SECTION I

CONSTITUTION AND FUNCTIONS OF COMMUNITY HEALTH COUNCILS AND THEIR RELATIONSHIP TO NHS MANAGEMENT BODIES

The National Health Service

Although the National Health Service was established in 1948, it was not until 1974 that any major re-organisation of its functions and management structure took place. The pre-1974 NHS was really three different systems working side by side. Hospitals in England and Wales were planned and supervised by Regional Hospital Boards, more locally by Hospital Management Committees. The general practitioner services - family doctors, dentists, chemists and opticians - were run by Executive Councils. Health Committees of local councils ran local authority services - including ambulances, home nursing, health visitors, home midwifery, child health, the school health service, health centres.

Under the 1974 re-organisation those services previously run by local authorities came under the NHS umbrella. Regional Health Authorities (RHAs) took over from the Regional Hospital Boards and Hospital Management Committees disappeared altogether. Area Health Authorities (AHAs) were introduced and made responsible to the RHAs. Depending on local circumstances, AHAs could divide their areas into more than one district. These districts would each have a district management team (DMT) to run their respective hospitals and community services. Services provided by general practitioners, dentists, chemists and opticians were to be administered through the Family Practitioner Committees (FPCs). Re-organisation preserved the tradition that these groups are independent contractors in the NHS.

The Department of Health and Social Security is the central controlling body under a Secretary of State who is answerable to Parliament for the running of the National Health Service. The Minister for Health deals with policy issues on, and the day to day administration of, the health and personal social services. He is assisted by two Parliamentary Under Secretaries of State.

A revised NHS management structure detailed in circular HC(80)8 was introduced in 1982. Area Health Authorities were replaced by new health authorities, known as District Health Authorities (DHAs). Family Practitioner Committees will be established as Health Authorities in their own right, with powers to engage their own staff.

Community Health Councils

To prevent the NHS management from becoming remote from the patients it serves, and to give the local communities a say in the health care services available to them, new bodies called Community Health Councils (CHCs) were established in 1974.

Every health district must have a Community Health Council, exceptionally there may be two CHCs in one district. Community Health Councils are set up by the relevant Regional Health Authority, called the "establishing authority" in the statutory regulations.

Constitution

Community Health Councils were established under section 9 of the NHS re-organisation Act, 1973, subsequently replaced by section 20 of the National Health Service Act, 1977. The additional provisions of Schedule 7 to the 1977 Act have effect in relation to Community Health Councils. Regulations governing the membership, proceedings and functions, etc., of councils were contained in the National Health Service (Community Health Councils) Regulations 1973 - Statutory Instrument 1973 no 2217 (SI 1973/2217) - operational from 21 January 1974.

Circular HC(81)15, issued December 1981, clarifies certain aspects of the role of community health councils and gives details of the changes in membership and appointment procedures which the Secretary of State decided to implement in the light of the proposals put forward in the consultative document "Community Health Councils in England" (DHSS January 1981), and the reactions to them. Guidance is also given on the special arrangements for appointments to CHCs in 1982 to take account of the constitution of district health authorities. The circular refers to new Regulations covering community health councils in the restructured NHS.

The National Health Service (Community Health Councils) Amendment Regulations 1982 - Statutory Instrument 1982 no 37 (SI 1982/37) amend the 1973 Regulations (the principal regulations) and revoke the Amendment Regulations 1976 (SI 1976/791) and the Amendment Regulations 1978 (SI 1978/21). References in the principal regulations relating to Area Health Authorities are substituted by references relating to District Health Authorities and provisions relating to membership of CHCs and the expenses of Councils are changed. SI 1982/37 came into operation on 1 April 1982.

Establishment and Membership of Councils

RHAs should ensure that CHCs of an appropriate size in accordance with Paragraph 3 of this Circular are brought into operation alongside DHAs. There should be one CHC relating to and established for the same district as each DHA.

The Secretary of State has decided that there should be separate CHCs for the Isles of Scilly and for Weston, and also for each of the two sectors of the Liverpool DHA, but that no further exceptions will be considered until the new structure of the NHS has had time to settle down, and then only where exceptionally strong arguments are advanced by the local communities concerned.

(HC(81)15)

CHCs should normally have 18-24 members. The Secretary of State expects most CHCs to be at or near the lower end of this range.

(HC(81)15)

At least one member of each Council must be appointed by each local authority of which the area or part of it is included in the Council's district, and at least half of the members of the Council must consist of persons appointed by those local authorities. At least one third of the members must be appointed in a prescribed manner by bodies (other than public or local authorities) of which the activities are carried on otherwise than for profit (voluntary organisations). The other members of the Council are appointed by such bodies, and in such manner as may be prescribed.

(Schedule 7, NHS Act, 1977)

Any member of a Council other than a member appointed by a relevant local authority or a voluntary organisation, shall be appointed by the establishing authority. (SI 1973/2217)

CHC members will continue to be appointed by local authorities, voluntary organisations and regional health authorities. For the time being, the proportions of the membership of CHCs appointed by local authorities and voluntary organisations as laid down in the NHS Act, 1977 will remain at one-half and one-third respectively. The RHA will appoint the remaining members after giving the matching DHA an opportunity to submit names for consideration. (HC(81)15)

Term of Office

Four years expiring on 31 August (30 June in Wales) in even years with one half the membership, as near as may be, retiring in 1984.

Where a member has completed consecutive terms of office amounting in total to eight years or more, he is ineligible for re-appointment until a further four years has elapsed. (SI 1982/37)

Members appointed by local authorities

Members appointed by local authorities may be, but need not be, a member of the appointing body. (SI 1973/2217)

The rule whereby local authority members appointed to CHCs automatically and immediately lose their CHC places if they cease to be members of that authority has been modified, to ensure greater continuity of CHC membership after local government elections and to give local authorities discretion to retain appointees on CHCs if they wish. Such persons shall cease to be members of the CHC unless within two months of their ceasing to be a member of the local authority, that authority gives notice in writing to the Secretary to the CHC and relevant RHA that the person appointed as a member is to continue in membership of the CHC. Members retained in this way will serve out their normal term of office unless they cease to be members for some other reason. (SI 1982/37)

Members appointed by a voluntary organisation

A member appointed by a voluntary organisation or by two or more such organisations acting jointly may be, but need not be, a member of an appointing body. (SI 1973/2217)

Disqualification

A member of, either the Regional or the District Health Authority or the Family Practitioner Committee cannot be a member of a Community Health Council at the same time.

(SI 1973/2217)

The regulations provide for former NHS employees dismissed from NHS employment for reasons other than redundancy to be disqualified, subject to appeal to the Secretary of State after two years for appointment as CHC members. (SI 1982/37)

The Secretary of State does not consider it appropriate for NHS employees or family practitioners to be members of CHCs matching their employing or contractual authority.

No one should be a member of more than one CHC (HC(81)15)

Termination of membership

A member may resign at any time by writing to the Secretary of the Council who must inform the appointing body by which that member was appointed and the establishing authority. Six months non-attendance at meetings (or other functions) of the Council must be reported to the appointing body and to the establishing authority. Appointing bodies did have a discretionary power to declare a member's place vacant. (SI 1973/2217)

This rule is now modified. In such cases the establishing RHA will, after consultation with the appointing body concerned, declare the place vacant unless satisfied that absence was due to a reasonable cause. (SI 1982/37)

Proceedings of Councils

Election of Chairman and Vice-Chairman

The Chairman and Vice-Chairman are elected by the Council. There is no fixed term of office, normally one or two years but at the discretion of the Council. The Secretary of the Council has to inform the establishing authority of the name of the Chairman and Vice-Chairman. (SI 1973/2217)

Committees, Working Groups and Joint Committees

Committees or other groups may be appointed by the Council subject to restrictions the Council sees fit to impose. Some, but not all of the Council's functions may be delegated to such committees. These committees may consist wholly or partly of members of the Council, but at least two thirds of any committee must consist of members of the Council, unless the establishing authority agrees to less for special reasons.

Joint Committees may be appointed with one or more other Councils. Membership must come from members of the Councils forming the joint committee. Councils cannot delegate all their functions to such Joint Committees. (SI 1973/2217)

Meetings

A meeting of the Council must be held at least once in every three months. Notice of meeting, including agenda, signed by the Secretary of the Council to be available to each member at least seven clear days before the meeting.

If the Chairman and Vice-Chairman are absent, members may choose one of their number to preside.

No business shall be transacted unless a quorum of one-third of the established membership is present.

The Council must meet their District Authority at least once a year. (SI 1973/2217)

The provisions of the Public Bodies (Admission to Meetings) Act 1960 apply to CHCs. The public, including the press, will therefore normally be admitted to meetings of CHCs. The public may be excluded if a CHC resolves in respect of particular business that publicity would be prejudicial to the public interest by reason of the confidential nature of the business, or for other special reasons which must be stated in the resolution. (These matters are normally indicated in part II of the agenda). Where meetings are open to the public, the CHC has a duty to give public notice of the time and place of the meeting normally three clear days at least before the meeting; to furnish for the benefit of any newspaper a copy of the agenda for the meeting; and to provide accredited representatives of the press, so far as practicable, with reasonable facilities for taking a report of the meeting.

(HC(81)15)

Officers of the Council

The RHA formally appoints the Secretary of the Council, subject to the person being acceptable to the Council. Additional staff will also be formally appointed by the RHA subject to acceptance by the Council of an individual officer appointment. (SI 1973/2217)

Premises and Expenses

It is the establishing authority's duty to provide office accommodation and to approve the annual expenditure of the Council. Estimates must be prepared by the Council for periods demanded by the establishing authority and submitted in a form acceptable to that Authority. (SI 1973/2217)

The RHA continues to be responsible for approving the budget of each CHC and for providing the funds from the regional allocation. (HC(81)15)

It is the statutory duty of a Council not to incur expenses in excess of the expenses approved for that Council by the establishing authority. (SI 1982/37)

Reports by Councils

Each Council is required to produce an annual report to the establishing authority on the performance of its functions. Copies must be given to the District Health Authority and the report brought to the attention of the public.

The relevant District Health Authority shall furnish the Council with its comments on the Annual Report and make known to the public of the district its comments on the CHC Report.

(SI 1973/2217)

Performance of Functions (SI 1973/2217)

Advising on the operation of services

A Council must keep under review the operation of the health service in its district and make recommendations for the improvement of such service or otherwise advise any relevant Health Authority upon such matters relating to the operation of the health service within its district as the Council thinks fit.

Consultation

Health Authorities must consult the Council on any substantial development of the health service in the Council's district or any substantial variation in the provision of services that already exist.

If there is no time for consultation, the Authority can act and tell the Council afterwards giving its reasons for non-consultation. The Health Authority may specify a date for receipt of comments but if the Council feel that sufficient time has not been allowed, then the Council may approach the establishing authority. The establishing authority has the power to require the Health Authority to consult further.

Information to be furnished by relevant Health Authority

It is the duty of the Health Authority to provide the Council with such information about the planning and operation of health services in the area as the Council may reasonably require in order to carry out its duties as long as the information is not about individual patients or officers. Any disputes must be referred to the establishing authority, whose decision is final.

Inspection of Premises

A Council has the right to enter and inspect any premises controlled by the relevant Health Authority at such times and subject to such conditions as may be agreed between the Council and the Health Authority or in default of agreement as may be determined by the establishing authority, except residential accommodation which must have the agreements of residents. Visits to general medical services, general dental services, ophthalmic or pharmaceutical services must have the consent of the persons providing these services. This is invariably carried out by contact with the Administrator, Family Practitioner Services.

CHCs do not have a statutory right to access to private hospitals or registered nursing homes. However, in the case of such premises where NHS patients receive services under contractual arrangements, representatives of the private health sector have agreed that CHCs should have access to appropriate parts of the premises concerned. It will be for the CHC and the management of the private hospital or nursing home to agree between them mutually convenient visiting arrangements. (HC(81)15 Appendix I)

Attendance at Meetings of District Health Authorities

The CHC has the right to send a member to meetings of the matching District Health Authority to act as an observer, with a right to speak but not to vote. (HC(81)15). A report from the observer should be given to the Council.

Matters for consideration by CHCs

NHS Re-organisation Circular HRC(74)4 (DHSS January 1974) gave guidance on matters to which CHCs might wish to direct their attention. Although the circular has been cancelled, the guidance may be of benefit to newly appointed Secretaries and is set out on page 8.

Additional Legislation

Statutory Instruments 1977 Nos 874 and 1204 established the Association of Community Health Councils for England and Wales and dealt with membership, proceedings, finance and secretariat.

Consultation Procedures

Consultation procedures on closures are laid down in the relevant circular - HSC(IS)207 Closure or Change of Use of Health Buildings (October 1975) - and in the regulations (SI 1973 No 2217). Further guidance, in the form of a letter from the DHSS dated 7 December 1979, is set out on pages 9 and 10.

MATTERS TO WHICH COMMUNITY HEALTH COUNCILS MIGHT WISH TO DIRECT THEIR ATTENTION

(i) General: the effectiveness of services being provided in the health district, and their adequacy in relation to health care needs. The relevant AHAs will consult Councils about their plans and intentions, but Councils will not be expected to wait until consulted; they may advise and make representations to the AHA on their own initiative.

(ii). Planning of services: criticism and constructive comment on AHA plans for provision of and development of services.

(iii) Changes in services: comment on AHA plans for important variations in services affecting the public, eg new services. Closures of hospitals or departments of hospitals or change of their use.

(iv) Collaboration: the effectiveness of co-operation between the health services and the related local authority services.

(v) Standards: assessment of extent to which district health facilities for patients conform with published Departmental policies in their administration and practices; the extent to which facilities match up to recommended standards (where these exist) or national or regional averages, eg numbers of hospital beds in particular specialties per 1000 population, average number of patients on family doctors' lists, number of persons per dentist (statistical and other information will be provided by the AHA on request); the share of available resources devoted to the care of patients unable to protect their own interests, especially those living in hospital for long periods or indefinitely.

(vi) Facilities for patients: eg hospital visiting arrangements for patients (including open visiting for children, facilities for mothers to stay in hospital with young children); waiting times and accommodation for patients in out-patient departments; amenities for hospital patients; arrangements for rehabilitation of patients.

(vii) Waiting periods for in-patient and out-patient treatment; and for domiciliary services.

(viii) Quality of catering in health service institutions in the district.

(ix) Complaints: the volume and type of complaints received about a service or institution. The investigation of individual complaints will be a matter for the health authority and its staff or (where appropriate) for the Health Service Commissioner or Service Committee but Community Health Councils will be able, without prejudging the merits of individual complaints or seeking out the facts, to give advice, on request, on how and where to lodge a complaint and to act as a "patient's friend" when needed. A CHC will also wish to bring any potential general causes of local complaint to the notice of the AHA.

(x) The CHC might wish to ask some of their members to take a special interest in a particular part of the district, or in particular institutions within the district.

(xi) Health care groups: similarly, a CHC might decide that sub-committees of the Council should take a special interest in services provided for particular health care groups, eg health services for the mentally handicapped.

(xii) Reports to the public: Councils are required to publish at least once a year reports on their activities and they will wish to ensure that these are made widely available to the public.

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REGIONAL ADMINISTRATORS

7 December 1979

Dear Regional Administrator

CLOSURE PROCEDURES

1. You will be aware that legal proceedings were taken against the Commissioners for the Lambeth, Southwark and Lewisham HA over the consultation procedures involved in temporarily closing a hospital in that area. It is possible that decisions to close hospitals elsewhere in the country may be challenged in the Courts, and the Department is therefore anxious that health authorities should be fully conscious of the need to follow the consultation procedures on closures laid down in the relevant circular and regulations (HSC(IS)207 Closure or Change of Use of Health Buildings, and the National Health Service (Community Health Councils) Regulations 1973, SI 1973 No 2217).

2. Although the circular only prescribes formal consultation on substantial permanent closures and changes of use, its spirit is that consultation should be undertaken on all closures whenever practicable. Where circumstances do not permit the full period of consultation or procedures prescribed, the health authority should nonetheless give as much time, and provide as much information, as possible to CHC, staff, and other interests. Staff can be consulted urgently through the Joint Staff Consultative Committee or equivalent arrangements. The rest of this letter deals with some points of difficulty that have arisen on arrangements for the temporary closure or change of use of health facilities.

SUBSTANTIAL VARIATIONS IN SERVICE

3. The CHC Regulations (SI 1973 No 2217) require an area health authority to consult the relevant CHC on any proposal "to make any substantial variation" in the provision of a district's health services (Regulation 20(1)). They do not distinguish between temporary and permanent closure. It is for the authority to decide whether a particular temporary closure constitutes a "substantial variation" for the purposes of the regulations, but its decision can be challenged in the courts. A temporary closure will often be no more than a short term measure of limited scope with minimal repercussions on health services in the district, for example when a hospital ward is closed for redecoration. This kind of insubstantial temporary closure was in mind when the advice was given in HSC(IS)207, Appendix B, Paragraph 2 that "temporary closure or change of use ..... will generally lie outside the procedures .....". A temporary closure could however have a considerable effect on district services, for example if it involved the temporary cessation of the only service of its kind in the district, or the removal of such a service to another centre elsewhere in the area. Such a temporary closure might well constitute a substantial variation in service and so fall within the scope of Regulation 20(1). Thus authorities should not assume that because a closure or change of use is only temporary it can for that reason alone be regarded as not being a "substantial variation" for the purposes of the regulations.

URGENT CLOSURES

4. The regulations provide that a health authority need not consult the CHC(s) on temporary closures if the authority "is satisfied that, in the interest of the health service, a decision has to be taken without allowing time for consultation" (Regulation 20(1)). The authority is, however, required to notify the CHC "immediately" of the decision taken and why no consultation has taken place. It is not difficult to think of examples of situations in which closure of a building is urgently required - an outbreak of infection or inadequate staffing levels are obvious ones, but the need to make immediate savings so as to avoid overspending may also make closure a matter of urgency. The urgency of the situation will not always rul out the possibility of consultation, and while the full procedures set out in the HSC may not be practicable, a health authority should do what it can in the time available.

5. Authorities are reminded that the Secretary of State expects there to be full consultation on all proposals for permanent closure or change of use. Further, if a substantial temporary closure has to be implemented without any prior consultation and if there is a possibility that the authority might eventually wish - or be forced - to make the closure permanent, he expects authorities to undertake consultation immediately the temporary closure has been made.

DOCUMENTATION

6. Where the full consultation procedure is not followed, a health authority should ensure that its decisions on the relevant questions are properly documented: its reasons for not consulting should be embodied in a formal resolution, duly recorded in the minutes of the authority's meeting. The wording should be consistent with that of the CHC regulations, ie that the authority has concluded that the proposal would not result in a substantial variation in the provision of a district's health service or that the authority is satisfied that, in the interest of the health service, a decision has to be taken without allowing time for consultation. Where both grounds are invoked for departing from normal consultation procedures, both should be recorded.

7. I am copying this letter to area administrators and, for information, to the local authority associations and the Association of Community Health Councils. Enquiries from CHCs or other interested parties about the procedures for temporary closure may be answered by reference to this letter: it may prove simplest in many cases to give them a copy. Further advice on closure procedures may be obtained from the Department (Mr R Venning 01-388 1188 Ext 836 or Mr K McDowell 01-388 1188 Ext 760).

Yours sincerely

D de Peyer

SECTION II

SOME GENERAL GUIDELINES

Day to Day Organisation

It is imperative that the Council is accessible to the public. Different individuals and organisations will have different expectations, i.e. the Health Authority will probably not expect an instant reply to a question of consultation whereas individuals wishing to make a complaint may well be disturbed if they do not receive a reply or contact within a maximum of four to five working days. The day to day organisation of the Council's office should take these different expectations into account.

Individual callers to the Council's office will expect personal attention to their particular problem. Most members of the public assume the CHC to have a considerable number of staff. The reception of members of the public should be friendly and, if necessary, an offer of an appointment at a later date be given.

Relationship with Members

This is one of the important aspects of the work of the Secretary. The Council's strength is the enthusiasm, interest and commitment of its members. If the members are not involved in what the Council is doing or not actively participating in the formation of ideas, responsibilities etc., the Council will be less effective.

The Secretary's job is to ensure members have sufficient information to enable them to make decisions. For this reason it is advisable that members of the Council, on appointment, should have the opportunity of meeting and talking to the Secretary. Good personal relationships with and between members are desirable.

Relationship with Chairman and Other Officers

It is entirely a matter for individual CHCs how they organise their activities. Whatever structure your Council adopts, you are strongly advised to ensure that several members are involved in matters of policy making and, if possible, that they represent a fair cross-section of the particular interests of members of your Council. It is essential that the Secretary maintains a sound working relationship with the Chairman of the Council and keeps the holder of that office fully informed of all activities.

Provision of Information

Members of the Council, as well as the general public, should be encouraged to use the CHC office as a source of health service information.

Visiting

Visiting has a three-fold purpose, namely:

1. To enable members to see at first hand the service provided for patients.

2. To demonstrate to those working in the service the interest, concern and enthusiasm of members carrying out their CHC work.

3. To encourage better discussion of issues based on a greater understanding.

The Council will wish to decide how it will organise its visiting arrangements, methods vary enormously from Council to Council. Whatever system is adopted it should be one which is agreed with the DHA. There should be no reason why a DHA should wish to restrict a Council's visiting arrangements, but it is safer that whatever is agreed has clearance on both sides.

Some visiting groups will wish the Secretary to accompany them, others will be happy to go on their own. Before the visit commences it is desirable to decide whether a report is to be written and, if so, by whom. Useful guidance is contained in the Kings Fund Guide for CHC Visitors. Although this is aimed at visiting in long stay units, the major part is appropriate to all types of hospital visits.

It is important that the Council keep an open mind during visits, making their own assessments and avoiding "internal hospital politics" or lobbying by a particular group of staff.

It is usually helpful for the visiting party to have prior information about the unit e.g. the kind of information contained in the annual SH3 statistics. CHC members must bear in mind that the primary aim of any visit is to look at the service to patients and the opportunity should be taken to speak to patients and their visitors in the course of visits.

Committees

Many Councils have decided to establish Committees, Working Parties, Interest Groups, etc. Committees may, subject to the agreement of the CHC, co-opt members (who can claim appropriate expenses) up to one-third of their membership, although in some instances the RHA can agree to waive this limitation. These groups are often the power-house of the Council, providing the real thinking base and policy development centre. They should be seen as part and parcel of the Council and their minutes and reports should be submitted to the Council for consideration and agreement if necessary. They may initiate visits or meetings on topics of special interest to them.

Notice of Meeting

Regulations governing the notice of meetings must be strictly adhered to. Public notice of meetings should be given in the required time and contain all relevant details. Failure to do this could invalidate the meeting and any decisions made. Likewise, the notice of business to be transacted must be sent to members to arrive at least seven clear days before the meeting.

Meetings and Minutes

The preparation of agenda is important and due time must be devoted to it. Ideally, the agenda for CHC meetings should be agreed by the Chairman, Vice-Chairman and Secretary. Any member

should be entitled to have an item included on the agenda, unless the Council has previously decided not to discuss that particular subject for a period of time. Notice should be required prior to the dispatch of the agenda. It will inevitably happen that some supporting papers for an item are late in being received at the CHC office. In such instances the item can be included on the agenda but supporting papers circulated later or laid on the table. The fact that the item has been noted on the agenda is all that is necessary. Members should not normally be asked to read and discuss papers which are "on the table". The Regulations do not prevent an exploratory and general discussion on a matter raised without prior notice, but it would be out of order to reach a final decision on such a matter.

The decisions of the Council should be clearly minuted, and preferably set apart e.g. IT WAS AGREED .... Minutes should always include a list of those members attending and contain the names of the members who propose and second formal resolutions.

The Council's minutes will certainly be read by officers and members of the DHA, officers and members of the RHA, MPs, health service professionals and members of the public. It should, therefore, be clear to anyone reading them what was debated, what comments and arguments were put forward, and what decision was finally reached. There are a number of useful guides to the conduct of meetings and to minute writing. You are strongly advised to equip yourself with one of them.

Availability of papers to the Public

All papers related to Part I of a CHC meeting should be available to members of the public on request. This is a principle which is sometimes difficult to observe when the Council is very successful in advertising its activities to the public.

Some Councils offer to send an agenda free of charge or make a small charge for each set of full papers. Any member of the public should, of course, be able to visit the CHC office to inspect papers. It is desirable to have a few spare sets of papers at a meeting to distribute to members of the public.

Participation at Public Meetings

The majority of CHCs have decided that there will be some participation of the public at their meetings. In some cases this is done by allowing members of the public present to speak at a specified time during the meeting, in others members of the public are given an opportunity to address the Council during debate prior to a decision being taken.

Broadly speaking, this is a useful safety device which means that the Council can never be charged with not listening to what the public have to say and CHCs up and down the country have often seen this procedure as a real contribution to a democratic procedure. However, beware the person who may seek to mis-use the opportunity thus afforded!

Right of Privilege at Meetings

Where a meeting is required by the Public Bodies (Admission to Meetings) Act 1960 to be open to the public during the proceedings, the publication of any defamatory matter contained in the agenda or in the further statements are privileged, unless the publication is proved to be made with malice.

Members should be reminded that they have no particular privilege for making statements at a CHC meeting. Provided statements are made in good faith and in a reasonable way, they should be allowed. Any personal attack, however, should never be allowed during the public part of a CHC meeting.

Press

Relationships with the media are of enormous importance to CHCs. Try to ensure that members of the press attend meetings and are informed about the topics which are going to be discussed. If a member makes what might be thought of as an injurious or incorrect statement, this will regrettably be 'fair game' for the press and it is unlikely that a request that this should be omitted will be well received. On such an occasion the Secretary should present the press with balancing information to ensure accurate representation. Some Councils have been successful in persuading their local newspapers to send the same reporter to each meeting; this is often the person who also reports on the Health Authority's meetings, and can mean that a very useful personal contact is made.

Use of Additional Staff

Although the DHSS intended that the final staffing levels (mainly two full-time staff) would be reviewed after the first year, there has not been, since 1974, a general review of CHC staffing needs. The Royal Commission reported that CHCs should be given further resources but this has not been accepted by Government to date. Staffing levels may be temporarily increased by making use of various schemes sponsored by the Manpower Services Commission or by volunteer labour (members and their friends) or researchers from places of higher education. A number of CHCs have successfully boosted their staffing resources in this way.

Political Impartiality

The Secretary is expected to give advice and guidance to members of the Council who represent various political persuasions. Consequently, as the Secretary to the Council, you should not show any political bias in dealing with the members, or the issues before the Council.

SECTION III

THE CHC AND THE COMMUNITY

Every CHC office needs a comprehensive list of the organisations in their locality including Social Services, Political Parties Church Welfare Groups and Chambers of Trade, Trade Councils, Community Relations Councils and those voluntary organisations who traditionally have an interest in health and welfare. Lists are kept by Social Services Departments, Councils of Voluntary Service and the Libraries.

Information on Community Councils, Local Authorities and Parish Councils is also useful. The National Consumer Council, The National Council of Social Services and Social Services Year Book can supply information about national bodies.

An important part of the Secretary's work is to develop and maintain good relationships with local organisations. This will mean attending annual meetings when invited, giving talks on the work of the CHC and its activities and keeping them informed of developments in the Health Service.

A newsletter is one way of maintaining regular contact and can include information about Health Authority policy as well as publicising the CHC and encouraging views from the community. To encourage greater awareness of the role of the CHC, posters can be displayed in as many public places as possible - such as Libraries, Citizens' Advice Bureaux and Parish notice boards. Most Health Authorities are willing to co-operate by displaying CHC meeting notices in hospital waiting areas, health centres and clinics but it must be remembered that practitioner doctors, dentists, opticians and chemists are independent contractors and can, if they wish, refuse to display such material.

Leaflets explaining the role of CHCs can be distributed through members of the Council who already have many contracts in your district. Some Councils have taken space in local commercial advertising campaigns. The Welsh CHCs have a very good film about CHCs and Yorkshire CHCs have produced a similar film, both are available on loan.

Talks to local community groups with or without slides, contributions to local radio, newspapers and community newsletters always prove worthwhile. CHC publicity material can be distributed to libraries. Book-marks have proved very effective in drawing the attention of the public to the CHC.

Each Council is required to issue an annual report. Although this is addressed to the Regional Health Authority it can be written with a view to informing the public about the work of the CHC and it is worth trying to get maximum distribution. Many CHCs take the opportunity to publish their annual report in a way that will attract public interest. Some retain the formal style, attractively printed, often including photographs.

Others have produced their reports in the form of a newsletter with eyecatching story lines. Many CHCs include information on services available through the NHS in their district and how to get the best use from them. These reports often prove a useful reference when answering simple requests for information.

Ideas for keeping the Council in the "eye of the public" are numerous and you will have to regard publicity as an important aspect of Council work. Remember that th job of the Secretary is to put over the views of the Council. CHCs have a duty to keep in touch with public opinion about local health care services. Some ideas on seeking the views of the community in your district are:

1. Local colleges may have a department able to undertake opinion surveys and be willing to co-operate in order to provide a project for the students.

2. "Mini" surveys can be carried out by members.

3. Letters to local newspapers and contributions to local radio programmes can be used to ask for views.

4. A discussion paper can be circulated to a cross section of organisations asking for their comments.

5. Representatives from relevant local organisations can be invited to a meeting to discuss a specific matter; business and professional organisations, diocesan authorities, neighbourhood, tenants' and residents' groups, trade unions and voluntary organisations might be considered.

6. A public meeting can be called.

7. In rural areas W.Is and Parish Councils provide a useful communication network and are usually knowlegeable about the needs and problems in their own communities. W.Is, Age Concern and Councils for Voluntary Service circulate a county news-letter and may be willing to include CHC items.

SECTION IV

THE CHC AS THE "PATIENT'S FRIEND"

It will fall to the lot of every Secretary, on occasion, to help an individual with information or advice about local services or to advise on how to lodge a complaint about some part of the health service. Some Secretaries would say that this is their major role but most would see it as only one facet of their complex two-way relationship with, on the one hand, the health authorities who provide services and, on the other, the public who use these services and whom we represent.

The following guidance is divided into 3 sections:

1. Providing an information service to the public.

2. Providing an advice service to the public.

3. Assisting people who wish to make a complaint about some aspect of the service to do so as effectively as possible.

1. Information

(a) about your local health and social services:

* Aim to build up a network of informed contacts within the health service, social services and voluntary organisations so that you can respond to requests for information speedily and efficiently.

* Some health authorities run their own information or public relations department but many do not and you may well find yourself as the main point of enquiry in the district. If you have High Street or shop front premises, this is particularly likely.

* Try to keep a collection of relevant local directories and year books of voluntary organisations - though remember that they very quickly become out-of-date.

* Obtain from your Health Authority an information profile about health services in your district. Every district should produce one for planning purposes.

* Read your local Newspapers.

* Ensure that your information on local Family Practitioner Services is accurate and kept up-to-date; your FPC Administrator will ensure that you have this information if you ask for it.

* Never be afraid to admit that you don't have a piece of information but do be prepared to find out or to direct the enquirer to the right source. This is where the "informed contacts" mentioned above can be invaluable.

(b) about the national health service outside your district:

* One of the most useful reference books is the IHSA Year Book and although your CHC is unlikely to be able to afford a new copy, your RHA or DHA library will probably be happy

to pass on to you an old copy - which is not as useless as it sounds!

* Make sure that you have information about hospitals in the rest of your region - especially those which are the home of the various "regional specialties".

* DHSS circulars are the official means whereby changes in government policy are communicated to the managers. Keep sufficient eye on them to ensure that you read and understand those that significantly affect the public.

* Ensure that your copy of the Directory of CHCs is up-to-date.

(c) about national voluntary organisations:

* The King's Fund Directory of Voluntary Organisations is one valuable source of information.

* The major national charities such as Mind and Age Concern will keep you informed of their activities and publications. The Mental Health Year Book, published by MIND, provides information on statutory bodies and voluntary organisations with interests and responsibilities in mental health.

(d) Read the journals - or as many as you can get hold of. Apart from CHC News, other journals frequently have articles of interest. The DHSS bi-monthly publication Health Trends is also worth watching for relevant articles.

(e) The Society of CHC Secretaries is a useful source of information on many subjects.

2. Giving Advice to Members of the Public

Most CHC Secretaries find themselves asked for advice about matters which could subsequently become the subject of formal complaints. While most enquiries will come direct, others may be referred by a district councillor, by the local CAB or even persons working in the health service who feel powerless to act. Examples of such problems include:

* Confusion over services offered by general medical practitioners, chemists, dentists and opticians.

* Hospital patients or their relatives who may feel that they have not been given adequate information.

* Parents who feel they are not being allowed free access to their children in hospital.

* Questions about the rights of the patient compulsorily admitted to a psychiatric hospital.

The list of possible subjects is endless. In most cases the CHC Secretary may offer an informed and sympathetic ear and perhaps offer advice as to how the problem can be resolved.

Familiarity with the way local services work - and to some extent familiarity with local personalities - will be needed in order to know what course of action is the best one.

In such matters, members of the CHC may have particular knowledge or experience which is helpful. Take an early opportunity of finding out what strengths and special knowledge your members possess.

Remember - if a problem can be resolved before it becomes a formal complaint, this is usually best for all parties.

3. Complaints - and how to deal with them.

The duty of the CHC in relation to people who may have a complaint was set out in the Appendix to HRC(74)4. In a list of "matters to which CHCs might wish to direct their attention", complaints are referred to thus:

"The investigation of individual complaints will be a matter for the health authority and its staff or (where appropriate) for the Health Service Commissioner or Service Committee but Community Health Councils will be able, without prejudging the merits of individual complaints or seeking out the facts, to give advice, on request, on how and where to lodge a complaint and to act as a "patient's friend" when needed. A CHC will also wish to bring any potential general causes of local complaint to the notice of the AHA".

Appendix 1 to HC(81)15 has this to say on the subject of complaints:

"Giving advice to members of the public on how to go about making a complaint about the health service has become a widely-established feature of CHC work. However, some CHC members and officers are prepared to go further than this, for instance, by acting as a "patient's friend" at service committee hearings. The Secretary of State does not see this as a formal role for CHCs, but he sees no objection to individual CHC members or officers providing such assistance if they are asked and wish to do so."

The extent to which individual CHCs act as complaints bureaux varies considerably and according to local inclinations and circumstances. Those with an easily accessible office for example, are more likely to receive personal callers (who may or may not wish to make an inquiry or lodge a complaint) than those whose offices are more remote.

Some mention specifically in their leaflets or other publicity material that they are willing to advise would-be complainants.

Others prefer to see themselves not primarily as a complaints bureau and wait for would-be clients to seek them out. It is important for a Council to be quite clear what attitude it wishes to adopt on this matter. However, you will probably wish to consider whether you feel that the CHC role includes the following:-

a) listening to any complaint or problem brought to you by a member of the public;

b) advising whether genuine and resonable grounds for complaint seem to exist in an individual case;

c) helping an aggrieved person to lodge a formal complaint, e.g. helping him to write a letter and/or even typing it for him;

d) making a study of the various procedures which exist within the Health Authority and the FPC and at DHSS level for dealing with formal complaints;

e) regularly obtaining from your Health Authority information about complaints received by them;

f) drawing the attention of the Health Authority or FPC to any one part of the service which seems to have been the subject of a number of complaints;

g) selecting for careful visiting by CHC members any institution that seems to have been the subject of a number of complaints.

No statutory procedure is laid down for patients to complain about hospital services or make suggestions for improving them although a memorandum of guidance HC(81)5, issued to health authorities in April 1981, to some extent consolidated earlier advice given by the Department and introduced a new procedure for dealing with complaints relating to the exercise of clinical judgement. All Secretaries should be familiar with the contents of this circular.

Secretaries will also find the background to the present position, set out in Chapter 11 of the Report of the Royal Commission on the NHS, worthy of careful reading.

Family Practitioner Services

The formal complaints procedure is set out in the National Health Service (Service Committees and Tribunal) Regulations 1974 (S.I. 1974 No 455). A copy of the NHS "Notes on Service Committee Procedure" should be available at the CHC office. The notes (Ref: C/56/02, March 1974) have been prepared by the DHSS to assist on aspects of the service committee procedure which can cause difficulty.

Service committee procedure do not exist to remedy patients' personal grievances but to settle disputes about whether or not practitioners have fulfilled the terms of their contracts.

Pay particular attention to the time limits for making complaints, and to the fact that the time limits apply in relation to the date a complaint is received by a Family Practitioner Committee, not the date it is made. A complaint against a doctor, chemist or optician should be received by the FPC not more than 8 weeks after the event which gave rise to the complaint. A "late"complaint can be considered

if the Service Committee are satisfied that failure to give notice in time was due to a reasonable cause. In the case of a dentist the normal time limits for making complaints are 8 weeks from the time when the complainant first became aware of the matter or 6 months after completion of treatment, whichever is the sooner.

Health Service Commissioner

The Health Service Commissioner holds an independent office under the Crown. His function is to investigate complaints from members of the public that they have suffered injustice or hardship as a result of:

a) a failure in a service provided by a health authority;

b) a failure by a health authority to provide a service which it is its duty to provide;

c) maladministration affecting the action of a health authority.

The Commissioner cannot normally investigate a complaint if:

a) it has not been put to the authority concerned, and the authority given the opportunity to reply;

b) it reaches him more than a year after the incident came to the notice of the aggrieved person;

c) if the aggrieved person has a right to appeal to a tribunal or recourse to the courts, or has exercised such rights.

But he has discretion to waive these provisions under certain circumstances.

Certain subjects are excluded from investigation by the Commissioner. The most important of these are:

a) action concerned with the diagnosis of illness or the treatment of a patient, if in his opinion that action arises out of the exercise of clinical judgement;

b) action taken by a Family Practitioner Committtee concerned with the investigation of complaints against practitioners;

c) actions taken by practitioners in connection with the services they provide under contract with Family Practitioner Committees;

d) Personnel matters.

Qualified Privilege at Common Law

CHC officers helping individuals to draft and present complaints should be aware of defences to an action

for defamation. The guiding principle is as follows:

> "A privileged occasion is an occasion where the person who makes a communication has an interest or a duty, legal, social or moral, to make it to the person to whom it is made, and the person to whom it is made has a corresponding interest or duty to receive it. This reciprocating is essential "
>
> (Lord Atkinson in Adam v Ward (1917) A.C. 309).

There is also the question of the maintenance of professional confidence in this. If the CHC Secretary "broadcast" erroneous information to people other than those legitimately entitled to receive it, it could be held that the qualified privilege of the occasion had been breached.

Carelessness in providing advice resulting in damage to a person can be held to be a breach of duty. In taking on the responsibility of providing advice there is a duty to take requisite care. If ever in doubt, contact the legal adviser to the RHA.

It could be useful to read "Health Services Law" (John D Finch, Sweet & Maxwell 1981). In addition to a Chapter on "Privacy, Records and Confidentiality", the book contains information on Liability; Rights, Remedies and Liberties; Treatment and Consent in Medical Practice; Admission of Mental Patients.

SECTION V

PRINCIPAL SOURCES OF STATISTICAL MATERIAL

A vast amount of information is gathered in the National Health Services and the following is no more than an outline of what is available. The Regional Statistical Officer will be able to give you further help and may have a booklet on basic information sources in the National Health Service. They do not represent absolute truth and the reasons underlying variation are likely to be as important as the figures themselves. Waiting Lists are particularly notorious in this respect and should be viewed with caution unless it is known how long people wait and whether the lists are regularly reviewed.

FORM NO.	HOSPITAL SERVICE
SH3	Annual Hospital/Clinic Work Load

Broadly, SH3 collects for each separately administered unit, (hospital or clinic) details, by specialty, of:-

Bed availability	Day cases
Bed use.	Waiting list
Number of discharges	New Out-patients
Average stay	Total attendances
Turnover per bed	Clinics held

In addition, data are recorded of the number of births, A & E work, R/T and Radiology units, Day patients and the work of Ancillary Departments e.g. Occupational Therapy, Hearing Aids, ECT, etc. Their main use is comparative, from year to year or between specialties across the District/Area/Region. Used this way they give some idea as to whether resources are being used to greatest effect. A multiplicity of questions arises if this appears not to be the case.

SBH 203 — Hospital Waiting Lists

These returns are made in March and September and include figures for urgent cases waiting over one month and non-urgent cases waiting over a year.

SBH 112 — Psychiatric Facilities

They form a fairly comprehensive data set covering details of beds and bed use by sex, age, and category of patient, night space, sizes of wards, medical, nursing, and other staff numbers.

SBH 6 — Pathology Statistics

SBH 61 — Sexually Transmitted Diseases

SBH 179 — Chronically Sick and Disabled

T.145 — Tuberculosis

SBH 140 — Cervical Cytology

FORM NO.	HOSPITAL SERVICE
SH9	Contractual Arrangements
	COMMUNITY SERVICES
LHS 27/1	Births
27/2	Maternity & Child Health - Clinics
27/3	Nursing Services
8 M (1)	School Inspections
28 M	Dental Inspection & Treatment
SBL 607	Vaccination
SBL 618	Chiropody
SBL 630	Mental Nursing Homes
SBL 631	Admissions - do -
SBL 655	TB Testing & BcG
SBL 708	Family Planning, Community & Hospital
SBL 709	Family Planning, Domiciliary
	STAFFING
	Medical Staff - Seniors
SBH 57	Hospital Consultants - Senior Registrars
SBH 50 A	Community Staff (Inc.Juniors)
SBH 59 & A	Return of Vacancies
	Medical Staff - Juniors
SBH 50	Hospital
DI Series (1) & (2)	
	General Practitioners.
	Nursing Staff
SBH 2	Hospital / Unit Return
SBH 2(c)	Primary Health Care
SH5	Professional & Technical
SH6	Administrative & Clerical
SH7	Regional Works Professional
SH13	Anciliary Staff (4 parts)

FORM NO.	NATIONAL MORBIDITY SURVEYS
(HAA)	Hospital Activity Analysis
	HAA is a computerised system giving, for each patient admitted to hospital as an in-patient, details of the patient's age, sex, area of residence, the condition treated, any operations done, the time the patient spent on the waiting list and how long was spent in hospital. Data about the area of residence of patients helps define the hospital "catchment population". Processing is carried out on a regional basis to provide management and clinical information for use by health authorities.
(HIPE)	Hospital In-Patient Enquiry
	Set up to be a survey of a 10% sample of patients discharged from hospital. Now the RHA provides a 10% sample of HAA data to OPCS for analysis nationally. This analysis concentrates on utilisation of facilities rather than on morbidity. There is a three-year delay between the data being collected and the publication of the preliminary report, a main report appears about four years after the year to which it applies - published jointly by OPCS, DHSS and the Welsh Office.
(MHE)	Mental Health Enquiry
	Statistics on Psychiatric Hospital and Units.
	Cancer Registration
	A Register is maintained by every Regional Health Authority.
	VITAL STATISTICS
SD52	Vital Statistics (OPCS)
SD(52)D	Births - Age of mother, party and legitimacy
SD 25	Cause of Death (OPCS)
	POPULATION STATISTICS (OPCS)
	Census Publications
	Mid Year Estimates
	Projections
	BASIC GOVERNMENT STATISTICS
	Lists of publications produced by Government Departments are available from libraries.

From OPCS

The Office of Population Censuses and Surveys publish tables of data in the OPCS Monitor Series.

Topics include:

- Population estimates for health areas
- Deaths by cause
- Infant and perinatal mortality
- Live Births
- Legal abortions

OPCS Monitors can be obtained, free of charge, by writing to Information Branch (Dept 17), Office of Population Censuses and Surveys, St Catherine's House, 10 Kingsway, London WC2B 6JP.

From DHSS

Health and Personal Social Service Statistics - England, published annually, contains tables relating to NHS activity and interests under the following headings:

I Population and Vital Statistics
II Finance
III Manpower
IV NHS Hospital Administrative Statistics
V Family Practitioner Services
VI Community Health Services
VII Personal Social Services
VIII Maternity & Child Health & Social Services
IX Psychiatric Services
X Preventative Medicine
XI Morbidity
XII Abortions
XIII Miscellaneous Health Statistics

On the state of the Public Health

This is the annual report of the Chief Medical Officer of the DHSS and covers:

- Vital Statistics
- Incapacity and Disablement
- Environmental Health & Communicable Diseases
- Sexually Transmitted Diseases
- Primary Health Care
- Maternal Health
- Child Health
- Dental Health
- Mental Health
- Services for Physically Handicapped and the Elderly
- Artificial Limbs/Appliances
- Medical Manpower/Education
- Other subjects.

INSERT WORKING FOR THE CHC Reprinted June 1984

Community Health Councils Regulations 1985 (SI1985/304)

New NHS Community Health Councils Regulations 1985 introducing consolidated and revised Regulations came into force on 1 April 1985. They replace the CHC Regulations 1973 (as amended) but perpetuate the relevant provisions of those Regulations. In addition, the new Regulations provide the basis for the relationship between CHCs and the independent Family Practitioner Committees, and for the termination of a CHC member's appointment for misconduct. Main guidance on the 1985 Regulations is contained in Health Circular (85)11 issued in March 1985.

In Section I of this booklet references to either SI1973/2217 or SI 1982/37 are replaced by reference to the appropriate Regulations of SI 1985/304.

Health Circular (85)11 makes specific reference to part IV (Performance of Functions) of the 1985 Regulations:

Advising on the operation of the health service - Regulation 18

The duty for CHCs to advise DHAs on the operation of the health service in their districts and to make recommendations for improvements has been revised to take account of the new status of FPCs. CHCs should direct their representations or recommendations about the family practitioner services to the Family Practitioner Committee and FPC matters to which CHCs might wish to direct their attention may include the general effectiveness of the service; collaboration between the health services and related local authority services; and the availability and standards of services.

Consultation - Regulation 19

The right of CHCs to be consulted by DHAs about substantial developments of, or variations in, service has been extended to provide for separate consultation of CHCs by FPCs in such matters. This is now a right of appeal to the Secretary of State if a CHC considers that a FPC has not allowed sufficient time for consultation or that the consultation has otherwise been inadequate.

Supply of information - Regulation 20

CHCs are entitled to basic information from FPCs about the family practitioner services in the locality, including appropriate statistics and information about the planning and operation of those services which the CHC very reasonably require to carry out its duties. Copies of minutes of the meetings of the FPC or any of its sub-committees and copies of relevant papers prepared for these meetings should routinely be given to CHCs.

If relevant and necessary information is unreasonably withheld CHCs have a right of appeal.

Continued.....

TABLE OF REFERENCES

Statutes

National Health Service Reorganisation Act 1973 (c32).

National Health Service Act 1977 (c49).

Public Bodies (Admission to Meetings) Act 1960 (c67).

Statutory Instruments

The National Health Service (Community Health Councils) Regulations 1973 (SI 1973 No 2217).

The National Health Service (Service Committees and Tribunal) Regulations 1974 (SI 1974 No 455).

The National Health Service (Association of Community Health Councils) Regulations 1977(SI 1977 No 874).

The National Health Service (Association of Community Health Councils - Establishment) Order 1977 (SI 1977 No 1204).

The National Health Service (Community Health Councils) Amendment Regulations 1982 (SI 1982 No 37).

Health Circulars and Health Notices

HSC(IS)207 - Change of use of health buildings.

HC(74)4, Appendix 5 - Matters to which CHCs might wish to direct their attention.

HC(80)8 - Structure and Management.

HC(81)5 - Health Service Complaints Procedure.

HC(81)15 - Community Health Councils.

HN(81)4 - Review of the NHS Planning System.

HC(82)6 - The NHS Planning System.

Reading List

Community Health Councils in England - Consultative Paper on Role and Membership (DHSS January 1981).

Closure and Change of Use of Health Facilities - King's Fund Project Paper No 26 (November, 1980).

CHC VISITING - King's Fund Project Paper No 23 (November 1979).

Health Service Commissioner for England - Notes issued by the Office of the Health Service Commissioner (May 1974 - amended August 1977).

Health Services Law - John D Finch (Sweet and Maxwell 1981).

National Health Service: Notes on Service Committee Procedure - DHSS (1974).

Royal Commission on the National Health Service: Report (Cmnd 7615) - HMSO (July 1979).

The Hospitals and Health Services Year Book - The Institute of Health Service Administrators.

The Mental Health Year Book 1981/82 - MIND (1981).

C O N T E N T S

GLOSSARY OF ABBREVIATIONS

ACHCEW	Association of CHCs for England and Wales
CHC	Community Health Council
DA	District Administrator
DHA	District Health Authority
DHSS	Department of Health and Social Security
DMC	District Medical Committee
DMO	District Medical Officer
DMT	District Management Team
DNO	District Nursing Officer
DT	District Treasurer
DTO	District Team of Officers
FPC	Family Practitioner Committee
FPS	Family Practitioner Services
GP	General Medical Practitioner
HAS	Health Advisory Service
HC	Health Circular (DHSS)
HCPT	Health Care Planning Team
HMSO	Her Majesty's Stationery Office
HN	Health Notice (DHSS)
JCC	Joint Consultative Committee
JCPT	Joint Care Planning Team
LA	Local Authority
LMC	Local Medical Committee
MEC	Medical Executive Committee
MIND	National Association for Mental Health
NAHA	National Association of Health Authorities
NHS	National Health Service
OPCS	Office of Population Censuses and Surveys
RA	Regional Administrator
RAWP	Resource Allocation Working Party
RHA	Regional Health Authority
RMO	Regional Medical Officer
RNO	Regional Nursing Officer
RT	Regional Treasurer
RTO	Regional Team of Officers
SI	Statutory Instrument
SSD	Social Services Department
UMT	Unit Management Team
WHO	World Health Organisation

Annual Report of the DHSS

This is submitted annually by the Secretary of State (as opposed to the previous report mentioned which is from the RMO).