CHC NEWS

A newsletter for community health council members and staff

Parents have no right to the truth

In an extraordinary judgement, three Appeal Court judges have ruled that, in civil law, doctors have no duty of care to tell the truth to the parents of children who die.

The case concerned a boy, Robert Powell, who had died of Addison's disease in 1990 after doctors had failed to diagnose the condition. The health authority admitted negligence and paid compensation to Mr and Mrs Powell. However, the Powells put in a separate claim for compensation on the grounds that GPs and a hospital consultant had allegedly lied to them about the lead-up to their son's death. After Robert died, Mr Powell suffered a mental breakdown and has not been able to work since, while Mrs Powell started to have panic attacks. Mr Powell alleges that, in order to cover up their negligence, doctors altered his son's medical notes, removing a document in which the hospital had pointed out that Robert could have Addison's disease and replacing with a forgery.

The court hearing did not consider the truth of the allegations. Instead the judges ruled that, *even if the allegations were proved*, the Powells would have no right to sue the doctors for compensation. Although the doctors had a duty of care towards Robert, they have no such duty towards his parents. The court refused the Powells leave to appeal to the House of Lords, but they are seeking leave to appeal by a petition direct to the House of Lords.

Another worrying aspect of the judgement is that the judges said that, although Mr and Mrs Powell were patients of the same GPs, the moment they made a complaint about the doctors the doctor-patient relationship was over and the GPs no longer had a duty of care towards them. They gave no explanation for this aspect of their ruling.

Guardian 2 July, Sunday Telegraph 6 July

Trust board meetings opened up

The Health Secretary, Frank Dobson, has written to all NHS trusts asking them to hold their board meetings in public. Parliamentary approval will be required to enforce the change, but Mr Dobson expects trusts to act immediately. Some matters will still need to be considered in closed session, but this should apply only if open discussion would result in "real harm" to individual staff or patients or to the operation of the trust.

Department of Health letter, 30 July

No priority for fundholder patients

Frank Dobson has also announced measures to do away with two-tierism in the NHS:

- NHS trusts must continue to operate a common waiting list for urgent admissions regardless of who is commissioning the care.
- Health authorities must have maximum waiting time standards that are common to all their residents.
- Admission of a health authority's residents for non-urgent treatment must be on the basis of clinical priority, regardless of who is the patient's GP.
- Trusts cannot offer preferential admission to the patients of GP fundholders.
- Fundholders cannot press for faster treatment except on clinical and social grounds.

Department of Health press release, 16 July

In this issue:

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ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES
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Rise in abortions

There have been calls for a review of family planning services after official figures showed that abortions in England and Wales rose by 8.3% between 1995 and 1996 – the first rise for five years. Numbers of abortions rose in all age groups up to 44 years old, with the highest rise (15.2%) in the 16-19 age group. There were 177,225 abortions in 1996.

Various reasons have been put forward for the rise, including the run down of specialist family planning services, a Pill scare in 1995 and "value-free sex education" in schools. The Family Planning Association is concerned that Health of the Nation targets are encouraging health authorities to restrict family planning services to younger women, thus forcing older women to rely on services from GPs.

Times 23 July, Independent on Sunday 27 July

NHS faces £1 bn negligence costs

A National Audit Office (NAO) report has warned that the NHS may need to pay out £1 billion in damages for incidents of negligence which have already taken place, but where no compensation has yet been paid. Few trusts or health authorities have made provision for such bills. The report also says that, since patients are increasingly ready to sue and since compensation awards are getting bigger, the cost of claims can be expected to rise by almost 25% over the next five years.

The figures can only cause further concern to trusts which are in financial difficulties. The NAO estimates that in England 168 of the 433 trusts in England were in financial difficulty at the end of 1996 and that, of these, 47 were in serious trouble.

Daily Telegraph 18 July

Calls for national debate on rationing

The King's Fund conference in July reiterated the call made by the BMA conference a week earlier for the government to open a public debate on rationing in the NHS and to take a lead in rationing decisions. Organisers of the King's Fund conference criticised government ministers for an apparently "deliberate decision" not to attend the conference and take part in discussions. Although there is little sign that the government has any plans for a national rationing framework, some recent court decisions have clarified the obligations of health and local authorities in relation to particular aspects of care.

Daily Telegraph & Guardian 12 July

Health authorities must fund beta interferon

One of the few areas in which the government has taken a national rationing decision is the provision of beta interferon, a drug which is of benefit to some people with multiple sclerosis. National guidelines state that the drug, which costs £10,000 for a year's supply, should be provided if consultant neurologists judge that it would benefit an individual patient. In a court case in July, the judge strongly criticised North Derbyshire Health Authority for refusing to pay for beta interferon for a man who had been prescribed the drug by two consultant neurologists 18 months ago. Stephen Thornton, the director of the NHS Confederation's health authority council, commented that other health authorities which are refusing to fund the drug will now have to review their policies.

Independent 12 July, BMJ 19 July

Council must help towards home costs

In an important judgement for elderly people in residential and nursing homes, the Court of Appeal ruled that Sefton Council must help towards the costs of home residents whose assets fall below £16,000. National policy is local authorities should meet some of the care costs for residents with less than £16,000 of assets and all of the costs for those with less than £10,000. Sefton Council had refused help to people until their assets fell below £1,500 – a decision which the judge said it had no authority to make. The case before the court concerned a woman who was already in a nursing home when her assets fell below the national threshold. The council is to seek leave to appeal to the House of Lords.

Guardian 1 August

Goverment opposes proposals to protect people needing care services at home

The situation for people with care needs who are not in residential or nursing homes is less promising. The government has said that it will oppose a private bill which seeks to prevent local authorities from withholding or withdrawing care services on the grounds of a lack of resources. In March, the Law Lords ruled that Gloucester County Council could take its funds into account when deciding to provide community care services to people living in their own homes. The government has backed this decision, adding that "resources are a factor, but not the only factor, to be taken into account".

Guardian 11 July

Ex-CHC member chairs Health Committee

The House of Commons Health Committee has been set up and had its first meeting. It is made up of seven Labour MPs, three Conservatives and one Liberal Democrat. David Hinchliffe has been elected to chair the Committee. Mr Hinchliffe was formerly a member of Wakefield CHC. He was on Labour's health team in opposition, although he resigned about 18 months ago, and is a former social worker.

From Parliamentary Answers

CHC role

Asked what steps the health secretary intends to take to increase the powers of CHCs, Alan Milburn said that the government will be keeping the role of CHCs under review as it develops proposals for wider changes to the NHS. It hopes to outline these proposals in a White Paper later this year.

Hansard 10 July, col 582

CHC funding

Figures on the Department of Health's top-sliced funding have recently been updated. Of a total of £247 million of such funding in 1997/98, £131 goes to special hospitals. CHCs are allocated £22 million.

Hansard 10 July, col 581

Publication formats

Paul Boateng gave details of some Department of Health publications which are available in Braille [B], on audio tape [AC] and in large print [LP]. The abbreviations in square brackets in the list below show what formats are available for each publication listed.

Health and well-being: a guide for older people [LP]
Health of the Nation [AC]
How to get the best from maternity services [B, AC]
Keep well, keep warm [AC, LP]
Maternity services – patient charter [B]
NHS complaints: listening, asking, improving [B, AC, LP]
NHS reforms and you [B, AC]
Patient's Charter [B, AC]
Practical guide for disabled people (HB6) [B, AC, LP]
While you are pregnant – safe eating [B, AC, LP]

Hansard 4 June, col 172

Insulin pens

The Department of Health is considering whether GPs should be allowed to prescribe insulin injection pens on the NHS. For more on this issue, see page 5.

Hansard 12 June, col 530

Radiotherapy injuries and compensation for medical accidents

In answer to a question about compensation for women who say they have been injured through radiotherapy treatment, Paul Boateng spoke of guidelines which have been drawn up over the last few years on quality assurance in radiotherapy and on the care of women who have suffered tissue damage following radiotherapy for breast cancer. A working group has been set up to consider the preparation of patient information leaflets on possible adverse effects following pelvic radiotherapy. A sub-group is also considering issuing guidelines on the care of women suffering adverse effects as a result of pelvic radiotherapy.

In answer to a separate question, Alan Milburn, made it clear that the government has no plans for a no-fault medical accident compensation scheme. For cases which involve negligence, the government is currently exploring alternatives to litigation which might offer a quicker and cheaper way of dealing with claims.

Hansard 16 June, cols 24 & 25

Private finance initiative

In May the government commissioned a "rapid review" of arrangements for the private finance initiative (PFI) which was to "make recommendations as to how to accelerate the flow of sound PFI projects". The review has now been published. Among other things it recommends standardisation of procedures and the development of model contract conditions with a view both to speeding up the negotiating process and reducing the costs of setting up PFI schemes.

Information is now collected centrally on total expenditure on fees for external consultants involved in major PFI schemes. These figures show that NHS trusts involved in leading schemes have spent £30 million on legal fees and advice. (In the currency always used in such debates, this is equivalent to 7,500 hip replacement operations.) The total amount spent on all major PFI schemes, including those at an earlier stage, is £37 million.

Two PFI schemes, at Dartford & Gravesham NHS Trust and Norfolk & Norwich NHS Trust, are now ready to proceed: commercial contracts have been signed and they have full planning permission. The two trusts have spent £1,990,000 and £2,200,000 respectively on legal and financial fees.

Hansard 11 June cols 446 & 634, 24 June col 668, HM Treasury Review of PFI: Summary and Conclusions

OMBUDSMAN'S REPORT

From Clive Wilson
Deputy Health Service Commissioner

Michael Buckley, the new Health Service Ombudsman, published his first *Annual Report* in June, along with another in the regular series of *Reports of Selected Cases*. These are now accessible via the Internet.[¶]

CHCs should have received their own copy of the *Annual Report* under cover of EL(97)36 dated 23 June. That letter drew particular attention to Chapter 5, which sets out the Ombudsman's experience of the first year of the new NHS complaints procedure and his wider jurisdiction.

Key points included:

- maybe only about 3% of formal complaints considered in local resolution led to requests for independent review panels;
- of those requests perhaps around one in eight led to panels – about 350 panels were held or were being set up in the first year;
- these figures are very much lower than many had predicted;
- about 350 complaints had been made to the Ombudsman after requests for panels had been turned down by the convener of the trust or authority;
- conveners were interpreting their responsibilities differently, and some were not following the national guidance properly;
- there was considerable variety in the way panels were conducted and the reports presented. More attention was needed to meet the requirements of the statutory directions on reports and to show an even-handed approach.

The role of conveners

The Ombudsman suggested that, to judge from the complaints he had seen, conveners need to pay particular attention to:

- demonstrating their impartiality and distancing their role from that of the trust in the local resolution stage;
- taking appropriate clinical advice whenever a complaint has a clinical element;
- not re-investigating or attempting to resolve the complaint themselves;
- providing reasoned explanations for the decisions, addressing the specific complaints raised.

Complaints against GPs

The Ombudsman noted that some complainants were finding difficulty in pursuing complaints in local resolution against GPs through practice-based procedures, and that this in turn could present problems for conveners.

Delays in complaints handling

The strict time limits in the national guidance for responding to complaints were frequently not being met, and the Ombudsman expressed concern that sometimes complainants were not told early enough of their right to request a Panel and that local resolution was being inappropriately dragged out.

Role of the Ombudsman

The Ombudsman explained also that when he considers a complaint following an adverse convener decision, he looks first at whether the convener has properly considered the complaint in accordance with the national guidance. If not, and he thinks this may have led to an injustice to the complainant, he will invite the convener to reconsider his or her decision. In law it is only if the Ombudsman so invites the convener that a decision not to set up a Panel can be reconsidered. The Ombudsman cannot, however, require a convener to take a different decision nor can he say that the original decision was wrong. Similarly, he cannot say that a Panel has reached the wrong conclusions, though he may criticise the way a Panel was conducted and, in effect, conclude that its findings are not soundly based. In such circumstances he might himself investigate the complaint.

Although the Ombudsman considers that complainants should have their concerns properly addressed within the NHS complaints procedure, he remains fully committed to investigate complaints about the NHS if he is satisfied that the complainant still has grounds for concern after NHS procedures have been followed.

[¶]The Internet addresses are:

Health Service Commissioner for England, for Scotland and for Wales, Annual Report for 1996-97
http://www.official-documents.co.uk/document/health/arep96/areport.htm

Report of the Health Service Commissioner, Selected Investigations Completed October 1996 to March 1997
http://www.official-documents.co.uk/document/health/commrep/creport.htm

CALLS FOR ACTION

Why are CHCs dragging their feet about gynaecology and obstetric abuse?

From Sandra Simkin, Member of North West Surrey CHC

Sensational stories about women who have major surgery performed on them – removing their womb, ovaries and cervix – without their consent, or without their informed consent, should send shivers down the spine of every right-thinking person. After all, these are their sex organs and they are effectively being castrated. Every year some 47,000 women lose one or both of their ovaries which are often perfectly healthy organs.

With almost weekly exposure of cases of surgical abuse against women in the newspapers and a constant stream of television programmes, CHC members should be in no doubt that this is not a sensation – these things are really happening. But where is the evidence that CHCs are even aware of it? Hundreds of women have contacted me since August 1995 when I set up the *Campaign Against Hysterectomy and Unnecessary Operations on Women*. All of these women have shocking stories to tell about how they have been treated. Many have been severely damaged and left in worse pain than the pain which took them to the doctor in the first place. I know for a fact that some have been to their CHCs for advice and support, but what happened to them? The answer is regrettably *nothing*.

As statutory organisations with obligations to patients, CHCs would seem to be the obvious organisations to take up an issue like this in a very strong way. Why then have they not been obvious in their advocacy? Yes, there has been a subtle pressure to rein in the independence of CHCs by government and a bureaucratic NHS Executive, but by abandoning their "crusading" role, CHCs have done themselves great harm. I have advised many women to make a complaint to their CHC, but a large number have come back and told me that they did not receive any useful help or support.

If anything needs to be challenged it is the UK gynaecology and obstetrics service, because a third of caesarean sections are unnecessary according to World Health Organization guidelines, as are 90% of hysterectomies, based on a study carried out in Scotland in 1995. Seven times the number of ovaries are removed than is required for the treatment of ovarian cancer. Most conditions of the cervix, womb and ovaries are benign and non-life threatening – they should be treated appropriately (and incidentally much more cheaply) with drugs and minimal surgery that would keep the organs intact.

I set up the *Campaign Against Hysterectomy* to raise awareness of the issues that surround women's healthcare and in the face of society's lack of interest in our suffering. We aim to achieve an Act of Parliament – a Woman's Medical Protection Act – to protect all women from zealous surgeons.

Sandra Simkin, Director and National Campaign Co-ordinator, Campaign against Hysterectomy and Unnecessary Operations on Women, PO Box 300, Woking, Surrey GU22 0YE

Sandra Simkin is author of **The Case Against Hysterectomy**, Pandora, £5.99

Need for pen needles on prescription

From the British Diabetic Association, 10 Queen Anne Street, London W1M 0BD

For people with diabetes, the lack of pen needles on the general practice prescription list is a daily injustice. Around 220,000 people in England and Wales have to inject themselves with insulin up to four times every day. They can inject insulin using either a hypodermic syringe or a pen. The latter is quicker and easier to use – children, elderly people and infirm people in particular can have difficulty using a syringe. As MPs prepare to return to Westminster after the summer recess, people with diabetes are urging you to support their campaign for pen needles on prescription and to write to your MP at the House of Commons, London SW1A 0AA, asking him/her to take this issue up with the health minister, Alan Milburn.

The British Diabetic Association believes that, while placing pen needles on prescription would cost the NHS an estimated £5 million a year (a relatively modest sum), it would greatly improve the lives of people with insulin-dependent diabetes.

We welcome contributions from members and from others who have things to say about CHCs. We also welcome any reactions readers may have to what appears in **CHC News**.

Striking off patients

The Royal College of General Practitioners has produced a leaflet giving guidance to GPs on when and how they should remove patients from their lists. Reasons which justify removal from the GP's list are listed under "Violence", "Crime and deception" and "Distance".

It is stressed that removal is *never* justified:

- "where there is an exacting or highly dependent patient, condition or disability;
- where a patient exhibits high levels of anxiety or 'demand' about perceived serious symptoms;
- where preference is displayed by a patient in relation to age, gender, ethnic origin, religion or sexual orientation."

Removal is *not normally* justified where a patient chooses a home confinement, refuses cervical screening, refuses immunisations for children, does not follow treatment advice, persistently questions practice standards or complains via the practice complaints system.

Turn-around in attitudes to a community pharmacy

There had been a great deal of local opposition to the opening of a community pharmacy in the village of Gilberdyke near Hull. However, in a detailed study of local reaction some time after it opened, 95% of respondents agreed with the statement "It is important to have a chemist shop in Gilberdyke."

The independent market researchers who undertook the study for the Rural Practices Standing Committee said that people had been put off from having a pharmacy by local doctors, and they did not know what such a service could offer. Commenting on the report, the director of ACHCEW, Toby Harris, said that people want local availability of a range of services: both medical and pharmaceutical. A pharmacy can provide advice readily and quickly, as well as easy access to and information about non-prescription medicines.

References to all these publications are given in **CHC Listings** which is sent to CHC offices.

Patient and CHC involvement in primary health care developments

Two recent publications on patient involvement give contrasting views of CHC participation in primary health care developments.

Involving Patients: Primary Health Care Teams, Examples of Good Practice from the NHS Executive includes two examples of positive involvement with CHCs. In Staffordshire, Potteries Health Care and the local CHC are committed to consulting over purchasing plans. The practice's purchasing intentions are circulated across the whole population of the health authority, not just to its own patients. The intention is that views of the local population will be taken into account in developing the final plan, and the CHC will be used as a voice of the local population.

In Nottingham, fundholding and non-fundholding GPs are working in partnership with the health authority and the CHC to develop local purchasing priorities. CHC members attend meetings of the Care Programme Board and the Care Programme manager is invited to address CHC meetings. In addition, CHC members receive quarterly briefings from the director of commissioning. Through these meetings and other discussions, primary health care teams in Nottingham have established "a strong collaborative relationship" with the CHC.

A research report from the College of Health and South Bank University, London – dealing with two examples of user involvement in primary health care in London – presents a rather less optimistic picture of CHC involvement. One of the case studies, into the development of a Primary Health Care Centre in North London, looks at how the FHSA put into practice its commitment to user involvement.

Although the CHC was involved in the consultation process, it felt relatively marginalised and unclear about its future role. The CHC chief officer commented that for local people to be able to comment on the plans, the FHSA should provide information directly to patients and get their views. In practice the FHSA undertook activities mainly through GPs, the CHC and the local Residents' Association. However, there were problems in all three avenues of communication. One of the two GP practices concerned was not committed to user involvement. The Residents' Association had good direct involvement with local people, but little knowledge of how the health services were organised – its members were at first unaware of the existence of the CHC. The CHC, by contrast, had established links with the FHSA, but did not have contacts with the locality.

Of patients surveyed, 99% said that it is important to get the views of local people about service developments and most said that there are not enough ways of doing so. Nevertheless, though people wanted to be kept informed, few were prepared to attend public meetings. 35% wanted to express their views through questionnaires, 15% said they would like local organisations such as the CHC to be involved in representing their interests and 10% wanted local patients to represent their views.

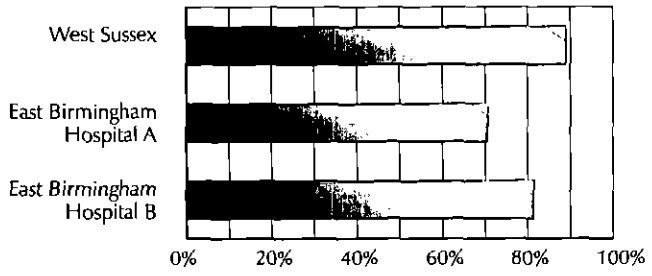
Day surgery

We have received three surveys on day surgery, two of them looking at the experience of patients and one at the perceptions of GPs.

West Sussex CHC surveyed patients from five hospitals and East Birmingham CHC from two, giving useful comparative data for local service providers. As the graph shows, a substantial majority of patients would opt for day surgery again. In East Birmingham there were extremely few patients who disliked being treated as a day case in principle: most of those who would not opt for day surgery in the future spoke of particular problems with the way they had been treated. In West Sussex only 5% said they would opt for in-patient care. A number of these said that they needed longer to recover and wanted professionals present to check that nothing went wrong.

Percentage of patients who would opt for day surgery in the future in a similar situation

Sources: Daycase surgery and procedures, East Birmingham CHC; The public's experience of day surgery services, West Sussex CHC



Solihull CHC surveyed GPs to find out if there was any truth in anecdotal reports that infection rates were increased following day surgery. The GPs' comments did not suggest that infection rates had risen. However, their opinions on timing of discharge are worrying: of 52 GPs, 20 thought that patients were discharged too soon after day surgery, and 32 thought that they were discharged too soon after elective surgery. Twenty-four GPs said that there was inadequate community nursing support.

Out-of-hours centres

Since the last government made £45 million available to fund GP out-of-hours schemes in 1995, new out-of-hours centres have been appearing all over the country. We have received reports on such schemes from North East Warwickshire, Newcastle and North Tyneside, Bury, Preston, South Durham & Weardale, Leicestershire and Blackburn, Hyndburn & Ribble Valley CHCs.

One of the most striking things about the reports is the great variability in the coverage of the schemes, with one centre serving anything from five GP practices to 30. The issues of concern in the reports are remarkably similar – travelling to the centre in the case of some patients, dissatisfaction with not getting home visits and access to pharmacies out of hours – but it is hardly surprising that these problems are much more acute where a centre has a large catchment area.

All the surveys look separately at patients who received a home visit, patients who attended the centre and patients who received telephone advice only. In general, the last group were least satisfied with the service. Many patients were happy to receive telephone advice only, and felt that it was helpful, but a substantial number felt that they should have had a home visit and might have done so under the previous system. Home visiting rates varied widely, with just over 10% receiving a home visit in South Durham & Weardale, for example, and 26% receiving one in Preston.

Although most patients had no difficulty in travelling to the centres, transport posed major problems for a small minority of patients. Some of the journeys sound a nightmare: surely no mother should be asked to arrange childcare for her children before taking another vomiting child in a taxi which she could not afford. A number of reports suggest that some patients should be offered transport to the centres or reimbursed their taxi fares.

Duty to consult CHCs

A judgement in a consultation case in Devon is a shot in the arm for CHCs since it confirms the explicit rights of CHCs to be consulted under the provisions of Regulation 18 of the CHC Regulations 1996. An successful application for judicial review was brought by a number of patients of two community hospitals threatened with closure. In his judgement Mr Justice Moses said that the health authority was under a duty to consult with the CHC when it became aware of proposals for substantial changes to services. This duty could not be undermined simply because the health authority needed urgently to make savings when, as in this case, the authority had allowed time to pass to a point where matters became so urgent that there was no time left for consultation. Marion Chester, ACHCEW's legal officer, has sent further details of the judge's comments to CHC offices.

Congratulations, Eleanor

Congratulations to Eleanor Young, who chaired ACHCEW from 1992 to 1995, for being awarded an OBE in recognition for her services to Darlington, where she is a borough councillor, and her work as a CHC member.

Meetings with ministers

ACHCEW staff and honorary officers have held five meetings with government ministers, including Frank Dobson, Alan Milburn and Baroness Jay, since the new government has been in office. Graham Girvan, the Honorary Treasurer, has had a further meeting with Alan Milburn in his capacity as MP for Darlington. The meetings were all positive in tone, although it is clear that a detailed approach to CHCs has not yet been developed.

ACHCEW's work programme and consultation with CHCs

By the time this newsletter is issued, CHCs should have received and returned a questionnaire which will give CHCs more opportunity to say what services they would like ACHCEW to offer and inviting views on themed work in CHCs. ACHCEW's Work Programme for 1997/98 will be considered at the next Standing Committee.

A working group of the Standing Committee is also being set up to look at a review process for ACHCEW and at related constitutional issues.

CHC offices have been sent copies of **Drug Issues**, ACHCEW's latest Health News Briefing which was prepared by apa – community drug and alcohol initiatives.

ACHCEW IT Users Group

The IT Users Group meets periodically to facilitate the exchange of good practice and new Information Technology developments for CHCs.

CHCs will have to become increasingly IT-literate. It was only around 10 years ago that fax machines were considered the cutting edge of communication. Today every CHC finds them essential. The spread of personal computers has been even faster. And soon CHCs which do not have access to the internet could be left behind.

There is some debate as to how CHCs should access the Internet. Certainly the easiest and cheapest way is to use a commercial service provider. One advantage of these is that they involve a relatively low initial price for a modem (to connect your computer to the Internet) and a monthly bill which depends on how much time you spend on the system. The NHS Executive is developing a dedicated NHS network, the NHSnet. This could offer greater access to NHS data. At present it is not clear that its relatively high costs justify any additional benefits that it offers, but some regional offices are investigating the possibilities of the system.

The updated version of the AMS complaints database should now have arrived at CHC offices. AMS runs a helpline – 01925 230102 – available 9:30 a.m. till 12:30 p.m. and then 1:00 p.m. till 5:00 p.m. weekdays.

If you want to contribute to the debate about IT use or find out more about the IT Users Group, then contact the group's convener, Gary Fereday, at ACHCEW or your regional representative:

Anglia & Oxford	Alan Eatwell	South Buckinghamshire CHC
North Thames	Julie Cox	North Thames Regional Association of CHCs
South Thames	Brenda O'Neill	Canterbury & Thanet CHC
South & West	Brian Burton	Salisbury CHC
North West	Geoff Ryall-Harvey	Chester CHC
Northern & Yorkshire	Peter Johnson	South Tees CHC
Trent	Phil West	North West Lincolnshire CHC
Wales	Sue Wilshere	CHC Support Unit for Wales
West Midlands	Sean Ward	Wolverhampton CHC

ACHCEW on the Internet

ACHCEW's email address is achcew@compuserve.com

ACHCEW also has a new home page on the world wide web. Address: http://www.nahat.net/achcew/index.htm