership for care in old age
Department of Health

Supplies Procurement and Materials Management in NHS Trusts
Audit Commission/Robson Rhodes

Consultation Paper on the EC Data Protection Directive (1995/46/EC)
Home Office

Mentally disordered offenders sentencing and discharge arrangements
NHS Executive

Complaints to the GMC: draft form
GMC

Audit Commission programme of NHS value for money studies
Audit Commission

Extra-contractual referrals: changes in notification requirements and steps to reduce volume
NHS Executive

Citizen's Charter consultation
Labour Party

Serious communicable diseases - guidance from the GMC
GMC

Elective Ventilation
Academy of Medical Royal Colleges/British Transplantation Society

On the Record. The Government's Proposals for Access to Criminal Records for Employment and Related Purposes in England and Wales
Home Office

NHS support for non-commercial externally funded research and development
NHS Executive

Patient partnership: building a collaborative strategy
NHS Executive

Partnership in Medicine Taking
Royal Pharmaceutical Society of Great Britain

Infant Formula and Follow-on Formula Regulations: Draft Guidance on Information about Infant Feeding
Department of Health

Primary Care: The Future
NHS Executive

National Report on Maternity Services
Audit Commission

Citizen's Charter programme
House of Commons Public Service Committee

Follow up Study of General Practitioner Prescribing
Audit Commission

Discussion Paper - Partnership with Industry for Disease Management: General Approach
NHS Executive

Proposals for specialisation in community dental practice
Faculty of Dental Surgery, Royal College of Surgeons of England

Inpatient accommodation: options for choice
NHS Estates, Department of Health

Community Care (Direct Payments) Guidances
Law Society, Department of Health

Records of prescription only medicines supplied through pharmacies
Medicines Control Agency/ Department of Health

Proposed changes to the UK Adverse Drug Reaction reporting scheme
Medicines Control Agency/ Department of Health

Community Care (Direct Payments) Guidances
Department of Health

Analgesic medicines available without prescription: proposed changes to product information and sale or supply of paracetamol
Medicines Control Agency

Efficiency scrutiny into prescription fraud
NHS Executive

Patient's Charter: Proposed revision to the national standard for immediate assessment in accident and emergency departments
NHS Executive

Developing Emergency Services in the Community
NHS Executive

Appraising doctors and dentists in training
SCOPME

A service with ambitions - Professional development - key issues
NHS Executive

Priority setting in the NHS
Academy of Medical Royal Colleges, BMA, NAHAT, NHS Executive

Value for money study - ambulance services
Audit Commission

From the Chair

Last year I talked of the "imminent" publication of the NHS Executive's report on the Resourcing and Performance Management of CHCs.

This long awaited document, that we have all now come to know and love as "The ***Insight*** *Report", was published some six months later than scheduled, at a cost of almost twice the original budget of £46,000. Unfortunately, the end result was hugely disappointing, particularly in the failure of the report to identify the cornerstone of future debate on CHCs - a consensus on the "notional" CHC.*

This main failing was complemented by numerous others and led to the document being viewed by CHCs as fundamentally flawed, this opinion being almost universally supported by outside commentators, and the unprecedented distancing from the main recommendations by Ministers prior to the consultation period.

The CHC movement has, however, taken a positive view of the inadequacies of the report and has grasped the opportunity to reinforce the many positive aspects of CHCs within the NHS arena and offered options for development of the CHC role in keeping with the twin themes of equitable resourcing and performance management.

The final ACHCEW response was endorsed at a special meeting held in mid-March and formed one of the reported three hundred individual responses received by the NHS Executive by the end of the consultation period.

Amongst the 25 recommendations put to the NHS Executive in our response has been the request that it should support a major campaign (managed by CHCs) to promote and publicise the work of CHCs. Given that the cost of our service is less than 0.1% of the total NHS budget - equivalent to 50 pence per person per year, I feel we give value for money - let's get out there and let people know.

The role of the CHC as an integral player in the development of the "partnership model" must not be underestimated. The recommendations made in our response to ***Insight***, if fully implemented, would give CHCs the recognition, the confidence, and the strength they require to fulfil their role as The Patient's Voice in the NHS.

This last year also saw the publication of *The Patients' Agenda* an ACHCEW paper based on comments received from CHCs and other patient organisations, on what the *Patients' Charter* leaves out - the rights the patient does not yet have in the NHS. This was published in November 1996, and the subject of an extremely well attended and well received one day conference in February this year. A programme of raising awareness on issues highlighted by this important paper will no doubt continue.

There have been several changes in ACHCEW staff, and I extend my thanks on behalf of us all to past and present staff for their continued high calibre of professionalism. The Health Perspective series of papers are highly valued and the Health News Briefings continue to attract attention on topical issues, not least the *Hungry in Hospital* paper, which most certainly hit a raw nerve, and created a vast amount of interest locally and nationally. An update is planned and the issue will be debated at this AGM.

Our Legal Officer in post since September 1996 has become an important member of the ACHCEW team, early calls on her time covering issues of Members Liability, Trust Powers in Consultation, and Guidance on termination of CHC membership. I know many of you have called upon this new service covering a wide variety of issues.

I must thank my team, two Vice-Chairs Joyce Struthers and Mark Winstanley, and Graham Girvan, Honorary Treasurer. We have worked well together representing you at every opportunity. Thanks also to members of the Standing Committee for their continued support. Particular thanks must go to Chye Choo whose organisational skills are second to none, as will be proven yet again at this year's AGM. My special thanks go to Toby for his wisdom, direction and counsel greatly appreciated in my role as Chair.

Thank you for allowing me the privilege to represent you as Chair for this second year, and together we look forward to the next which, as ever, promises to be eventful.

Jennifer Elliott

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND AND WALES
1996/97

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MS SUE WILSHERE

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Roselyn Wilkinson *(until Dec.1996)*	Information Officer *(Development)*
Liz Rickarby	Training Organiser
Helen Richardson *(until Jan.1997)*	Publicity Officer
Marion Chester *(from Sept.1996)*	Legal Officer
Vera Beswick	Administrative Assistant (p/t)
Estelle Kiss	Administrative Assistant (p/t)
Anne Hamilton *(until Dec.1996)*	Secretary to the Director (p/t)
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