

***“Cock-up” or “Conspiracy”?:
Government Policy and
Community Health Councils***

**A dissertation in partial fulfilment of the degree of Master of Business
Administration in Health Services Management in the University of Hull**

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ABBREVIATIONS AND ACRONYMS

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ACHCEW Association of Community Health Councils for England and Wales	5
CHC Community Health Council	1
MBA Master of Business Administration	36
NHS National Health Service	1

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ABSTRACT

This dissertation uses the experience of Community Health Councils (CHCs) as a case study of policy development and change management within the National Health Service (NHS). Policy development and theory concerning patient and public involvement and scrutiny of the NHS is reviewed with particular reference to CHCs.

The dissertation presents results of a survey of Councils for Voluntary Service conducted in August and September 2001 concerning views about CHCs and new proposals for patient and public involvement and scrutiny. The results of interviews with individuals who had been involved in or effected by policy development in this area, conducted between September and October 2001, are also presented.

The research found that CHCs remained a relatively popular means of patient and public involvement and scrutiny in spite of perceptions of inconsistency between them and government proposals to abolish them. It was also found that the process of developing the new policies regarding CHCs and their replacements were not perceived to be inclusive or transparent, and that the way that the policy was developed and announced had had a negative effect with regard to the objective of engineering a positive process of change.

It was concluded that more inclusive approaches to policy development are needed in this area in order both to arrive at the right policy and to help make effective change management more realistic. It is also concluded that a balance needs to be struck between political accountability for a service such as the NHS, and avoiding policy being over politicised or dominated by personal preferences of Ministers. Furthermore, it was concluded that in this area of policy in particular, maximum consensus is desirable in order to secure public confidence, and that the proposals as they stood regarding the replacement of CHCs seemed unlikely to achieve this.

1. INTRODUCTION

This dissertation will examine the development of policy on patient and public involvement, scrutiny and advocacy in the NHS with particular reference to the *NHS Plan* (Department of Health, 2000 – hereafter referred to simply as the *NHS Plan*) and the intention announced in it to abolish Community Health Councils. At the time of writing, Government policy on how patients and the public are to be represented and involved in scrutiny of the NHS is in a state of confusion. The fate of Community Health Councils (“CHCs”), which, as will be discussed, have been central to the NHS approach to these issues for over twenty-five years, remains far from clear. The *NHS Plan* had specified the Government’s way forward in this area of NHS policy, introducing a number of new mechanisms and announcing the intention to abolish CHCs with effect from March 2002. However, in the face of widespread criticism of the effectiveness of the proposed measures and fierce opposition to the proposal to abolish CHCs, the plans were altered significantly. Nonetheless, the continued intention to abolish of CHCs was opposed by both the Conservative and Liberal Democratic parties. The House of Lords amended the *Health and Social Care Bill* (HMSO, 2001) taking out the “abolition” of CHCs and replacing it with “reform”. Faced with the prospect of having to accept the Lords amendment or lose the entire Bill due to the parliamentary timetable in the run up to the general election in June 2001, the Government removed the abolition of CHCs altogether and the *Health and Social Care Act* was passed on 10th May 2001 (HMSO, 2001a). The Act allows for the new role for local authorities in scrutinising the NHS through “overview and scrutiny committees” and a new responsibility for the Secretary

of State to ensure the provision of "independent advocacy" for people in dispute with the NHS (a measure introduced since publication of the *NHS Plan* in response to concerns about the loss of this function performed by CHCs). However, in the absence of further legislation being introduced to allow the abolition of CHCs, these would be in addition to the ongoing roles of CHCs. A long period of silence on the future of policy in this area followed. A new junior minister with responsibility for it, Hazel Blears MP, replaced the previous post-holder, whilst Alan Milburn was re-appointed as Secretary of State.

It is hoped that this research can be used to help inform the emerging policy itself and to identify lessons from the process that has been followed thus far. A key criticism of the process has been the lack of consultation with stakeholders – in particular those who the new measures are supposed to "empower" (local individuals and communities) and the people with the most experience of involving and empowering the public in the NHS (CHC members and staff). It is hoped that this research gives some useful insights into how these people see the issues. The analysis draws on two key concepts – those of *policy development* and *change management*. Common to both of these is the question of to what extent different stakeholders are consulted or involved in the process, which is discussed in some depth. It will be suggested that this particular study provides evidence that consultation and involvement is more likely to lead to better policies and facilitate the management of change. The links and conflicts between policy making and implementation and management in the NHS will be discussed. The NHS is a huge public sector organisation which is directly under

political control but seeking to adopt textbook approaches to management, drawn mainly from the business sector, it is argued.

The author was Chief Officer of the Community Health Council in Croydon and a member of the board of both the London and National associations of CHCs, before being appointed Director of the Association of Community Health Councils for England and Wales in November 2001. As such, he has been in the privileged position of being able to have relatively easy access to colleagues in the CHC and wider patients' movement, to civil servants and other NHS managers. The ideas behind this study have been discussed with CHC colleagues and others interested in exploring this area of policy further, and the final result will be shared widely and fed directly into the Department of Health. As well as research carried out via a survey of local voluntary sector umbrella groups (Councils for Voluntary Service – "CVS") and interviews conducted with CHC members and staff, civil servants and other stakeholders, there is will be an analysis of the history of patient and public involvement in the NHS, and of theory in relation to policy development, and change management.

Before going on to analyse the relevant literature, it is necessary to provide some additional background. CHCs were created as part of the 1974 reforms, having been envisaged under the Conservative government but implemented under the incoming Labour government. Their creation was, as Ham (1999) observes, an attempt to introduce community representation into the management of local NHS services and independent scrutiny of the NHS.

CHCs have remained largely unchanged by legislation or guidance since their creation in 1974, although they have adapted themselves in order to fulfil their role following the various reforms that have taken place. Although not prescribed for in the legislation for example, CHCs filled the void in access to independent help and advice for individuals with complaints about the NHS. Periodically, there have been doubts about whether CHCs are worth their salt. Most notably, in 1979 in the Government's consultative paper *Patients First* (DHSS, 1979) their abolition was formally floated. However, as Levitt, Wall and Appleby (1995) point out the result of that consultation showed "widespread and somewhat unexpected support for CHCs" and they were retained. Their cost, compared with the total cost of the NHS is marginal (approximately £23 currently) and it has suited both political parties who have held power to continue with them. They fitted well with the notion of consumerism within the NHS developed in the 1980's. After all, most major industries have their consumer "watchdog". They also fit with the notions of accountability of public institutions, and of empowerment of service users and citizens to influence public services. They have therefore enjoyed all party consensus, perhaps for different ideological reasons at times. That is, until publication of the *NHS Plan*.

During the 1990's debates intensified about how to strengthen patient and public involvement. In 1992 the NHS published *Local Voices* (NHSME, 1992), which encouraged health authorities to develop a variety of methods of involving local people in priority setting. Cooper et al published *Voices Off* in 1995, which talked about "tackling the democratic deficit in health". A number of commentators have discussed the issue in general and in respect of CHCs.

Cooper et al (1995) called for the “overhauling” of CHCs. A number of commentators have referred to the variability of CHCs’ ability to represent the public interest (Klein, 1995; Ham, 1999; Iliffe and Munro, 1997).

The CHC movement itself has been keen to encourage modernisation and to bring CHCs in line with other NHS reforms. Dabbs (1998), a CHC chief officer himself, concludes, “the status quo is not an option for CHCs. Whilst recognising their achievements, there is a need for radical thinking and change”. Rolfe, Holden and Lawes (1998) draw the same conclusion: “no change is not an option”. The national association of CHCs published its own set of proposals for modernisation and reform of CHCs (*Old Watchdog; New Tricks*, ACHCEW, 1999). In the absence of any indication from the Department of Health that it would review patient and public involvement, the national association also helped establish an independent commission on the NHS whose report, *New Life for Health* (Hutton; 2000). As well as making some radical proposals such as taking the NHS out of direct political control, Hutton recommended the strengthening of CHCs.

In all of the texts analysed for this study (except *The NHS Plan*) there is not a single recommendation for abolishing or replacing CHCs, but many for strengthening them. The Department of Health had commissioned a report to look into ways of making resource allocation and performance management of CHCs more consistent (Insight; 1996) and part funded *In the Public Interest* (Bridge Consultancy 1998) which explored a range of community involvement approaches and was critical (without citing evidence) of the alleged variability

of CHCs. However, *The New NHS; Modern; Dependable* (Department of Health, 1997) seemed to confirm CHCs' continuity. In 1999 the Prime Minister himself congratulated CHCs on their "excellent work" and over one hundred MPs signed an early day motion similarly congratulating CHCs on the occasion of their twenty-fifth anniversary.

New Labour; New NHS; New CHCs?

As Hunter and Harrison (1997) point out that the Labour Party's latest policy position on CHCs upon being elected in 1997 had been to strengthen them, re-packaging them as "Local Health Advocates" (see The Labour Party, 1995, *Renewing the NHS; Labour's Agenda for a Healthier Britain*).

The pre-cursor to the *NHS Plan* (Department of Health, 2000) was the white paper on the NHS – *The New NHS; Modern, Dependable* (Department of Health, 1997). Disappointingly for the CHC movement, there was little in *The New NHS; Modern, Dependable* to suggest that the movement's aspirations for a fresh injection of life to keep it in touch with the wind of change sweeping the rest of the NHS. On the other hand, there was relief that the white paper had no suggestion that CHCs were no longer to be needed:

"The government wants a strong public voice in health and healthcare decision-making, recognising the important role played by Community Health Councils in providing information and advice, and in representing the patient's interest."
(Department of Health, 1997, p29)

The first indication of a shift in policy towards CHCs came with the publication of the *NHS Plan* itself in July 2000.

The NHS Plan

The NHS Plan (a White Paper) was launched by the Prime Minister in a speech to Parliament at the end of July 2000. The timing is seen by some as significant as it was just before the summer recess, therefore limiting the amount of debate and immediate political response. The now infamous “Chapter Ten” of the Plan – “Changes for Patients” – contained the Government’s plans for patient and public involvement in the NHS. As well as representation for patients on various national bodies, the key proposals involved the creation of new mechanisms at the local level. In summary, the new mechanisms for patient and public involvement and scrutiny proposed in the *NHS Plan* comprised of:

- the Patient Advocacy and Liaison Service (“PALS” -Trust employees to trouble-shoot on behalf of patients);
- Patients Forums (to involve patients directly in monitoring and discussing individual Trust services, supported by the Trusts’ PALS staff);
- a Citizens Panel (also described as a local advisory forum, to act as a “sounding board” for health authorities);
- and the introduction of formal scrutiny of the NHS by local authorities via their scrutiny committees (which would take on the power up to now vested in CHCs to refer contested service changes for consideration at a higher level).

It is not the intention of this dissertation to analyse the relative merits of the new proposals or of CHCs, but rather to examine the policy *process* and the

management of change. However, to summarise, the main arguments levelled at the new system have been the lack of independence of PALS and the Patients Forums which they would be responsible for; the fragmentation of the various roles so far carried out by CHCs across a number of different bodies; cost (which has been estimated at up to five times the cost of CHCs); and questions over whether elected councillors in local authorities can be as objective and independent in scrutinising the local NHS as CHCs, given the increasing trend for integration between health and social services. On the plus side, it has been argued that the involvement of elected councillors would fill the "democratic deficit" in the NHS; PALS would help resolve problems at the point of service, reducing the need for independent help provided by CHCs; and the other measures would distinguish more clearly between "patients" being directly involved in commenting on the services they receive and "citizens" with a more general interest in the efficient and equitable operation of the NHS.

In the whole of the 144 pages of the *NHS Plan*, just one sentence at the end of the tenth chapter is devoted to the new policy of abolishing CHCs.

"As a result (*of the new measures*) Community Health Councils will be abolished and funding redirected to help fund the new Patient Advocate and Liaison Service and the other new citizens empowerment mechanisms set out above."
(Department of Health, 2000, page 95)

As the results of the research recounted later in this dissertation confirms, the proposed abolition of CHCs came as a shock even to those who had been involved in discussions in the run up to the *NHS Plan*. As part of developing the *NHS Plan*, the Secretary of State for Health, Alan Milburn had established a number of "modernisation action teams" including one on patient and public

involvement. Membership of the teams was hand picked. A CHC officer was invited to the patient and public involvement modernisation team, but not an official representative of CHCs. Members of the team interviewed for this assignment confirm that abolition of CHCs was not discussed. (The Department of Health have refused to release any notes or reports of the work of the modernisation action teams, claiming confidentiality is important for the team members). A senior civil servant with responsibility for this area confided at the time (and confirmed when interviewed as part of this research) that he was "shocked" when he discovered abolition of CHCs in the final draft, as plans had already been drafted for "reforming them" (Civil Servant A, 2001). Ministers have subsequently referred to the pre-NHS Plan consultation exercise with the public as justification for not consulting on the proposal to abolish CHCs. However, the report on the consultation exercise (Office for Public Management, 2000) contains no reference to feedback which would seem to support the measures contained in the *NHS Plan*, and the summary of public feedback in the Plan itself does not mention the topic of patient and public involvement (Department of Health, 2000, Appendix 1). Therefore, the actual reasons and process leading to the change of policy remains somewhat of a mystery. As one of those interviewed for this research commented, theories seem to range from "cock-up" to "conspiracy".

At the third reading of the Health and Social Care Bill (HMSO, 2001), amendments were passed which would create "Patients Councils" to "co-ordinate" the work of patients' forums, and an "independent advocacy" service provided or commissioned by Patients Councils. However, as this chapter begun

by explaining, these amendments did not go far enough to win the confidence of the main opposition parties or the House of Lords. Although the House of Lords passed further amendments aimed at reforming and strengthening CHCs rather than abolishing them, these were not acceptable to the Government. Left without enough time to force the measures through before a general election, they opted instead for an Act with the abolition of CHCs removed. The newly re-elected Labour government, through a new Parliamentary Under Secretary of State with responsibility for this area of policy, published revised proposals in September 2001: *Involving Patients and the Public in Healthcare: a Discussion Document* (Department of Health, 2001), followed by *Involving Patients and the Public in Healthcare: Response to the Listening Exercise* (Department of Health, 2001a). Although accompanied by a much more positive tone (the document recognises much good work by CHCs and talks of their “replacement” as opposed to “abolition”), the new set of proposals contain no direct replacement for CHCs. Most of their functions are split up amongst a range of new bodies. Patients Forums are still proposed and an Independent Complaints Advocacy Service, but gone is the concept of a Patients Council agreed during the political debates. New proposals introduced are the Commission for Patient and Public Involvement – a national body for the various involvement mechanisms- and local “networks” of the Commission. These are staff-only branches of the Commission, intended to build capacity, outreach to local communities, and facilitate the co-ordination of the Patients’ Forums. Initial reactions to the proposals have been mixed and further controversial debates can be expected during the course of the *NHS Reform and Health Care Professions Bill* (HMSO, 2002).

Summary

The policy espoused in Chapter 10 of the *NHS Plan* has been the source of great controversy, particularly concerning the proposed abolition of CHCs. The Government had been forced to make substantial changes to their plans in an attempt to secure passage of the Health and Social Care Bill (HMSO, 2001), but were forced to remove some of the key elements, including abolition of CHCs, in order for the rest of the Bill, now the *Health and Social Care Act* (HMSO, 2001a), to be passed. The new Labour government's revised plans, encompassed in the *NHS Reform and Health Care Professions Bill* (HMSO, 2002), again contain the abolition of CHCs with no direct replacement, or the compromise measure of "Patients Councils" agreed during debates on the previous legislation. This remains a highly controversial issue at the time of writing.

This study will attempt to:

- analyse the development of policy regarding patient and public involvement and scrutiny in the NHS, with particular reference to policy regarding Community Health Councils
- research the views of different stakeholders (particularly Councils for Voluntary Service, but also CHC members and staff, a civil servant and members of the modernisation action team) over the effectiveness of CHCs, the policy process and future options for patient and public involvement
- critically discuss the Government's approach to policy development and change management in this area in the light of the research findings, and make recommendations

In the next chapter, the relevant literature covering theory in relation to patient and public involvement in the NHS, to policy development and change management is discussed in more detail. Literature produced in reaction to the *NHS Plan*, including discussion in the media is also analysed.

2. LITERATURE REVIEW

Introduction

The subject of patient and public involvement in the NHS has generated a lot of thinking and literature, particularly during the 1990's, however there is relatively little research or literature on CHCs specifically. It is important, in any case, for CHCs to be seen in the wider context of patient and public involvement and scrutiny. They are considered in terms of what they do and can bring to these pursuits rather than in isolation. It is also important in the context of this study to explore theory on the development and implementation of policy and change management. This review therefore deals with some of the key theoretical literature relating to these issues and focuses in particular on discussion of CHCs in the context of the development and implementation of policy on patient and public involvement in the NHS. Some research on the effectiveness of CHCs is identified and reviewed. Attempts were made at accessing data collected as part of the Government's pre- *NHS Plan* consultation exercise, and feedback received since its publication through the feedback section of the Department of Health's website and correspondence dealt with by the Department of Health. 250,000 responses were received to the pre-plan consultation and a report was produced on the results for the Department of Health by a firm of consultants (Broadata, 2000). However, the Department of Health did not publish this report. A copy was obtained in the course of this research, but it does not contain any reference to responses that indicate a desire to change the system of patient involvement, scrutiny or CHCs. The only other summary of what members of the public fed in via this exercise is contained in

an appendix to the *NHS Plan* and this does not mention anything regarding CHCs or the policy issues being explored here. The Department of Health also said that it was unable to provide details of what members of the public and others have said about these issues through correspondence since the Plan's publication or via the website. As part of this research the above information was formally requested, together with an explanation of how such data is presented for consideration as part of reviewing and developing policy. The Department of Health responded only that they had received a "substantial" number of representations about CHCs. However, it was possible to obtain a report produced by the Office for Public Management (Office for Public Management, 2000) covering the results of its fieldwork with stakeholders prior to the *NHS Plan*, which is reviewed for what contributors said about the issues under consideration here. Also, because the Welsh Assembly is empowered to develop its own policy in this area and it chose to conduct a consultation exercise specifically on the options, it has been possible to draw on the results of that consultation exercise. Finally, the reaction of various stakeholders to government policy on patient and public involvement, recent media coverage, reports and statements from patients' organisations, politicians, and debates in both Houses of Parliament are also discussed.

Policy Development, Implementation and Change Management

Walt (1994), Klein (1995), Ham (1999), and Hogg (1999) all stress the unique characteristics of developing and implementing policy in the field of health. Health, and particularly for the interests of this study, the NHS, are seen as things in which the population at large have a shared interest. Consequently,

governments usually exercise a responsibility for health policy generally and health services. Walt (1994) describes the tension between a "pluralist" approach to policy development – involving a wide range of stakeholders – as opposed to an "elitist" approach. In the latter, only senior politicians and civil servants have a significant say on policy. Ham (1999) describes a similar tension in terms of "pluralism" and "corporatism". Walt sees health policy falling mainly into the pluralist category, being subject to influence from a wide range of interest groups. Ham sees both trends apparent in the health policy process in Britain. However, there is no mistaking in either analysis the potential for influence from a variety of interests on health policy. Hogg (1999) and Hutton (2000) both argue that the theory of the NHS being accountable to the people it serves through the ballot box – through them being able to vote out the government who had been responsible for the NHS – is unrealistic. Although the NHS regularly features prominently in general election campaigns, there are too many factors determining the way people vote for this to be a meaningful way of influencing the way that the NHS is run. Although, as Ham (1999) describes, there are checks and balances designed into the British political system (such as Select Committees, the ability of individual MPs to ask questions, and the House of Commons and House of Lords themselves), there are limited opportunities for the public to influence policy or call policy makers to account. Hutton (2000) describes this as a "democratic deficit". As Ham (1999) observes ministers, particularly the Secretary of State for Health as far as the NHS is concerned can, depending on their personality, wield immense power. Their accountability is to the Prime Minister, Cabinet and ultimately Parliament. However, Hogg (1999) also points out:

“Though there is no tradition of democratic accountability or participation, managers have gradually taken on board that they need to consult and find out the views of ‘customers’ in order to make sure services are appropriate and acceptable to them.”

(Hogg, 1999, page 84)

It is interesting to compare how the process of developing and implementing policy in the NHS with approaches to change management. It can be argued that the two are part and parcel of the same thing – that although policy in the NHS is subject to politics and the influence of many different stakeholders, it is essentially about bringing about desired change successfully. McCalman and Paton (1992) see change management as comprising of four key layers of what they call “perpetual transition management” – the TRIGGER LAYER; VISION LAYER; CONVERSION LAYER; and MAINTENANCE and RENEWAL LAYER:

“Change is about identifying triggers, seeking vision, recruiting converts to the vision, and maintaining and renewing the need for change on an ongoing basis”
(McCalman & Paton, 1992, page 217).

In varying degrees, most other theorists have developed a similar way of describing change. For example, Burnes (1992) describes nine elements, starting with “Creating a Vision” and progressing to “Continuous improvement”. Hussey (1998) describes six stages, starting again with “Envisioning” and ending with “Ensuring”. These are all developments from earlier action research models and which Lewin (1952) developed in his three-step model of organisational change, encompassing “UNFREEZING”, “MOVING”, and “RE-FREEZING”. All build on Lewin’s theory by introducing the notion of perpetual change as opposed to the more static “re-freezing”. Of most interest

for the purposes of this dissertation are the earlier stages, and in particular "the vision".

Hussey describes vision as providing

"a view of what the organisation will be as a result of the action and clarity about why the change is necessary to take the organization towards achieving that vision."
(Hussey, 1998, page 69)

Kanter says that vision

"must be both challenging and realistic, based on an assessment of that particular organisations strengths and traditions."
(Kanter, 1983, page 306)

Robbins and Finley (1998) warn of the danger of vision statements being rendered relatively meaningless by being too vague. Hussey (1998) says that clarity is needed not only of what the vision is, but also how it is arrived at.

McCalman and Paton (1992) are quite explicit about a "trigger layer" involving the process of analysing strengths, weaknesses, opportunities and threats, preceding the formation of a vision, whilst others see this as part of the "envisioning" process itself. Nonetheless, according to any of the theories it would be reasonable to expect some form of "SWOT" analysis or "PEST" analysis – looking at political, environmental, social and technological factors before embarking on a programme of organisational change. In many cases a force-field analysis would be a useful way of assessing pressures for and resistance to change.

All theorists studied for this assignment seem to agree that in preparing an organisation for significant change, involvement or empowerment of stakeholders (especially internal stakeholders) is important. For example:

“Possibly one of the most fundamental steps in achieving the successful implementation of change is that of obtaining a shared perception amongst those affected, concerning their view of the issues and implications associated with change.”
(McCalman and Paton, 1992, page 23)

“Levels of resistance will inevitably be higher if the levels of involvement and information are low.” (Plant, R., 1987)

Burnes (1992) attempts to construct a framework indicating the level of involvement that might be desirable, according to the nature of the change envisaged. The more change necessitated in individual behaviour he argues, the greater the need for involvement. Hussey (1998) argues that it is a fallacy to assume that involvement of those affected by change necessarily results in a smoother, more successful implementation of change. He identifies circumstances in which involvement is not practicable, for example in a crisis situation where there is insufficient time; and where resistance to the proposed change is fierce and “too much discussion can actually reinforce resistance”.

These theories will be tested in the discussion part of this dissertation against the process for developing and implementing the proposed changes of policy in respect of patient and public involvement and CHCs.

Patient and Public Involvement and CHCs

CHCs are just one component in a wider system of scrutiny and engaging with patients and the wider public – of addressing the “democratic deficit” referred to above. Webster (1998) recounts how CHCs were created through the 1973 NHS Reorganisation Act “in order to give some compensation to the public for the reduction in local accountability of the management structure”. Although 50% of CHC members are nominated by local authorities, the taking away of locally elected representation on area health authorities was seen by many as still representing a reduction in local accountability. The role of local authorities vis a vis the NHS has been a recurring theme ever since, with some commentators, for example Klein and Lewis (1976), and Cooper et al (1995) asking whether local authorities should not be given full responsibility for local health services. This recurrent concern to address the so-called democratic deficit resulted most recently in the apportioning of responsibility for scrutiny of the local NHS to local authority “overview and scrutiny committees”. This was first proposed in the *NHS Plan* and was formalised in the *Health and Social Care Act* (HMSO, 2001a).

Another recurring theme which perhaps has had a bearing on what the Government eventually proposed in the *NHS Plan* and most recently in *Involving Patients and the Public in Healthcare* (Department of Health, 2001), is the drawing of the distinction between “patients” and “citizens”. Most notably, Cooper et al (1995) articulate this distinction. “Patients” as actual users of the service having particular perspectives based on their direct experience and needs. The general public as “citizens” on the other hand, have a right to have a

say in how public services paid for by their tax payments are managed. Cooper et al argue that patients' views are more likely to be skewed by their individual needs, whilst citizens may be more objective and be able to weigh individual needs up against the effect on the wider population. This was becoming increasingly important in the context of the need to "ration" health services because of limited resources. In the *NHS Plan* the distinction is embodied although not clearly articulated in the replacements for CHCs. *Patients Forums* were to focus specifically on trusts' services, drawing on the experience of current or recent patients and *Patient Advocacy and Liaison Services* would deal with patients' specific concerns at the point of service delivery. Meanwhile, the views of citizens would be harnessed through an "Independent Local Advisory Forum" or "Citizens Panel" or represented by local councillors on "overview and scrutiny committees". In the revised proposals by the Department of Health (2001) citizens' views would be sought out by specialist staff in new bodies called "Local Voice".

Klein and Lewis (1976) describe how the creation of CHCs was somewhat of an afterthought:

"They were invented almost by accident because, when the plans for the reorganised NHS were almost complete, all those involved realised something was missing: an element which could be presented as providing a degree of local democracy, consumer participation or public involvement in the affairs of the NHS."

(Klein and Lewis, 1976, page 11)

Most commonly described as local NHS "watchdogs" and the "patient's friend", CHCs were the most significant attempt yet made to give local people a say in decisions about the local NHS and make local NHS organisations more accountable to the communities they served. As discussed in the introductory

chapter, a number of commentators have questioned how effective a means of delivering local involvement and accountability CHCs have been (Ham, 1995; Klein, 1995; Iliffe and Munro, 1997). As early as 1976 (two years after the creation of CHCs), Klein and Lewis (1976), in the most substantial discussion of CHCs this review of the literature was able to find, were already questioning whether they were an experiment with which it was worth continuing. However, what is most notable is the dearth of evaluation or evidence to support one view or another about CHCs. In *Patients First* (DHSS, 1979) doubts were expressed about whether CHCs were worth their salt and this consultative document floated the idea of their abolition. Levitt, Wall and Appleby (1995) point out that the results of the consultation showed “widespread and somewhat unexpected support for CHCs” and they were retained (page 21). The Royal Commission on the National Health Service (1979) concluded:

“In our view CHCs are an experiment which should be supported further.”

(page 159)

From the time of this first “escape”, CHCs have remained a familiar part of the NHS landscape. Whenever there has been a reorganisation of the NHS there have been rumours that something radical might happen to them, but very little has. For example, Hogg (1999) recounts how CHCs were considered under threat as a result of the introduction of general management in the 1980s (due to a perception that managers would be able to represent patients’ interests), and the 1990 reforms with the creation of the purchaser – provider split in the NHS led many to conclude that health authorities could act as “champions of the people”.

Responsibility for CHCs rests ultimately with the Secretary of State for Health and the regional offices of the NHS Executive (previously, Regional Health Authorities) are responsible for their performance management. However, the different regions have always had an inconsistent approach to CHCs (ACHCEW, 1999). In recognition of the inconsistent approach to resource allocation and performance management of CHCs the Department of Health commissioned a management consultancy firm, Insight, to come up with suggestions for a more consistent approach. Their report (Insight, 1996) was controversial because it seemed to go beyond its brief and make recommendations for changes to the roles of CHCs. It recommended that CHCs should scale down their complaints work (something which they were never statutorily required to do or funded for) and move away from their "general" monitoring of the local NHS and work on specific pieces of work agreed with the health authority in their area. As Barnes (1997) points out, this did not go down well with many in the CHC movement, where their independence from health authorities is much prized. As part of their role of monitoring the NHS, CHCs monitor (and often challenge) the policies and decisions of health authorities. When it was distributed, the Insight report was accompanied by a letter from the Department of Health distancing themselves from the controversial recommendations and reaffirming that the independence and complaints advocacy role of CHCs were valued. The new Labour Government was quick to reject its recommendations.

However, Insight (1996) did underline the extremely diverse range of activity that CHCs are engaged in with very modest resources. Barnes (1997) was not

the first to point out that this caused some confusion as to what the main roles of CHCs were and should be in the future. This was emphasised by the inconsistent degree of priority which CHCs across the country attach to their various roles, she argues. (Some CHCs for example do not provide a complaints advocacy service to the public, or choose to focus their monitoring activity on very specific areas). The same point is articulated by Hogg (1999) and Hutton (2000). The inconsistency of approach and very wide remit of CHCs has also been perceived by some in the CHC movement as weaknesses. Dabbs (1998) advocated relinquishing the complaints service and the honing down of CHC roles to one of four options:

- Independent monitoring/scrutiny of service provision and commissioning
- Facilitation and coordination of lay involvement and participation in service provision and commissioning
- Independent monitoring/scrutiny of public health/health improvement
- Facilitation and coordination of lay involvement and participation in public health/health improvement

(Dabbs, 1998, page 9)

Apart from the early work by Klein and Lewis (1976) there has only been one serious attempt to evaluate CHCs which has been identified as part of this research. *An Evaluation of the Role and Effectiveness of Community Health Councils* (Buckland, Lupton, and Moon; 1995) drew on interviews with CHC staff and members, interviews with NHS purchasers and providers, and street surveys of members of the public. The report identifies different kinds of approach adopted by CHCs (for example, *Patients Friend; Health Authority Partner; Consumer Advocate; Independent Arbiter and Independent Challenger*). There was found to be varying perceptions on the part of NHS

managers of the effectiveness and usefulness of CHCs' contribution according to the kind of style adopted by the CHC. Not surprisingly, perhaps, the *Independent Challenger* style was the least appreciated by NHS managers. However, in spite of the growing trend for consumer views to be sought from a variety of means as opposed to relying on CHCs and the espoused role of health authorities as "champions of the people", NHS managers were found to be reasonably positive about the ongoing role of CHCs. The report points out that the two major criticisms made by health authorities about CHCs appear to be contradictory. On the one hand they are criticised for being too well informed (i.e. not "representative" of the public). On the other hand, they are criticised if they are not perceived to be "professional" enough or sufficiently well informed. Although needs for greater resources, training, consistency, and changes to structure and methods of appointing members are identified by both NHS and CHC respondents, no views are expressed to the effect that the *role* of the CHC was in any way redundant.

Buckland, Lupton and Moon (1995) rely very heavily on the comments of the NHS managers in health authorities and NHS trusts. Whilst a valuable insight into how CHCs are perceived by the "establishment", it can be argued that NHS managers' views of CHCs need to be treated with caution. After all, it can be seen as in NHS managers' interests and a natural human reaction to seek to question the credibility of an organisation which is critical of one's own work. As the authors point out, following the introduction of the 1990 reforms, CHCs were to monitor purchasing activity of health authorities as well as the provision of services by trusts. Given the "champions of the people" tag given to health

authorities following *Local Voices* (NHSME, 1992), there is also the potential for rivalry between health authorities and CHCs. As an evaluation of the role and impact of CHCs, the authors should perhaps have put more emphasis on establishing the views of those whose interests CHCs are supposed to represent. A street survey of 400 members of the public was carried out, which established low public awareness of CHCs (only 2.5% of respondents mentioned CHCs as an organisation that represents the views of the public to the health authority). Although this low awareness is in itself a potential cause for concern, the authors point out that few members of the public take an active interest in Health matters until they are directly affected. It may have been useful to incorporate the views of those members of the public and voluntary organisations who did have knowledge of the CHC in the evaluation. Although the methodology included interviews with officers of Councils for Voluntary Service (voluntary organisation umbrella groups), the results are not reported on. This was a potentially useful source of feedback on the effectiveness of CHCs from an independent and relatively well-informed source. This research will draw largely on feedback obtained from an extensive survey of Councils for Voluntary Service.

Apart from Buckland, Lupton and Moon (1995), what attempts at evaluation there have been seem to have been generated by people in the CHC movement themselves. *At The Crossroads* (Dabbs, 1998) was written by a Chief Officer of a CHC, as was *Reflecting the Public Interest* (Rolfe, Holden & Lawes, 1998). Both attempt come up with a future strategy for CHCs in the wake of the tide of change sweeping the NHS following publication of *The New NHS; Modern,*

Dependable (Department of Health, 1997). Both also comment on the effectiveness of CHCs. Dabbs states as a primary objective "to review the effectiveness of CHCs" as well as "to develop options for the future" (Dabbs, 1998, page 3). However, whilst his methodology included "consultation with CHC members and staff in England and Wales (seminars, workshops, questionnaires, correspondence), and communication with other informed people and organisations", there is no analysis or examples of feedback given to support his conclusions. No attempt was seemingly made to ask the recipients of CHCs services (patients and the public) what they thought. Again, Rolfe, Holden, and Lawes (1998) put forward persuasive arguments for change and innovative ideas, but provide little or no analysis or examples of the evidence leading them to their conclusions about the effectiveness of CHCs. (Although results of the "evaluation framework" developed by CHCs in south-west England and which takes in the views of various stakeholders is cited as a source). Similarly, a report commissioned by the NHS executive, Institute of Health Service Management and the NHS Confederation on public participation in the NHS, *In the Public Interest* (Bridge Consultancy, 1996) was critical, without citing evidence, of a lack of focus and inconsistency amongst CHCs. Nonetheless, there is enough consistency in what a variety of commentators have to say to begin to identify two consistent themes about perceptions of CHCs: the perceived variability in individual CHCs' effectiveness, and the potential for lack of focus because of their very wide ranging roles.

Although there appears to be widespread agreement on the variability of CHCs and a need to reform them in some ways to bring them more up to date with

other changes in the NHS since 1974, this review of the literature has been unable to identify any formalised views that, in essence, CHCs are not still a good idea or that they should be replaced wholesale. (Apart from the *NHS Plan* itself). CHCs came up with their own ideas for modernisation in *Old Watchdog, New Tricks* (ACHCEW, 1999). This signalled a willingness to change with the times, introduce stronger performance management arrangements to iron out inconsistency, and called for more powers and resources to help CHCs be more effective. The Health Select Committee (1999) had called for the allocation of a health advocate to each CHC recognising how valuable the role most CHCs perform in this regard is, but that CHCs had never been resourced or required to perform this function. The independent commission established to look into the issues of public interest and accountability in the NHS (Hutton, 2000), whilst being appreciative of the important role played by CHCs, was under no illusions about the need to reform and strengthen them and even produced a "blueprint" for going about it. However, both Hutton (2000) and Hogg (1999) also point out that an additional challenge CHCs have had to face has been the defensiveness and sometimes antagonism of some NHS managers (and politicians) as a result of them representing the public interest forcefully within the system.

"There has been an ambivalence and often hostility in government and managers' attitudes to CHCs, which illustrates the intrinsic difficulties of participation. Intellectually it is easy to appreciate the importance of participation and how this will lead to better decision-making in the long term. In the short term, however, it is time-consuming, messy, challenging and can delay or destroy best-laid plans."
(Hogg, 1999, page 92).

As will be seen from some of the reactions to the plan to abolish CHCs, it is precisely this intrinsic difficulty of dealing with consumer representation when

it does not come up with what the establishment wants to hear, that some have concluded led to the decision to abolish CHCs.

Unfortunately, as explained above, it has proved impossible to access information from the Department of Health which may have shed important light on the rationale for development of policy in this area and reactions to the Government's plans to replace CHCs with a range of new initiatives. However, it was possible to access a report produced for the Department of Health by the Office for Public Management – *Shifting Gears; Towards a 21st Century NHS* (Office for Public Management, 2000). This summarises the results of the two stakeholder conferences, ten focus groups and twenty four telephone interviews which OPM carried out in the run up to the *NHS Plan*. Topics explored included "patient empowerment". The key message regarding this was that:

"A more coherent approach should be taken towards patient, carer and public involvement at a policy level."
(Office for Public Management, 2000; page 6)

None of the discussions seemed to indicate serious concerns about the role of CHCs or views that they were no longer needed. On the contrary, the limited specific mention of CHCs (from stakeholder interviews) seems to be in the context of an anticipated developing role for them, and to echo the above call for more a more coherent approach, which includes CHCs:

"The role of Community Health Councils and others monitoring standards across agencies needs to be clarified."
(Office for Public Management, 2000; page 47)

The Welsh Assembly has devolved responsibility for this area of policy, and decided rather than follow the English lead, to consult the public and other stakeholders directly on future options for patient and public involvement, including CHCs. The response to the consultation was collated for the Assembly by an independent consultant (Scowcroft, A., 2001). It showed support for one of the new ideas from the *NHS Plan* – “patient support officers” – a Welsh version of the English “patient advocacy and liaison service” or “PALS”. However, whilst this was seen as a useful trouble-shooting role it was not seen as in any way a substitute for independent advocacy or complaints support. Most striking about the feedback from this consultation was the strong and consistent support for retaining and strengthening CHCs:

“A common thread passing through all of the types and sources of responses was support for CHCs with a need to clarify and legitimise their remit.”

(Scowcroft, A., 2001; paragraph 44)

CHCs in England and Wales share the same national association and there is nothing to suggest that CHCs in Wales should be more or less effective or highly regarded than those in England. Nor does there appear to be an obvious reason why the Welsh public and other stakeholders’ views on the key principles of patient and public empowerment should be radically different from the English.

In England, there has been no similar consultation and it is therefore more difficult to be as precise about the public and other stakeholders’ views of the patient and public empowerment proposals and CHCs. However, it is possible to

draw some conclusions from reactions to the *NHS Plan*. Although the Department of Health has been unable or unwilling to provide details of the correspondence it has received about the plan to abolish CHCs, a civil servant (Civil Servant B, 2001) did confirm to the author verbally that “a large number – probably thousands” of letters expressing concern over the abolition of CHCs had had to be responded to (by standard letter) by the Department. Just after the *NHS Plan* had been published the Health Service Journal, a widely read journal amongst NHS managers, conducted an online opinion poll asking the question “*Do CHCs deserve to be abolished?*” (reported in ACHCEW, 2001). The result showed 89% answering “no” to the question. Although crude, the result is significant, particularly bearing in mind that the Health Service Journal’s readership is mainly NHS managers and clinicians who may be the subject of criticism by CHCs, or even see themselves as in competition with CHCs, as discussed above. The same journal, often said to be critical of CHCs in the past, ran an editorial headed “Present Imperfect, but better than Future Ghastly” which was heavily critical of the plan to abolish CHCs (Health Service Journal, 2000). A number of other important stakeholders have also put on record their disagreement with the proposal to abolish CHCs or advocate their strengthening or reform instead. The Association of CHCs in England and Wales have compiled an impressive list of “statements of support” (ACHCEW, 2001). This includes statements not only from voluntary organisations and patients’ groups, but also the Chairman of the British Medical Association, and most recently a motion passed by a majority of 95% at the Royal College of Nursing Annual Conference (23rd May, 2001), which “condemns” the abolition of CHCs and calls for a national debate (ACHCEW, 2001).

In conclusion, most of the literature that exists on CHCs tends to be in the form of commentary as opposed to research based. Where evidence has been collected about CHCs and their perceived effectiveness, they tend to be from NHS managers or CHC staff and members. There has been very little attempt up to now to elicit the views of informed and independent stakeholders – particularly local stakeholders - as to how well CHCs perform their role of representing the public interest. This is an area where this research attempts to make a useful contribution. No evidence or arguments were found to suggest widely held support for the view that there was not still a legitimate and important role for CHCs to perform. Indeed, reactions to the proposal to abolish CHCs in England appear to indicate widespread divergence from that view. Where the public and other stakeholders' views have been directly sought, for example in Wales, there appears to be strong and consistent support for a continued and evolving role for CHCs as part of a wider, coherent strategy for patient and public empowerment.

However, there is strong consistency within the literature over a number of key themes:

- Inconsistency between different CHCs, and the lack of enforceable standards or quality control
- The need for more resources for CHCs to improve effectiveness, and for changes to the structure and appointment of members
- A possible need to redefine or limit the functions of CHCs
- A perceived need to “overhaul”, “reinvigorate”, “reform”, “strengthen” or” CHCs

Summary

This chapter has reviewed some of the key literature regarding health policy development and implementation, and change management. This will provide a starting point for further discussion of the roles of consultation, involvement and visioning in the development and implementation of health policy, with particular reference to CHCs. Some of the key theoretical themes behind the wider issues of patient and public involvement have been explored, and a detailed look taken at what literature exists on CHCs themselves. It was identified that the themes of addressing the “democratic deficit” in health and distinguishing between “patients” and “citizens” seems to have been picked up in the Government’s new proposals for patient and public involvement. However, both the literature on CHCs and the response generated to the proposed abolition to them suggest that whilst there is variation, the *roles* and the *concept* of CHCs are still highly regarded. These theories and findings from the literature review will be explored further in the discussion part of this dissertation, in the light of the results from the research undertaken.

The next chapter looks at the chosen methodology for this study. It will be seen that an attempt is made here to fill a “gap” in the literature and research so far (and indeed the government’s policy process in this area) by seeking the views of informed and independent local stakeholders who, it is argued, are in a better position than most to comment on the effectiveness of CHCs and the proposed new mechanisms.

3. METHODOLOGY

The literature review for this study established that very little research had been carried out on the effectiveness of CHCs at all. Furthermore, what research there was tended to concentrate on the views of NHS professionals or CHC members and staff. What is more, the process of developing policy on patient and public involvement and scrutiny in the NHS resulting in the plan to abolish CHCs did not appear to have taken account of the views of patients or the public (this is discussed further in chapter 5). A glaring gap seemed to be research which could help answer the questions:

- *What do the people and communities whose interests CHCs are supposed to represent think about the effectiveness of CHCs? And,*
- *How would they like their interests to be represented in the New NHS?*

A full-scale public consultation on these issues, although an option for the Department of Health, was clearly beyond the capacity of a study of this size. Consideration was given to using one or more "citizens panels" which exist in many parts of the country. These panels are made up of a representative sample of the local population, usually comprising around 1,000 individuals. They are usually administered by a local authority or a health authority. This method was eventually ruled out for a number of reasons. Firstly, the questions put to these panels are ultimately the decision of the body that administers them. Although it may have been possible to identify an authority to agree to submit questions designed for this study, there would be a charge which made it unfeasible and the timescale of the questions going to panels could not be guaranteed to coincide with the timetable for this study. There is also the difficulty of asking fairly specialised questions to a general public who it is established usually

become interested in health only when directly effected, and whose knowledge of CHCs is very low (9% "had some idea of the work of CHCs" in Buckland, Lupton and Moon's study; 1995). Nonetheless, this method may prove useful in some future study of public attitudes to the more general issues and principles.

For the purposes of this study it was decided instead to seek the views of chief executives of Councils for Voluntary Service ("CVS"). One of the roles often carried out by voluntary organisations is to represent the interests of their members or service users. CVS act as local umbrella groups for voluntary and community organisations, often covering the same or similar geographical areas as the corresponding CHCs. CVS are entirely independent of the NHS and of CHCs and often play an important role, alongside CHCs and other voluntary organisations in representing local communities and service users in local planning systems for health and social care. It was assumed that most CVS would be reasonably aware of CHCs and the policies set out in the *NHS Plan* for patient and public involvement and scrutiny. CVS are usually the bodies with which the NHS Executive contracts to run the voluntary sector elections for members of CHCs. (One third of CHCs' membership is elected by their local voluntary sector). The "Modernisation Action Teams", including one on "patient empowerment" were set up by the government as part of the process leading up to the *NHS Plan* and included representatives from national voluntary organisations. However, there was no representation for local voluntary organisations. The Government's proposals for involvement at a national level have been almost universally welcomed, whereas as discussed above, the proposals for the local level have been highly controversial. Tapping into this

local knowledge and expertise seemed to be a practical and helpful contribution that this study could make to the development of policy which could enjoy public confidence. A questionnaire-based survey was conducted which is described in more detail below.

Whilst the survey of CVS will provide useful feedback about CHCs and indications of what options still being considered for patient and public involvement and scrutiny are most preferred by local voluntary organisations, there was also a need to understand more about the process of policy development and change management which had led to the current situation. It was hoped that this study might then begin to be able to answer the questions:

- *To what extent were stakeholders involved in the development of this policy? And,*
- *What did the process look and feel like for the people directly affected, and what has been the effect on their ability to deliver change/modernisation?*

For this, it was decided to hold a number of structured interviews with CHC chairmen and chief officers. This, it was hoped, would not only be useful in gauging their opinion about future options, but would elicit information about the effect that the process had had on them, their willingness to embrace change, and their motivation to continue to make a contribution in this field of work. It was felt that interviews would provide the best way of exploring these kinds of issues.

In addition, it was possible to conduct interviews with a civil servant and two people who had been involved in helping develop policy in this area before the *NHS Plan* as members of the modernisation action team, and the Director of the national association of CHCs. These interviews provide valuable insights into the process of policy development in the run up to the *NHS Plan*. The interview part of the study is described in more detail below.

Because the author of this study is employed in a CHC and actively involved in the national association of CHCs, access to certain individuals was easier than it might have been. The costs of the survey (address labels, copying, postage, envelopes) could also be met from the author's CHC budget as the work was relevant and the CHC was sponsoring the author's study for a Masters Degree in Business Administration (MBA) anyway. The results of the research would be shared with the CHC, the national association and the Department of Health. However, the study was conducted independently by the author as an individual rather than "on behalf of" any particular body. The independent nature of the study and also the author's affiliations were made explicit in all dealings with people approached about the study.

Questionnaire-based Survey

The questionnaire used and the accompanying letter are attached as Appendix 1. As separate arrangements for patient and public involvement and scrutiny in the rest of the United Kingdom, only CVS in England were targeted. This meant

writing to 350 CVS, whose addresses were obtained from the National Association of Councils for Voluntary Service.

It was decided to ask questions that were directly relevant to current debates in this area of policy so that the study could make as useful a contribution as possible. The issues currently being debated were : What should become of CHCs? How should the new responsibility on the Secretary of State to ensure the availability of "independent advocacy" be delivered? Whether, and if so how, should the concept of "patients forums" be taken forward? In order to throw light on these questions it was decided to seek views on the effectiveness of CHCs in their three main areas of activity, and to ask directly whether the respondents favoured "reform" of CHCs, their "abolition" or the status quo. Up to this point the Government and Department of Health had not been prepared to enter into debate on these issues (apart from in the Houses of Parliament), and as has been discussed, little or no research evidence exists on the effectiveness of CHCs as perceived by the communities they serve. As legislation had been passed to give local authority "scrutiny committees" a new role in scrutinising the NHS, it was also necessary to ask whether this development replaced the need for a "watchdog" body such as CHCs. With "patients forums" a key debating point was whether they should be completely separate bodies or organised along the lines that CHC sub-committees presently are, thus requiring fewer members and coming together to share an overview of the health economy. A major concern was over the feasibility of attracting substantially more volunteers to join the proposed new forums than are currently required for CHCs, when there are significant problems in filling CHC membership

vacancies in some areas. As CVS are involved in voluntary sector elections to CHCs, and are experts in voluntary activity and organisation, it was decided to ask their opinion as to which kind of organisation would be more likely to attract voluntary members. With the independent advocacy, the key debating point was whether this service should be commissioned (most probably by the new strategic health authorities) or provided by CHCs (or their successors). (A Government amendment to the *Health and Social Care Bill* (HMSO, 2001) had seen this service being provided by "Patients Councils"). These options were put in the form of a question on the questionnaire.

As this study is concerned also with the process of policy development and change management, it was decided to take the opportunity to ask respondents how much consultation there had been on these policies with local voluntary organisations, and whether they perceived that public confidence had been strengthened or weakened as a result of the process. Rebuilding public confidence in the NHS had been one of the Government's main objectives in these reforms.

Advice was sought and obtained on the content of the questionnaire from contacts in the Kings Fund and the Association of CHCs in England and Wales. The questionnaire was then piloted with a local CVS. On the basis of the advice and the one pilot going so successfully, it was not considered necessary to conduct a wider pilot of the questionnaire. The questionnaires were mailed out during the last week of July 2001 with a cut off date for responses set for 31st August 2001. The results were to be analysed early in September 2001.

It was originally planned to follow up CVS who had not responded to the initial mailing in order to improve the response rate. However, because during the course of the survey the Government published its discussion document (Department of Health, 2001), it was felt that this might cause some confusion. It was decided that the initial response rate was sufficient for the purposes of the study.

Interviews

Structured telephone interviews were held with four chief officers and three chairmen of CHCs. These interviewees were selected using two basic criteria: that they were not personally well known to the author; and that they covered as wide a geographical spread across England as possible. The Director of the national association of CHCs ("ACHCEW") was interviewed in person. The questions for the structured interviews are attached as Appendix 2. One chief officer asked to have their anonymity protected. The questions were designed to elicit the following information:

- *Respondents' views about the process of policy development and change in the field of patient and public involvement and scrutiny and its effect on their motivation to contribute to future development*
- *Their views about options for patient and public involvement then under consideration*

Interviews were also conducted by telephone with a civil servant, and two people who had participated in the modernisation action team on patient and

public empowerment in the run-up to the *NHS Plan*. The civil servant and one of the members of the modernisation action team requested to have their anonymity protected. The aim was to gain:

- *Information about the process leading to the policy to abolish CHCs*

In all the case of all the interviews, the interviewees were contacted first of all by telephone and given a verbal explanation of the nature of the research before obtaining their approval.

Problems with the Methodology

Questionnaire-based survey

The issues under discussion are fairly complex, so that although a basic awareness of the issues could be expected, sometimes-lengthy pre-amble to the actual questions was required. Although there is a strong case for CVS chief executives being a fairly accurate barometer of local community organisations' perspectives on these issues, as discussed above, they were responding individually and views may be personal/subjective. In some respects the respondents are asked to give a personal perception on what "the public" reaction to the issues would be. Although valuable, these perceptions need to be seen in context and not be taken necessarily as reflecting "public" opinion. As discussed above, seeking public opinion about these issues was beyond the scope of this limited study. There is potential for further research in this area. The use of "citizens' panels" for example, or focus groups to explore particular issues.

As mentioned above, the publication of the Government's discussion paper (Department of Health, 2001) led to a decision not to follow up non-respondents in case this caused confusion, but the response was considered sufficient, in any case. Response may also have been adversely affected by the timing (during August, when many people are away).

Interviews

The number of interviews conducted with CHC members and staff was too small to provide conclusive evidence in themselves of views from CHCs across the country. However, interviewees were chosen from a range of geographic regions, each interviewee was in touch with networks of CHCs in their region and were asked how representative their views were. As the views expressed are so consistent and were also confirmed by the national association of CHCs and by discussion at national and regional events involving CHCs at which the author himself has been present, the author is confident that the views expressed are broadly representative.

The interviews with the civil servant and members of the modernisation action team were not intended to provide representative samples, but specific insight to processes and events.

A number of interviewees expressed unease about the political sensitivity of the issues being explored and some asked to have their anonymity protected. It is possible that interviewees may have been cautious with their answers.

Potential Bias

Although every attempt has been made to maintain the objectivity and independence of the research, the fact that the author is employed in a CHC may have effected the way that some respondents responded. There was a danger that respondents to the questionnaire survey may have felt that a "pro-CHC" response may have been expected or desired. However, it was attempted to avoid this perception by careful wording of the questionnaire and the accompanying letter, and there is no indication from the responses received that they were influenced in any way. In the case of the interviews, it could be argued that the interviewees might have a bias towards the CHC movement's official position on the issues in question. However the approach to the interviews attempted to elicit objective individual responses, and these responses will also be analysed in the context of where they came from and other evidence collected. The CHC interviewees were selected so that they were not personally well known to the author.

One other area where a potential for bias was identified was in the questionnaire for CVS. In some parts of the country there is overlap in the voluntary sector and CHCs' roles in representing community interests to the statutory bodies responsible for health and social care and potential for a degree of "rivalry". Also, as regards the question about how the independent advocacy should be delivered, as the voluntary sector (and CVS themselves) are potential bidders should the service be put out to tender by health authorities, there was potential for bias in responses to this question. However, the potential for bias is not

considered significant and there is no indication from the responses that there was significant bias.

Summary

This section described the methodologies used for this research, which comprises of a postal questionnaire survey of chief executives of Councils for Voluntary Service, and interviews with a range of stakeholders. From the questionnaires it was hoped to elicit the views of well informed people from localities across England as to the perceived effectiveness of CHCs and views about the new proposals and whether they replace the need for bodies such as CHCs. From the interviews it was hoped to learn more about the actual process of policy development that was followed by some key players, and to obtain personal perspectives from those involved of the change management process, how it has affected them, and their views about the new proposals for patient and public involvement. The steps taken to avoid potential bias and the limitations of the chosen methodology have been described. Further research utilising focus groups and possibly citizens' panel surveys are suggested.

The next chapter turns to the results of the research, where any further problems, for example with the way that individual questions were interpreted are dealt with.

4. RESULTS

Introduction

As has been described, the primary research comprised of two key elements – a postal survey of councils for voluntary service and a series of interviews with individual stakeholders. The total number of responses to the survey was 142, representing a response rate of 40%. The following results tables give the details of the answers received to the questions as they were asked in the questionnaire, under the theme of the question. Percentages have been rounded up or down to the nearest percentage point. The results of the nine interviews are also presented under the same thematic headings where they relate to the same issues. The questionnaire and accompanying letter are reproduced in Appendix 1. The standard questions used in the interviews are presented in Appendix 2.

Effectiveness of Community Health Councils

Most respondents to the survey of councils for voluntary service (see table 1 below) felt that CHCs have been effective in their three main roles. However, whilst the figures for perceived effectiveness in the roles of scrutinising the NHS and seeking improvements (question 1a) and of providing support to individuals (question 1c) are almost identical (68% and 67%), only 52% felt CHCs had been effective in involving local people in debates about local services and policies.

TABLE 1: Effectiveness of Community Health Councils

Question: "Based on what you know of Community Health Councils (CHCs) in your area, do you consider CHCs to be effective in the following roles":

A) Their 'watchdog' role of scrutinising the NHS and seeking improvements for local people:

EFFECTIVE	n=96 (68%)
NOT EFFECTIVE	n=30 (21%)
DON'T KNOW	n=14 (10%)
DID NOT ANSWER	n=2 (1%)

B) Their role in involving local people in debates about local services and policies:

EFFECTIVE	n=74 (52%)
NOT EFFECTIVE	n=51 (36%)
DON'T KNOW	n=12 (9%)
DID NOT ANSWER	n=5 (4%)

C) Their role in providing independent support to people concerning their rights or addressing a problem or complaint about the NHS:

EFFECTIVE	n=95 (67%)
NOT EFFECTIVE	n=17 (13%)
DON'T KNOW	n=29 (20%)
DID NOT ANSWER	n= 1 (<1%)

Whilst a large majority of the comments offered on the questionnaires were positive about CHCs, they also mirror the variety of respondents' views about CHCs around the country and suggest that perceptions of, or actual effectiveness of CHCs, may have a lot to do with the personalities and relationships developed by individual CHC staff and members. For example:

- *"CHCs appear to vary considerably across the country"*
- *"They are reliant on the staff employed and relationships they develop"*
- *"Effective because of personalities of individuals involved"*
- *"Problems with chief officer and council members"*
- *"Personality based more than anything"*

Where respondents perceived weakness or "ineffectiveness" of CHCs and offered comments as to why, these broke down into a small number of common areas such as:

- Lack of staff or resources
- Insufficient powers
- Individual personalities involved
- 'Politicisation' by council appointed members
- Lack of publicity / awareness of CHCs
- Not representative of local community
- Apathy of local people

Stakeholders who were interviewed were also asked about their views on how effective CHCs have been overall. None of the nine interviewees expressed an opinion that CHCs had been ineffective overall. Three interviewees (two CHC members and a CHC chief officer) felt that CHCs had been "very effective" and the other six were more qualified in their assessment of CHCs' effectiveness. The common strains amongst the comments made were the inconsistency of effectiveness between individual CHCs and their effectiveness and achievements needing to be seen in the context of their very limited resources and the lack of support and powers provided to them in the exercise of their responsibilities. For example members and officers of CHCs themselves commented:

I think they have been very effective, but hampered by their limited remit and lack of resources (Shortland, A.)

They have been modestly effective, but could have been more effective in reaching the wider public and hard to reach groups. There was some resistance from the establishment to allowing CHCs to be too powerful. (Furr, B.)

Given the lack of resources and modernisation over the years, they have done a bloody good job. I didn't realise until the reaction to the abolition announcement just how appreciated CHCs were. Everyone has been so supportive. (Richards, T.)

It has been mixed, not brilliant, but CHCs filled a void and there have been a lot of achievements, which without them wouldn't have happened. Their biggest fault has been in achieving representativeness such as involving ethnic minorities and young people. (Woodcock, M.)

Donna Covey, Director of the national association of CHCs commented:

CHCs' effectiveness has been patchy, it is true, but at their best CHCs have been brilliant and the many successes of CHCs are often hidden. The vast majority have been held back by a lack of powers and resources.
(Covey, D.)

One chief officer of a CHC pointed out that the regional offices of the NHS Executive were responsible for the performance management of CHCs, and that the feedback from them had consistently been that CHCs were performing effectively.

The Proposed New Arrangements

70% of respondents to the questionnaire felt there was still a need for the "NHS watchdog" role currently performed by CHCs notwithstanding the introduction of local authority overview and scrutiny committees (see table 2, page 48). Respondents were far less clear about the implications of finding recruits for the proposed new patients' forums (see table 3, page 49). This is an interesting finding as much of the debate about the new structures had pointed out the difficulty in recruiting large numbers of new (volunteer) recruits for this role. It was already hard to find volunteers to join some CHCs, it was pointed out, and there might also be doubts about the credibility of the new organisations and the way that CHC members had been treated. However, respondents were more or less equally divided over whether it would be easier or harder to recruit members for patients' forums. Whilst some pointed to the above considerations in the comments they provided, others commented that it might be easier to recruit members for a patients forum with a specific NHS trust focus as it may be easier to understand and relate to than the wide-ranging remit of CHCs. A third of those surveyed did not express an opinion on this question. The Respondents had much clearer views however on how the promised new "independent advocacy" service should be organised. 74% felt

that the service should be provided by CHCs (or “the equivalent”) as opposed to the other option being mooted at the time, of it being commissioned by health authorities from a range of providers. This is a particularly significant finding as the way that the independent advocacy service is to be organised has been left open in all of the government’s proposals to date.

TABLE 2: Overview and Scrutiny Committees / Need for local “NHS watchdog” Role

Question: “*Following the Health and Social Care Act, “overview and scrutiny committees” of local authorities will take on a new role of scrutiny of the local NHS. Do you think this will take away the need for the local NHS “watchdog” role which has been performed by CHCs?*”

YES, this takes away the need for the CHC ‘watchdog’ role	n=26 (18%)
NO, this does not take away the need for the CHC ‘watchdog’ role	n=99 (70%)
DON’T KNOW	n=13 (9%)
DID NOT ANSWER	n=4 (3%)

TABLE 3: Patients Forums

Question: *"It has been suggested that separate "Patient Forums" should be created, concentrating on each individual NHS Trust and Primary Care Trust's services. Do you think that it would be easier or harder for local voluntary and community groups to get people to join this kind of Patients Forum as opposed to a CHC?"*

EASIER	n=45 (32%)
HARDER	n=48 (34%)
DON'T KNOW	n=45 (32%)
DID NOT ANSWER	n= 3 (2%)

TABLE 4: Independent Advocacy

Question: *"As a result of the Health and Social Care Act, it will be a requirement for the Secretary of State to arrange for the provision of 'independent advocacy' for individuals in dispute with the NHS. (This is in addition to the Patient Advocacy & Liaison Services - 'PALS' - which is an internal customer care or trouble-shooting service within NHS Trusts). Do you think that this kind of independent advocacy should be provided by CHCs (or a reformed version of CHCs) OR be commissioned by health authorities according to local circumstances or as the need arises?"*

SHOULD BE PROVIDED BY CHC OR EQUIVALENT	n=105 (74%)
SHOULD BE COMMISSIONED BY HEALTH AUTHORITIES	n=34 (24%)
DID NOT ANSWER	n= 3 (2%)

Several respondents to the survey also stressed the potential for resourcing the voluntary sector more to carry out some of the functions expected, especially the 'independent advocacy'.

The interviews of stakeholders did not ask as specific questions as these about the new proposals. However, they were asked "*What is your view of the latest proposals for patient and public empowerment? Do they adequately replace Community Health Councils?*". This question was set in the context of the government's discussion document (Department of Health, 2001) which placed great emphasis on the argument that CHCs were being "replaced". Some of the "new proposals" such as "Voice" had not been mentioned before, and so the context is slightly different from when the questionnaires had been compiled. However, the main elements mentioned in the questionnaire still remained in the latest package of proposals. The major themes that emerged from the interviews were questions about the "fragmented" nature of the proposals or their lack of co-ordination, and whether adequate resources would be devoted to them. There were also concerns about "Voice" – the proposed new body comprised solely of staff and deployed across strategic health authority areas. On the whole, they were seen as an improvement on *The NHS Plan*, but still with significant weaknesses and uncertainties. For example:

They are much better than the HNS Plan, but the devil is in the detail. Will they be given adequate resources? The fragmentation is still there. The proposals are very confusing for the public. They have possibilities but I am not convinced. (Woodcock, M.)

They are better than the NHS Plan, but not nearly as good as when the Bill was amended in the Commons and later by the Lords. (Covey, D)

The proposals are not independent or integrated enough. There are some good elements in the ideas, but some kind of one-stop access point is needed. Above all, they lack integration and coherence. (Furr, B.)

The remit of patients' forums is too narrow and the concept of "Voice" across strategic health authorities is absolute nonsense – far too remote. There are a lot of ideas but they are not connected up. (Richards, T)

I am concerned that no lay input is proposed for Voice. On the whole, the proposals are fragmented, and lack independence. (Shortland, A.)

There are large gaps. The more I speak to people about local authorities' role in scrutiny the more worried I am. They will need to be supported. There needs to be something like a CHC. "Voice" is only staff – lack any lay membership. (Clarke, A)

I see value in the role of Voice, but it does not relate to local people. It is not local and it is not "theirs". The people-determined agenda would be lost. Patients' forums are too narrowly focussed. There is a gap in the ability to work across districts as CHCs have done. (Chief Officer A)

There were a number of comments which questioned whether CHCs were being "replaced" adequately by the most recent proposals, or indeed at all. These are reflected in the results in the next section.

The Future of Community Health Councils

The response to the question of what role, if any, voluntary and community organisations would like to see for CHCs was particularly illuminating. (As has been discussed, not even the discussion document about patient and public involvement issued following the first failure to abolish CHCs invited any comment on this). A large majority of respondents (73%) were in favour of reforming and strengthening CHCs as opposed to abolishing them and replacing

them with completely new bodies. As the question about the effectiveness of CHCs had revealed, there was some polarisation of views and 20% of respondents were in favour of the latter option. Only 4% were in favour of keeping CHCs as they are. (see table 5, below).

TABLE 5: Future of Community Health Councils

Question: *"Do you think that local community and voluntary organisations would rather see CHCs : a) reformed and strengthened to play a pivotal role in the new arrangements b) left as they are c) abolished and replaced with completely new bodies?"*

REFORMED AND STRENGTHENED TO PLAY A PIVOTAL ROLE IN THE NEW ARRANGEMENTS	n=103 (73%)
LEFT AS THEY ARE	n=4 (3%)
ABOLISHED AND REPLACED WITH COMPLETELY NEW BODIES	n= 29 (20%)
DID NOT ANSWER	n= 6 (4%)

Further analysis of the questionnaires of respondents who advocated abolition of CHCs indicated that 50% of these respondents still wanted one or more of the current roles of CHCs continued through a new organisation. (50% of these respondents thought that independent advocacy should be provided by CHCs or "an equivalent" and/or that there was an ongoing need for the local "NHS watchdog" role which CHCs had tried to perform).

Interviewees were even more emphatic about wanting to see CHCs reformed and strengthened rather than abolished, and this included non-CHC people. None of those interviewed suggested that the new proposals were an adequate replacement for CHCs. Angela Coulter, who had been a member of the modernisation action team and who has no connections with CHCs said:

If I had known about the proposal to abolish CHCs I would have argued strongly against it. It would make more sense to reform CHCs.
(Coulter, A.)

Even the civil servant who had had involvement in this area of policy expressed disappointment at the intention to abolish rather than reform.

We had been working on the reform of CHCs. The first I heard about abolition was when the NHS Plan was published. The newest proposals are much better than The NHS Plan – that was a bit of a ‘dog’s dinner’. But the structures need to be developed bottom-up and be properly funded. (Civil Servant “A”)

Perhaps unsurprisingly, all of the CHC members and staff interviewed expressed strong preference for reform rather than abolition of CHCs. However, it is significant that none of them advocate the status quo either and all of them expressed not only a willingness but enthusiasm for embracing change, modernisation and reform if they were allowed to. For example:

I am committed to real reform. Colleagues and I have already worked on a document actively asking for change and reform. (Clarke, A.)

The status quo is not an option and change would be very welcome. I perceive that feeling to be widespread amongst CHCs. (Shortland, A.)

We are absolutely open to change and actively desire it. (Spilsbury, D)

I am not only open to change, but an advocate for it. (Furr, B)

I am, and I believe CHCs are very open to change – so long as it is of benefit to local populations. I am open minded about different ways of doing things, but if CHCs are to go they need to be replaced by something as good or better. (Woodcock, M.)

CHCs had already shown their readiness to embrace change through acceptance of the independent Hutton commission and 'Old Watchdog, New Tricks'. This included modernisation in tune with the New NHS and consistent standards. Even after the NHS Plan came out, the campaign wasn't about keeping CHCs as such. (Covey, D.)

The Process and its effect on Stakeholders and the Public

The survey of councils for voluntary service attempted to glean information about how the wider community had perceived the level of involvement and consultation about the patient and public empowerment proposals and any effects this had had on public confidence. This proved to be difficult and the results are a little inconclusive. Table 6 provides the results of questions about the degree of involvement and consultation. The results suggest that only a small minority (10%) consider that local voluntary and community groups had been sufficiently involved or consulted. It should be borne in mind that the survey was conducted before the most recent "listening exercise" was conducted. However, given that it is a matter of record that no consultation had taken place at this stage, it is perhaps surprising that even 10% felt that this had been sufficient. This might mean that respondents felt consultation and involvement was not necessary in this case. However, individual comments made on questionnaires suggest that many respondents interpreted the question as being about consultation and involvement more generally, or how the local NHS had communicated the changes to them. The question about the effect on public confidence (see table 7) was more problematic. Over half could not say how

public confidence had been affected. In hindsight, it may have been unrealistic to expect CVS to be able to make a judgement about the general public, and it would have been better to phrase the question in relation to the respondent themselves of voluntary and community groups. Several respondents commented that it was unlikely many of the general public had any knowledge of the process under discussion. It is interesting nonetheless that 29% felt that public confidence in the NHS had been damaged by the approach taken to reforming patient and public involvement and scrutiny.

TABLE 6: Consultation Process

Question: "To what degree do you think that local voluntary organisations have been involved or consulted about changes to patient & public involvement, advocacy and scrutiny in the NHS?"

"SUFFICIENTLY"	n=14 (10%)
"A LITTLE BIT"	n=84 (59%)
"NOT AT ALL"	n=39 (27%)
DID NOT ANSWER	n=5 (4%)

TABLE 7: Effect on Public Confidence

Question: "Do you think the approach to reforming patient & public involvement and scrutiny in the NHS through publication of the NHS Plan and since has strengthened or weakened public confidence in the NHS?"

STRENGTHENED PUBLIC CONFIDENCE	n=19 (14%)
WEAKENED PUBLIC CONFIDENCE	n=39 (29%)
DON'T KNOW	n=73 (54%)
DID NOT ANSWER	n=4 (3%)

The stakeholder interviews proved to be a more fruitful method of exploring the process and its effects on people – especially CHC staff and members. The interviews with a key civil servant and two members of the modernisation action team were particularly helpful in confirming some of what went on in the process leading up to publication of the *NHS Plan*. It will be recalled that it had been implied that the listening exercise prior to the *NHS Plan* and the work of the modernisation action team might have contributed to the eventual decision to abolish CHCs. The results of the interviews confirm that this was not the case. The civil servant interviewed was involved in policy work on public involvement leading up to and during the work of the modernisation action team. They confirmed:

We had been working on the reform of CHCs. The first I heard about abolition was when the NHS Plan was published...Arguments for abolition were not proffered by civil servants or the modernisation action team. That part was written by the Secretary of State (Civil Servant "A")

Angela Coulter, a member of the modernisation action team was shocked to hear that CHCs were to be abolished:

The government's intentions vis-à-vis CHCs as outlined in the National Plan were as much a surprise to those of us involved in the patient empowerment group of the modernisation action team as they were to anyone else. They clearly didn't listen to our advice on this issue and Chapter 10 bears little relation to our group's report. If I had known about the proposal to abolish CHCs I would have argued strongly against it. It would make more sense to reform CHCs. (Coulter, A.)

The other interviewee who was a member of the modernisation action team but who would rather remain anonymous also confirmed that there had been no arguments put forward by any members of the team for replacing or abolishing CHCs. They had only ever been discussed in the context of reform and strengthening them.

Donna Covey, who as Director of the national association of CHCs was the key person linking the CHC movement with civil servants and ministers, described what she had been lead to expect and how she learnt of the proposed fate of CHCs:

Before the NHS Plan, civil servants were talking privately of an extended role for CHCs and strengthening them. The first I heard about abolition was in a telephone call one and a half hours before the NNS Plan was announced in the Commons. (Covey, D.)

The interviews with CHC staff and members produced some interesting insights as to the effect of the whole process on them, and ideas on how policy and change management should be developed and managed. Interviewees confirmed that they had even less notice of the proposed abolition than Donna Covey and the fact that most of them heard the news first of all indirectly through the internet or media clearly had an effect on them.

The way it was done was appalling, a real smack in the eye for people (mostly volunteers) trying to do something worthwhile. (Clarke, A.)

I was devastated. The way it was done was unbelievable. I could not imagine how the patient could be properly represented by what was proposed. (Shortland, A.)

My first reaction was disgust – to be abolished without so much as a comment. Also, fear and apprehension for the future. For staff to be left to find out via the internet was outrageous. (Woodcock, M)

I felt let down and ignored. I had been expecting reform and strengthening of CHCs. (Furr, B)

It made me determined to do something about it. (Spilsbury, D)

I was incandescently angry – especially having worked so hard to make things work (Chief Officer A)

The Director of CHCs' national association summed up her perception of the effect of the way the proposed abolition was sprung on CHC staff and members:

Initially there was huge demoralisation. The way it was done, even if the alternative proposals had been good, meant people were alienated and couldn't have accepted them. A turning point was when the Prime Minister claimed there had been consultation when there clearly hadn't been any. The dishonesty in the way things were handled made people more determined to do something to change the government's mind. (Covey, D)

All of the interviewees were highly critical of the way that the proposed changes were handled and the way CHC staff and members were dealt with. Many made practical suggestions of how things could have been handled better. For example:

They should have spoken to people already doing the job. (Clarke, A)

There should have been proper consultation. (Shortland, A)

There should have been transparency and an open exploration of alternatives. (Woodcock, M)

They should have evaluated what existed and looked for improvements. (Furr, B)

Just about everything should have been done differently. There should have been a proper process of engaging a wide range of people about how best to move forward. The starting point should have been asking the public. (Covey, D)

One of the members of the modernisation action team expressed the view that the authors of the *NHS Plan* (Chapter 10) lacked an understanding of the people they were dealing with (both CHC staff and members – their “workforce”, and the wider public – their “customers”):

It was written by managers seeing the public as volunteers to be ‘used’. They have no knowledge of why people give their time, what makes it worthwhile. They look at fitting people into structures. Successful change management addresses people’s core values – why they do what they do. You have to deal with culture and belief.
(Modernisation action team member A)

The civil servant who had had some involvement in this policy area also had some particularly interesting insights into the process:

Chapter 10 of the NHS Plan was a ‘dog’s dinner’. The process should have been more transparent and the way that the abolition of CHCs was tucked away within the Plan was stupid. The case needed to be argued coherently. (Civil Servant A)

As well as the lack of transparency and coherence of argument, the civil servant cited the marginalisation of civil servants in then process as one of the problems:

Arguments for abolition were not proffered by civil servants or the modernisation action team. That part was written by the Secretary of State...We (civil servants) did not have much say...Special advisors and the private sector are replacing civil servants at the top level. Politics should be about overall direction not point scoring.
(Civil Servant A)

The issue of the role of civil servants and of the engagement of stakeholders in policy development and as part of managing change is returned to in the discussion section below, as is the personal influence of ministers. It was seen earlier how there had been widespread speculation within the media and in political debates about the abolition of CHCs being a personal bugbear of the Secretary of State, Alan Milburn. The civil servant's statement confirms at least that there was direct personal involvement of the minister in this decision. Donna Covey confirmed that in her view, the decision to abolish CHCs was personal:

It was put in at the very last minute. It was a personal thing for Milburn. That was the view of Labour MPs themselves who were asking about it. (Covey, D)

In several of the interviews, interviewees discussed the proposed abolition of CHCs and the way it was handled either in terms of a "cock-up" – naïve or poorly planned – or of a "conspiracy" – a deliberate attempt to weaken the strength of patient and public representation or to exact some kind of vengeance on CHCs. According to Donna Covey:

It started off as a "conspiracy" but ended up as a "cock-up" in terms of the way it was handled. (Covey, D)

Angela Coulter was more inclined to see the whole affair as

More "cock-up" than "conspiracy". (Coulter, A)

Summary of Main Findings

The survey of councils for voluntary service confirmed that local perceptions of the effectiveness of CHCs in their three main roles was mixed, but on the whole quite positive. CHCs were perceived to be most effective in their 'watchdog' role and in supporting individuals in dispute with the NHS. The interviews with stakeholders, including CHC staff and members confirmed the finding of the survey that the activity in which CHCs most needed strengthening was involving patients and the public in debates about health services. (This was never intended to be solely the responsibility of CHCs).

The survey produced quite strong evidence that local voluntary organisations and community groups would like to see CHCs reformed and strengthened rather than abolished, with 73% of respondents choosing this option. Even amongst respondents who advocated the abolition of CHCs and their replacement with completely new bodies, a high proportion saw the need for the roles of CHCs to be retained in "equivalent" or similar bodies. (50% of these respondents felt that the independent advocacy service should be provided by CHCs or "an equivalent" and/or that there was an ongoing need for a local "NHS watchdog" role, which CHCs currently perform).

Neither the survey nor the interviews detected any significant support for maintaining the status quo. Most significantly, the interviews with CHC stakeholders suggest that CHC staff, members and their national association

were not only ready and willing to embrace significant change and reform, but were strongly advocating it.

The way that the proposal to abolish CHCs was handled clearly had a marked effect on CHC members and staff, according to the interviews. Anger and hurt were prominent in the reactions of those interviewed, and morale seems to have been severely dented. However, also apparent was a determination to fight the perceived injustice of what they had had thrown at them which seems to have been fuelled by the way matters had been handled by the government.

Interviewees also declared a determination to fight for the broader public interest, and perhaps surprisingly, most were still prepared to devote their time (voluntarily in the case of members) to work in this field in the future.

Interviews with members of the modernisation action team and a civil servant seem to confirm that the abolition of CHCs was never actually discussed within the modernisation action team and that its members even expected CHCs to be strengthened in the *NHS Plan*. The civil servant's evidence supports the theory that abolition of CHCs was inserted at the last moment at the personal wish of the Secretary of State and that civil servants' advice was not followed.

Both the interviewees who had been involved in policy discussions prior to the *NHS Plan* and the CHC stakeholders considered the process of arriving at the policy on the abolition of CHCs and trying to implement it, as fundamentally flawed. Chief amongst the complaints was the lack of consultation or involvement and of transparency. Also, the apparent failure to understand

people's motivation or treat them with respect and courtesy in the way the policy was announced.

With regard to the government's proposals for patient and public involvement, aside from the abolition of CHCs, both the survey and the interviews threw up some recurring concerns. Most prominent amongst these were the lack of integration of the various proposals and a perceived lessening of independence. The interviews, which were conducted after publication of the government's discussion document (Department of Health, 2001), point in particular to concerns about "Voice" – its remoteness from local communities and separation from lay membership and the patients forums. Patients' forums themselves were considered by most interviewees to be too narrowly focussed, leaving a gap in terms of a patient/public organisation with an overview of local health economies and pulling the various threads of patient and public involvement together.

In the next chapter, the implications of these findings are discussed, compared and contrasted with the findings of the literature review.

5. DISCUSSION

Introduction

This research sought to examine the Government's policy on patient and public involvement in the NHS, and in particular on CHCs, in the context of theory on change management and policy development. The review of literature provides an historical overview of how CHCs have fitted into the overall picture of patient and public involvement and how policy has changed. The review of literature also provides an overview of some of the key literature on change management and policy in the health field. The primary research provides some evidence on how people in local communities view CHCs and some of the key issues around patient and public involvement. It also sheds light on the perspectives of other stakeholders both on the various mechanisms and approaches being considered and on the actual process of policy development and change management. This section discusses some of the issues that arise from the analysis of the results of the research and the relevant literature and theory. In so doing it is hoped to develop conclusions about the handling of change management and policy development in the NHS and about patient and public involvement in the NHS.

Policy Development and Implementation and "Change Management"

The literature review found that change management theory consistently advocates attempting to achieve "ownership" or at least acceptance of the proposed change by the people in the organisation effected by change. This was described in various different ways such as the "freezing" and "re-freezing" of Lewin (1952), to "visioning" described by several authors. Some go as far as

advocating direct staff involvement in identifying the desired change. The Department of Health portrays the NHS as an organisation which directly involves and empowers its staff. The listening exercise prior to the *NHS Plan* placed much emphasis on listening to what staff and the public wanted and reflecting this in the final plan. However, it was seen that the changes proposed in Chapter 10 of the *NHS Plan*, at least the changes relating to CHCs, were not arrived at through any form of inclusive process. The result from a change management point of view, supposing that the abolition of CHCs and replacement with other measures was a desired change, was disastrous. It was seen how the proposed change was not only resisted but was prevented through the political process. The research with CHC members and staff suggested that the way that the change was sprung on them both made them even more determined to resist the change but also had a negative impact on CHCs ability to deliver their services and on the morale and motivation of CHC staff and members. Although the CHC people interviewed saw the successful campaign against the abolition as a moral victory and saving the NHS from what would have been a damaging change, as the Director of their national association said, even if the proposals had been good they would have met with resistance because of the way that the issue was handled. However, it is also clear from the interviews and the literature that not only was there no resistance to the idea of radical changes to the way CHCs work prior to the *NHS Plan*, but a positive thirst for it. There does not seem to be a case therefore for the imposition of the change without the involvement or visioning that would normally be expected for fear of this building resistance. As Hussey said, there are circumstances when "too much discussion can actually reinforce resistance" (Hussey, 1998,

page 20). However, with CHCs there was a workforce ready and willing to embrace change if people had had the will and capacity to work with them on it, it would seem.

There are lessons here for any proponents of change. Communication and involvement with those effected by change really does matter. Whether the Government's ideas were better or worse than CHCs, the way that its plans were put forward were a textbook example of how not to manage change. The fundamental mistake of not considering the human implications of the changes appears to have been made here. It is worth noting also that some special consideration should be given to the role of volunteers and what motivates them. CHC members are volunteers. At a stroke the *NHS Plan* rubbished the contribution that they make and simply assumed that these volunteers would move into the new structures and that a host of new volunteers would be forthcoming to take up places on the new Patients' Forums. Nobody thought to ask the people who volunteer themselves what motivates them and how they would like to contribute. Volunteers were seen, it appears, as assets simply to be deployed as the Secretary of State sees fit.

The CHC story does beg the question of what change management means in the context of an organisation like the NHS, which is ultimately under political control. There is a growing abundance of literature and training for NHS managers about managing change. However, this is usually in the context of operational change in small branches of the NHS such as hospitals and community teams. At a national level the NHS is managed by civil servants.

However, politicians are in control of the NHS ultimately and key policy and organisational direction is set by them. Several commentators have observed that this puts the NHS at a disadvantage, with the prospect of change of direction each time the political colour of government changes. Hutton (2000) recommended that the NHS be changed into an independent institution like the BBC or Bank of England, at arms length from government. Ministers would simply define overall policy and resource allocation. He stops short of advocating taking the NHS completely out of political control. However, the fact is that currently the NHS is very much under the day-to-day control of the Government. Some would argue that as a public institution taking up a fair proportion of the nation's resources, that is perfectly appropriate. However, this study has raised some interesting issues about the differences and connections between making and implementing policy and change management. On the one hand, it can be argued that it is the prerogative of the Government to set policy and have it implemented as regards the NHS, and that "change management" is just for the managers who have to implement it. However, if that is how it works, there is a gulf between the policy and direction setting and the implementation of change in the NHS which means that policies may be ill informed and lack ownership by those who are effected by change, therefore leading to resistance and reluctance to change. If politicians are to remain the ultimate "managers" of the NHS, there should perhaps be much stronger application of change management approaches within the process of setting policy. Ironically, it appears from the rhetoric around the *NHS Plan* that this is what is intended (for example greater involvement of staff and the public in developing a vision of the "new" NHS), but the approach to CHCs seems to fly

in the face of this. Doubly ironic is that if any area of NHS policy is appropriate for real and meaningful stakeholder involvement in agreeing the vision of the way forward, it should surely be how those stakeholders are to be involved in the future. In the context of this study this would have included both the workforce (CHCs) and the "customers" (patients and the public).

The story of CHCs highlights another interesting dynamic in the way that the NHS is governed – the personal authority of the Secretary of State for Health. The research found some evidence to support the theory widely vented by opposing politicians and in the media that the abolition of CHCs was a personal preoccupation of the Secretary of State (see interviews with Civil Servant "A" and other stakeholders). Certainly, it has proved impossible to trace a logical pattern as to the development of this policy. It must be questionable whether it is a good thing for NHS policy to be so susceptible to the personal preferences of an individual, even if Ministers are elected and are accountable to Parliament. Another perspective brought to the fore by the civil servant interviewed for this study, is that the traditional role of civil servants in policy development may be changing and in this case was by-passed altogether. The abolition of CHCs came as a complete surprise even to key civil servants. He spoke of an increasing trend in Ministers taking advice from personal advisors rather than civil servants. If this is the case it undermines the balancing non-political role of civil servants described by Birch (1993) and Ham (1999).

However, the case of CHCs does provide evidence of the potential influence of stakeholders over health policy and of the parliamentary system itself having an

impact. Few could have expected the campaign to stave off the abolition of CHCs to be so effective. Most commentators, for example Walt (1994), Hogg (1999), see the influence of lobbyists and stakeholders such as patients, the public and voluntary organisations over health policy as having diminished. Certainly, doubts have been raised about the effectiveness of the House of Lords. However, supporters of CHCs had such an impact that even a Government with a large majority could not get the policy through (although it has to be said that the omission of the abolition from the *Health and Social Care Act* (HMSO, 2001a) had as much to do with the timing of the Lords amendment and lack of time before the general election as anything else).

Patient and Public Involvement in the NHS

The review of literature found that there had been a growing sense since the inception of the NHS that it had to find a better way of reflecting the experience and priorities of its users and the public at large. The creation of CHCs was, despite the fact that it was a less than thoroughly planned way of addressing the issues – “an example of back of the envelope planning” according to Hogg (1999) - a significant demonstration of the will to address this shortcoming. However, as various commentators and the CHC movement itself has noted, CHCs alone were never going to be the answer to making the NHS more responsive to its users and the public or making good the “democratic deficit”. The literature, and in particular the reaction of most stakeholders to the proposed abolition of CHCs suggests that their contribution has, however, been seriously underestimated. Apart from the consultation exercise in Wales, it was found that there had been little or no attempts to seek the views of the public about CHCs.

This research sought to make a contribution to filling this gap by surveying Councils for Voluntary Service in England. Although not an ideal replacement for a full and comprehensive evaluation or consultation, the research provides at least some insight into how local community organisations feel about CHCs and some of the other issues around patient and public involvement. In spite of the full weight of governmental backing and promotion of their new proposals, the results of the survey showed quite widespread confidence in the effectiveness of CHCs and a general desire to build on the best of what CHCs have achieved rather than "throw the baby out with the bathwater". This is in keeping with the trends in the literature that was reviewed and with the overall reaction to the Government's plans. A fuller consultation, undertaken by the Department of Health itself, could have yielded much more information about how people in local communities actually want to be involved, represented and supported within the NHS. Whether carried out by the Department of Health or not, it is recommended that further research is conducted on these issues with local organisations in addition to CVSs and with members of the public, utilising methods such as focus groups.

The Government's proposals themselves seemed to represent a tangible effort to reflect the distinction between "citizens" and "service users" or "patients" which had become more and more frequently articulated by the literature. For example, the concept of "patient forums" for each NHS trust seems to reflect a desire to give current patients direct representation within the organisation providing the services. Citizens' more general interest in a public service which most of them pay for through taxation would be reflected by the new scrutiny role given to

local government. This latter innovation also has the perceived benefit of addressing the perceived "democratic deficit" by giving the role of scrutiny to democratically elected local politicians. This of course falls some way short of giving local government an actual role in managing or commissioning NHS services, which had been a concept, flirted with by commentators (for example Cooper et al, 1995) and different political parties.

However, the concepts of such a black and white distinction between "citizen" and "patient", and of local politicians as a suitable proxy or representative of citizens' views on health matters and the NHS, requires further discussion.

Whilst it is unlikely to be questioned that actual users of a service have a unique and experience based perspective on quality of service for example, which any organisation should seek to capture and use in order to improve quality and satisfaction, the complete separation of "patient" and "citizen" is perhaps too simplistic. When does one stop being a "citizen" and become a "patient" and vice versa? The majority of people will only make occasional use of any NHS service for example. Those that have long-term health problems may have to receive services from a range of NHS organisations rather than identify their needs with one NHS trust or primary care trust. It is a matter for further examination perhaps, whether people prefer to identify themselves with public service centred on an institution like an NHS trust, or whether they identify themselves more with local communities and see the variety of local services provided contributing to the overall "health" of the community. Whether by accident or design, CHCs seem to be a reasonable manifestation of the latter philosophy. Based on recognisable localities, members are drawn from a variety

of sources (including patient and health-related groups) to not only pursue issues of service quality and patient experience in individual service providing organisations, but to come together in an organisation that has to balance competing priorities and form an overview of local priorities. There is also the potential with such a framework to do more work around the wider health agenda such as health inequalities and issues effecting health, which some CHCs have begun to pioneer. This would appear to be more in line with the government's wider agenda for addressing health inequalities. The removal of an organisation capable of contributing both citizens' and patients' perspectives would seem to leave an unnecessary gap.

The counter argument to this perspective might be that the involvement of local authorities in scrutiny of the NHS fills that gap and/or that citizens perspectives can be obtained by the other methods envisaged (for example citizens panels, outreach and research) and fed into the system. This could be taken as an argument that a community-led organisation such as a CHC would therefore no longer be needed. The arguments for and against organisations to represent the public interest are explored below in the context of what "empowerment" means. However, before moving to that it is worth discussing the arguments for local politicians as the representatives of local citizens on health matters further. Concerns were expressed when the *NHS Plan* was published that giving NHS scrutiny to local authorities would lead to "politicisation" of local issues along party political lines. These are concerns which may well have some legitimacy. For example, might not the way a local authority considers a proposed controversial and unpopular hospital re-configuration in its area be influenced

by a forthcoming local election? Might there be a strong temptation to represent the "popular" opinion of the public rather than the "public interest"? Might not local authorities' views on issues be influenced to some extent by the political colour of the council and the government of the time? Will councillors have sufficient time and understanding to take on scrutiny of the NHS as well as their local authority duties? A more general question applies to how members of the public perceive local politicians' role. It will take some time for people to have an understanding that their choice of councillor may affect how their local NHS services are scrutinised and how changes to them will be received. There would seem to be a case for considering direct election of members of local authority scrutiny committees or the co-option/nomination of members from CHCs or the patients' forums which are proposed to replace them.

"Consultation", "Involvement" and "Empowerment"

The story of CHCs raises some fundamental questions about the definitions of "consultation", "involvement" and "empowerment" of patients and the public. The literature review and interviews with key informants seems to confirm that the views of patients and the public were not taken into account in any meaningful way by the authors of chapter 10 of the *NHS Plan*. That this should be the case when the very subject matter is the involvement and empowerment of patients and the public is staggering, and does not bode well for how much influence patients and the public will have when the subject matter is more the home territory of "experts". Even the more recent decision to conduct a "listening exercise" over the Government's slightly modified proposals does little to inspire confidence. Why just a "listening exercise" with a limited

duration of six weeks when a formal consultation would seem by many to be called for? The discussion document invites comment on a number of questions about how to implement the Government's proposals, but does not invite any comment on the central and most controversial intention of abolishing CHCs. Although the survey of CVS did not provide conclusive evidence of damage to public confidence caused by the approach taken at that stage, it is clear that the approach has done nothing to help. The interviews and press coverage seem to confirm an increased level of cynicism about the government's motives and sincerity.

An additional rationale that could be offered for replacing CHCs with different methods of involvement and empowerment is the theory that formal organisations like CHCs distort the views of patients and the public. It can very reasonably be argued that the membership of CHCs is not "representative" of local populations for example, and therefore not appropriate to represent the interests of local people. There are of course problems with achieving true representativeness in any organisation. That problem does not disappear when it comes to local authorities, even though councillors are elected. Citizens' panels and other research methods can obtain representative samples, but the trouble is that answers can only be obtained to questions that are put. Who sets the questions and interprets or uses the answers? Whilst research using representative samples, and research specifically targeted at reaching the "hard to reach" groups who rarely get involved in committees and formal consultations is clearly to be welcomed, it is far from clear why this should be at the expense of having mechanisms for local communities to organise

themselves, to set their own agenda, ask their own questions, and exert influence. That is arguably where CHCs have been most successful – not as a substitute for other forms of engagement but often as a stimulator of them and a means of empowerment. None claim to be the sole voice of the community, but many seem to have been successful in helping different voices to be heard; in asking the questions that the NHS establishment would rather not be asked; and in exerting influence by being able to argue in the same language as NHS managers and to campaign. Many would argue that it is the opposite of empowerment to take away the community's ability to mobilise in this way and simply leave it to managers and politicians to interpret the results of research into community views. It is in any case not at all clear that the two approaches of researching the views of representative samples of the community and having a community-led body which represents the public interest, are mutually exclusive.

Summary and Recommendations

This chapter has discussed the issues of policy development and change management in the NHS in the light of the literature and research carried out. Also, through analysis of the literature and the results of this research, it has been possible to give consideration to approaches to patient and public involvement in the NHS, which remains a hotly debated issue. A number of broad recommendations are considered appropriate as a result this analysis:

- 1. Policy Development should embrace Change Management theory and techniques. These should be applied even when the decisions rest with politicians. In particular, staff and other stakeholders affected by potential change should be involved as early and as much as possible in development of**

policy proposals. These processes need to be open and transparent.

2. Consideration should be given to ways of distancing management of the NHS from direct political involvement and in particular from the personal influence of the Secretary of State.
3. Research into the role of civil servants in the development of policy would be useful, as would more comprehensive research into how people in local communities would like to be involved and represented in the NHS.
4. With regard to the future of patient and public involvement, if CHCs are to be abolished, consideration should be given to establishing a new community-led organisation at the local level. This would provide a means of enabling local people to have an overview of local health issues and a stronger voice, more in tune with what the evidence suggests local communities want.

6. CONCLUSION

This study has analysed the development of policy in respect to CHCs and patient and public involvement and scrutiny in the NHS, and sought the views of key stakeholders. The research has its limitations in that the chief executives of Councils for Voluntary Service surveyed are not a perfect proxy for people in local communities, and the numbers of people interviewed are relatively small. However, it has been possible at least to expand upon the limited opportunities that were afforded to people to influence the Government's patient and public involvement plans for England. In particular, the evidence regarding perceptions of CHCs is especially valuable in the absence of any evidence from the Department of Health over this and given that their discussion document (Department of Health, 2001) did not invite any discussion over the thorny question of the future (or lack of) for CHCs. The interviews with stakeholders help confirm the paucity of stakeholder involvement leading up to chapter 10 of the *NHS Plan* and throw light on the views of people in the CHC movement and the effects on them of the Government's approach to policy development and change management in this area. Even though the timing of the research itself pre-dates the latest government proposals encompassed in the *NHS Reform and Healthcare Professions Bill* (HMSO, 2002), the broad issues and principles remain essentially the same. This dissertation will be made available to civil servants and the Minister responsible for this area of policy, and may in a small way contribute to current deliberations over patient and public involvement and future approaches to policy development and change management in the NHS. The Health Service Journal has already published an article based on the

research for this dissertation, which highlights the lack of consultation on the abolition of CHCs and how the policy seems at odds with the results of the research and responses in other parts of the United Kingdom (Walsh, 2001).

The analysis of the literature and results of the research suggest an ongoing dilemma over how to make the NHS more accountable and responsive to the people that it serves. It seems that whether by accident or design, CHCs have played an integral part in seeking to address this dilemma and still enjoy widespread support in spite of the Government's determination to abolish them. It would seem that something like a CHC is desirable at a local level even if all the other proposals are put in place. In other words, there needs to be an organisation that brings together the intelligence from patient experience and monitoring of NHS services with a considered overview of the local health economy and policies effecting health and health services from a lay perspective. It is unclear why the obvious option of reform and modernisation of CHCs to perform this function was not considered.

Unfortunately, the "conspiracy" theory about this is as easy to argue as the "cock-up" theory. At best, the Government took the issue too lightly and perhaps the personal preferences of the Secretary of State or a few people usurped the rational and evidence based consideration of the options. In the rush to create a new system of patient and public involvement and scrutiny to underline the *New NHS* approach of *New Labour*, a few snazzy ideas were thrown together and inserted into the *NHS Plan*. Calls for local authority power in health were to be quietened by offering them a role in scrutiny of the NHS.

The popularity of CHCs and their ability to mount an effective campaign were underestimated. At worst, the proposals are a cynical attempt to muzzle an effective watchdog. Embarrassed by the monthly "casualty watch" surveys of accident and emergency trolley waits and other "reality checks" on the performance of the NHS and opposition to hospital reconfigurations or private finance arrangements in the NHS, there was a conscious decision to control the voice of patients and the public. The replacement of CHCs by patients' forums for each NHS trust (without any staff of their own) could be seen as a "divide and rule" technique. Deprived of their own staff and narrowly focussed on trust services, patients forums will be unable to see the big picture or organise effectively against changes considered contrary to the public interest. As was discussed earlier, the abolition of CHCs has even been portrayed in the media as a personal vendetta on behalf of the Secretary of State, so hard is it to find a logical rationale. The answer to these theories is unlikely ever to be known, but is more likely to be a mixture of them than any single one.

It is also possible to see the Government's proposals (at least in their latest modified form), however they came about, as an improvement on the current system. Even if this is the case, there are serious lessons about the way that policy was developed and the process of change management handled. There seems to be a case for further research on the role of civil servants in the development of policy, and the links between policy development and change management. In particular, it could be extremely useful if there were guidelines on the degree of stakeholder involvement there should be in developing policy and planning for change. An accepted definition of what requires formal

consultation as opposed to differing forms of "listening exercises" and more openness and transparency about the process of seeking and considering the views of stakeholders would also be welcome. There may also be positive potential in considering ideas put forward by Hutton (2000) for introducing a more arms length approach to managing the NHS, with less direct involvement from politicians other than overall policy. The area of patient and public involvement and scrutiny of the NHS would appear to be particularly suitable for this. Ironically, more by accident than design, this could be the outcome of the current debates and the development of the proposal for a Commission for Patient and Public Involvement in Health. This may help avoid personal or political interference in this area of policy which seems to have been apparent in the approach depicted in this case study.

More important even than the precise mechanisms or structures which may be in place once the current debates have been finalised, are the culture and principles underlying the approach to involvement and scrutiny in the NHS. The approach taken so far does not bode well, suggesting a patronising "we know best how you should be empowered" attitude. If people are not allowed a direct say in how they are to be involved, empowered or represented, they are unlikely to have any more confidence in the NHS than they do now.

Lastly, as this study goes to press, there remains no consensus over the adequacy of the proposals to replace CHCs. Two of the three main political parties in England are opposed to the proposals in the *NHS Reform and Health Care Professions Bill* (HMSO, 2002) and they have also been criticised by the Labour

chair of the Health Select Committee, David Hinchliffe (Health Service Journal, 2002), and other Labour backbenchers. Matters of scrutiny and patient and public involvement have traditionally enjoyed political consensus. CHCs themselves were proposed by a Conservative government but created by a Labour government. Whatever the merits of the current proposals, because of the opposition that has been generated through the way the policy was developed and the change management process mishandled, ways need to be found to recreate consensus. The public are unlikely to have confidence in a system over which there is so stark a party political divide and suspicion about motives.

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**APPENDIX 1: SURVEY COVERING LETTER AND
QUESTIONNAIRE**

Peter Walsh
c/o Croydon CHC 90 London Rd Croydon CR0 2TB
Tel: 020 8680 1503 Fax: 020 8401 3919

TO: Chief Executives of Councils for Voluntary Service in England

23rd July 2001.

Dear Colleague

**RESEARCH ON LOCAL PUBLIC & PATIENT INVOLVEMENT,
SCRUTINY AND ADVOCACY IN THE NHS**

I am undertaking some research on this topic as part of my personal study for a Masters degree in Business Administration (MBA). As well as using the results for my MBA, I intend to make the results available to the Department of Health and others to help in the current consideration over the best ways forward. Your co-operation in completing and returning this form would be greatly appreciated and could be an important contribution to the current debates. I believe that chief executives of CVS are in a unique position to be able to offer a local perspective on these issues. If you would like to consult your committee or other local organisations directly that is fine, but please don't let it stop you responding personally. The questionnaire can be completed anonymously.

As you may already know, the government published the *NHS Plan* in July 2000 which included proposals for new mechanisms for involving local people in the NHS; for scrutiny of the local NHS; and for helping people in dispute with the NHS. The proposals included the abolition of Community Health Councils (except in Scotland and Wales, where they are being strengthened) and have been the subject of intense debate, which is still not resolved. The enclosed questionnaire assumes a basic level of knowledge about Community Health Councils (CHCs) and some of the proposals emanating from the *NHS Plan*.

**Please return the questionnaire in the FREEPOST envelope provided or
by FAX to arrive by 31st August 2001.**

If you wish to discuss anything further about this research, I can be contacted at the above address and telephone number. THANK YOU.

Yours sincerely

**PATIENT & PUBLIC INVOLVEMENT, SCRUTINY & ADVOCACY IN THE
NHS**

Please circle the appropriate answer to the following questions, and comment if you would like to.

1. Based on what you know of Community Health Councils (CHCs) in your area do you consider CHCs to be effective in the following roles:

- a) Their 'watchdog' role of scrutinising the NHS and seeking improvements for local people

EFFECTIVE

NOT EFFECTIVE

DON'T KNOW

Any comment why?.....

- b) Their role in involving local people in debates about local services and policies

EFFECTIVE

NOT EFFECTIVE

DON'T KNOW

Any comment why?.....

- c) Their role in providing independent support (including advice and/or 'advocacy') to people concerning their rights or addressing a problem or complaint about the NHS

EFFECTIVE

NOT EFFECTIVE

DON'T KNOW

Any comment why?.....

- 2. Following the Health and Social Care Act, 'overview and scrutiny committees' of local authorities will take on a new role of scrutiny of the local NHS. Do you think this will take away the need for the local NHS 'watchdog' role which has been performed by CHCs?**

YES this takes away the need for the CHC "watchdog" role

NO, this does not take away the need for the CHC "watchdog" role

DON'T KNOW

- 3. It has been suggested that separate "Patient Forums" should be created, concentrating on each individual NHS Trust and Primary Care Trust's services. Do you think that it would be easier or harder to recruit volunteers from local voluntary and community groups to join new "Patients Forums" for each NHS Trust than it is to recruit them to a CHC?**

EASIER

HARDER

DON'T KNOW

4. As a result of the Health and Social Care Act, it will be a requirement for the Secretary of State to arrange for the provision of 'independent advocacy' for individuals in dispute with the NHS. (This is in addition to the Patient Advocacy & Liaison Services - 'PALS' - which is an internal customer care or trouble-shooting service within NHS Trusts). The Department of Health has indicated that "independent advocacy" may be "commissioned" from different providers by each health authority. Another suggestion is that it could be provided by local branches of a national network of patients' organisations (CHCs or their successors). **Do you think that this kind of "independent advocacy" should be provided by CHCs (or a reformed version of CHCs) OR be commissioned by health authorities according to local circumstances or as the need arises?**

**SHOULD BE PROVIDED BY
CHC OR EQUIVALENT**

**SHOULD BE COMMISSIONED
BY HEALTH AUTHORITIES**

**Any other
suggestion?.....**

5. **Do you think that local community and voluntary organisations would rather see CHCs :**

- A) reformed and strengthened to play a pivotal role in the new arrangements B) left as they are C) abolished and replaced with completely new bodies

6. **To what degree do you think that local voluntary organisations have been involved or consulted about changes to patient & public involvement, advocacy and scrutiny in the NHS?**

SUFFICIENTLY

"A LITTLE BIT"

NOT AT ALL

7. **Do you think the approach to reforming patient & public involvement and scrutiny in the NHS through publication of the *NHS Plan* and since has strengthened or weakened public confidence in the NHS?**

**STRENGTHENED
PUBLIC CONFIDENCE**

**WEAKENED
PUBLIC CONFIDENCE**

DON'T KNOW

Further comments? Please use reverse side or attach sheet.

THANK YOU. Please return to P.Walsh, c/o Croydon CHC, Freepost CN3302, Croydon CR9 2WZ, or Fax: 020 8401 3919 BY 31st AUGUST

APPENDIX 2 : INTERVIEW QUESTIONS

A. PEOPLE INVOLVED IN THE NHS PLAN

1. How were you involved, in the run-up to the NHS Plan, in discussing possible policy development for patient and public empowerment?
2. When and how did you first become aware that CHCs might be abolished?
3. Were you aware of what evidence or arguments were being put forward in reaching the decision to abolish CHCs?
4. What was your view before the NHS Plan of what the policy should be regarding CHCs, and patient and public empowerment generally?
5. How effective do you feel CHCs have been?
6. Do you think that there was any resistance from CHCs to change or modernisation prior to the NHS Plan?
7. What effect do you think that the way the abolition of CHCs was arrived at and announced had on CHC members and staff?
8. What, if anything, do you think could or should have been handled differently in order to bring about change and improvement in the field of patient and public empowerment?
9. What is your view about the latest proposals for patient and public empowerment? Do they adequately replace the roles of CHCs?

B. COMMUNITY HEALTH COUNCIL STAFF AND MEMBERS

1. What were your feelings when you heard that CHCs were to be abolished?
2. What if anything do you think could or should have been handled differently in order to bring about change and improvement in the field of patient and public empowerment?
3. What was your view prior to the NHS Plan as to what should be done about CHCs and patient and public empowerment generally?
4. Were you open to the prospect of changes to CHCs?
5. How effective do you think CHCs have been?
6. What is your view about the latest proposals for patient and public empowerment? Do they adequately replace the roles of CHCs?

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