HEALTH NEWS BRIEFING

ASSOCIATION OF COMMUNITY HEALTH
COUNCILS FOR ENGLAND AND WALES

Consultation:
An Aide-Memoire for CHCs

Prepared by CL Hunter for the West Yorkshire Association of CHCs

March 1998

CONTENTS

Introduction

In December 1996 a group of representatives from the West Yorkshire County of CHCs met in Leeds to discuss the situation with regard to recent experiences of Consultation. There were some examples of good practice but in the main CHCs had found that Consultation meant different things to different people and that often only lip-service was paid to the concept. The overall result was that the public was cynical and regarded Consultation as a meaningless exercise. The public and CHCs were in agreement that there was no point in allocating substantial resources to a process that was unsatisfactory and unlikely to affect the decision taken.

All those present at the meeting felt that it would be useful to draw up guidelines and criteria for consultation procedures that would be common across the County and would help CHCs in deciding on how to proceed when faced with having to respond to proposed changes in health services delivery.

Following the presentation of a discussion paper it was agreed that it would be virtually impossible to produce prescriptive advice or guidelines that would cover all situations that might be encountered with regard to consultation. However, it was agreed that it would be useful for CHCs to have a reference guide that could be used as an 'aide memoire' and that gave examples of good practice that would be helpful to all CHCs.

This document has been written as an aide that can be used by CHCs when they are preparing for 'Consultation'; it is not intended to be prescriptive. Each CHC will encounter new situations and unique circumstances; I hope that this document will help to alleviate some of the initial anxiety, use it as you choose.

In preparing this paper, I have been assisted by a number of other people and to them I extend my thanks: Chairs and Chief Officers of the West Yorkshire Association of CHCs; the Support Staff of Huddersfield CHC; Rachel Chapman, Duncan Innes, Lesley Hilton, all from the Northern and Yorkshire Regional Office; Barry Slater, Quality and Consumers Branch of the NHS Executive; Chief Officers and members of North and South Tees CHCs; Marion Chester, Legal Officer, ACHCEW.

C L Hunter
October 1997

1. Definitions, Regulations and Interpretations

1.1 Definition of Consultation

Quote - 'Consultation is the communication of a genuine invitation to give advice and a genuine receipt of that advice..... to achieve consultation, sufficient information must be supplied by the consulting to the consulted party to enable it to tender helpful advice... by helpful advice in this context, I mean sufficiently informed and considered information or advice about aspects of the formal substance of the proposals, or their implications for the consulted party,.....'[1]

This wordy and legalistic definition of Consultation lays down the principles for any Consultation Process.

- There is an invitation to relevant parties to express their views on the issue for consideration.

- The views expressed by the parties have to be listened to and considered by those who have responsibility for making the ultimate decision.

- There is a responsibility on behalf of the authority/agency/party seeking views to supply sufficient information to those whose views are being sought to enable them to express an informed opinion. The information supplied, should fully explain what the proposal is and what effect or impact the proposed change would have on local services and for users. The proposal should also include an appraisal of the options and explain the disadvantages as well as the advantages to be gained from the proposed changes.; the whole proposal should be fully reasoned and considered.

With regard to the public, it is their expectation that if consulted their views should be taken into account in reaching a decision. Therefore, there should be options available within any proposal and the effect/implication of choosing any one of the options should be fully explained.

If consultation is to go ahead no decision should be made before the public/users have had an opportunity to express their views. A consultation should not go ahead merely as a public relations exercise.

1.2 Statutory Position on Consultation

Where substantial changes in service provision are proposed, health authorities have a statutory responsibility to consult Community Health Councils (CHCs) and, as good practice, other representatives of the local community. This should be a genuine consultation process and comments should be carefully considered.

It is for individual health authorities to decide on the form, content, extent and timing of a consultation. This should include a full degree of involvement by interested parties including consumers, at all stages of strategy and operational change.

If a CHC contests a health authority's proposal substantially to change the service provided and the health authority maintains its original view, the matter is referred to Health Ministers to decide in the light of all the circumstances.

Barry Slater
Quality and Consumers Branch
NHS Executive, July 1997

1.3 The Regional Office

Any proposals for changes which are formally opposed by the CHC are sent to the Regional Office which makes a submission to Ministers on the pros and cons expressed during the consultation process. Following the abolition of Regional Health Authorities, the Regional Office does not make a decision on such proposals at regional level but would recommend either their acceptance or rejection by Ministers. As the Regional Office operates on behalf of the Secretary of State, it needs to remain slightly detached from local discussions around proposals so that Ministers are advised impartially. However, the Regional Office frequently passes on advice from the NHS Executive when required.

Duncan Innes
Locality Performance Manager
Northern and Yorkshire Regional Office, July 1997

1.4 Mergers

In the case of proposed mergers of Trusts the Regulations place a legal responsibility on to the Secretary of State to carry out consultation with CHCs. This consultation is usually carried out by the NHS Executive Regional Office on behalf of the Secretary of State.

Where mergers between health authorities are proposed the responsibility for consultation used to be with the Regional Health Authority, this responsibility has similarly passed to the Regional Office of the NHS Executive.[2]

1.5 Formal / Informal Consultation

CHCs need to be clear about the difference between normal everyday discussion, **informal** consultation, between the Health Authority and the CHC (often described as 'consultation') and a **formal** consultation process carried out by the HA concerning a specific proposal for **substantial** change in service.

Example

The three Cleveland CHCs developed a protocol and guidelines for consultation, jointly with Tees Health Authority which set out the CHCs' expectations and the Health Authority's responsibilities in respect of consultation. The guidelines also listed specific issues/plans on which the CHCs would be consulted, including:

a) The long-term strategic direction of the Purchaser (10 year long-term commissioning strategy and primary and community development strategy)

b) The programme of possible changes and developments in services (three year programme 'Opportunities and Priorities')

c) Purchasing intentions (including consortia contracts)

d) Service specifications (including consortia contracts)

e) Quality specifications (both general and for individual services)

f) Health programmes

g) Proposals to tender which arise outside the programme of annual purchasing intentions

h) Ad hoc proposals which influence significantly the provision, change, or removal of a service, or facility, outside the program of annual purchasing intentions

i) Ad hoc strategies and policies arising as a result of local, national or regional initiatives

j) Ad hoc strategies emanating from joint exercises in purchasing where there is a health service element

The above list was not exhaustive and the important overall aim was to involve CHCs at an early stage whenever Tees Health was contemplating change and development in either a strategic or operational sense and for

that involvement to continue through as the strategies or operational changes evolved.[3]

It is for the Health Authority to decide whether the change it proposes constitutes a **'substantial'** development or variation. Such decisions can and have been challenged in the Courts, where their reasonableness has been called into question.

Example

A Yorkshire working group, composed of Managers from the Regional and District Health Authorities, Trusts, CHC Chairmen and Officers, and the NHS Executive, which met during 1993 defined substantial as follows:

> "anything involving significant change in provision, location, style or method was felt to qualify, as did sensitive local issues, apparent removals or introduction of new services. The point was made that a modest adjustment, as proposed by local management, may be perceived differently in the community."[4]

Similarly, with regard to timescale, a failure to consult cannot be justified on the grounds that the proposed change was a temporary measure.

Example

A CHC became aware of a ward closure after the event. Both the Trust and Health Authority insisted that consultation was unnecessary, on the grounds that the closure was temporary as a result of perceived changed requirements and a reduction in demand for the facility. Clarification of this statement was sought. In the meantime members of the public made complaints to the CHC about the closure and its effects, being that patients were placed in mixed sex wards, without the appropriate safeguards by way of separate washing and toilet facilities. Other patients were being placed on wards where the type of care was inappropriate to their condition. Staff at the hospital complained that they had no prior warning of the closure.

The CHC Chief Officer was advised that under the provisions of Regulation 18 of the 1996 CHC Regulations, the CHC did have the right to be consulted over this closure. The effect on patients, was in itself sufficient to establish that the closure amounted to a substantial variation in health services. The Health Authority could not sustain the urgency exemption contained in Regulation 18(3) and, in any event, had not complied with its provisions by formally informing the CHC of its decision and the reason why no consultation had taken place. Further, the CHC was advised that they had the right to information about the planning process and reasons for the closure by virtue of Regulation 19. The CHC was advised to make a referral to the Secretary of State for Health, asking him to intervene on the basis that this was a disputed closure and as such should have been referred to him in line with the guidance in 'Consultation and Involving the Consumer'. The

CHC was advised to ask the Secretary for State to agree to fund a judicial review application against the Health Authority in the event that they continued to refuse to consult over the closure.[5]

Neither can health authorities justify a lack of consultation about a proposal because of an urgent need to save money in order to achieve a balanced budget.

Example

The Lynton Judgement: North Devon Health Authority: 4 August 1997 (See Appendix 1)

1.6 Public Consultation

There is a type of consultation that comes between informal consultation and formal or statutory consultation: in the absence of a better definition I have used the term Public Consultation for this type of interface.

Public Consultation is used where health authorities and other agencies including the CHC want to consult the public and receive their views on the future of a range of services. There may not always be a proposal for change but there could be a strategy document or vision for the future that views are sought on to influence the final shape. In such cases the consultation process may follow a formal structure and the stance of the CHC has to be as carefully considered prior to any engagement in the process.

Example

Rochdale CHC were involved in a major consultation over the review of hospital services carried out by Rochdale and Bury Health Authority. Early in the process the CHC considered what commitment and how it could co-operate with the Health Authority without compromising its independence. The CHC felt that it could not refuse to co-operate with the health authority but carried out its own research to discover the priorities and views of local people. The findings of the research exercise provided the basis that Rochdale CHC used in reaching its view of the way services should be provided in the future.

The research exercise/public consultation focused on natural groupings of residents, members of existing groups, community school councils and patients groups. A full description of the difficulties faced by Rochdale CHC and the outcome of the consultation was given in a recent magazine article. The consultation was deemed to be successful because it informed public opinion and the views expressed did influence future thinking; there was little

conflict and both the CHC and the Health Authority maintained their credibility with the public.[6]

1.7 The Consultation Document

In practice, it is often the Trust which draws up the consultation document in collaboration with the main purchaser, in whose name it is issued.

The consultation document does not explain the hidden agendas nor does it say whether the proposed change is finance led or concerned with clinical outcomes. These issues never come out in debate and thus there is a danger that CHCs might be consulting on a 'no win' consultation.

The CHC needs to read the document carefully, teasing out the issues that lie behind it and then formulate a list of questions. The questions raised by members are valuable as they will generally reflect those that will be raised by the public and will start to identify what additional information needs to be gathered.

Any consultation is as much about education as anything else. There is a need to inform the public so that the proposed changes are seen within the context of the whole service.

The role of informing the public is vital, as much information as possible needs to be put before the public so that all the issues are discussed and similarly, the implications of the possible options are fully explored.

1.8 Why is Consultation so often Unsuccessful ?

- Failure to clarify the aims and objectives of the exercise before starting on the process.
- Failure to involve key stakeholders, ie those whom the proposed change in service is most likely to affect; including Clinicians/GPs and other staff.
- Failure to recognise and/or understand public interest.
- Failure to actively engage the public or effectively communicate with them during the consultation process.
- Failure to share the context in which the proposed change has been put forward.
- Failure to share understandable information.

- Timing and lack of a realistic timescale.

- Different agencies conducting separate consultations on the same issue and at the same time as each other.

- Recognition of one or several of the failures listed above but no action taken to remedy or retrieve the situation: a failure to learn from past mistakes.

- The failure of many consultation exercises have left us with a deeply cynical public who feel that all decisions are made before they have heard anything about the proposal and that it is a waste of time to bother to voice an opinion. Over the last two years many organisations have used the term 'consultation overload' and have become both tired and disillusioned about the usefulness of such exercises.

1.9 What is Regarded as Successful in Consultation ?

The first question that should be asked is - 'Who is asking the question?'

It will be recognised that those people who evaluate a consultation exercise as having been successful will be those who have achieved their desired outcome; whether this is a balance of opinion favouring the proposal or opposing it. If public opinion is in favour of the proposal then the authority who has put the proposal forward will deem the consultation a success. If public opinion is against the proposed change, the proposer will deem the consultation a failure. Whilst, this may seem an obvious fact, very few consultation exercises have been fully evaluated with this in mind. Evaluation is important but is only valid if the views of all participants are sought and the outcome of the process records their outcomes.

It has to be expected that there is an inherent danger in going out to consult; ie the outcome may not accord with your preferred option: Authorities need to be able accept this and the point illustrates the need to have more than one option for consideration. In cases where alternative options can be proposed there is more room for manoeuvre and it is more likely that a compromise can be reached which might not suit everyone 100% but could be as close as 90% to the desired outcome.

A successful consultation exercise is one where all participants feel that they have achieved a 'win' situation.

1.9.1 What Contributes towards making Consultation Worthwhile and Successful?

- Careful initial planning with those responsible for facilitating the process and the ability to contribute to the brief/remit of the process.

- An agreement between the Health Authority and its constituent CHCs on the process and timetable for consultation. (Example: Leeds service reconfiguration, Leeds health Authority and Leeds CHC)

- Clearly defined and understood proposals with alternative options/models put forward for consideration and discussion.

- Targeted and focused meetings and discussions with users and carers.

- Realistic timetable for planning and carrying out the consultation exercise.

- Commitment from all parties to attend meetings and to attend briefing sessions throughout the consultation period.

- Both pros and cons of each of the options put forward fully explained by spokes people from different agencies including acceptable or known experts.

- Meetings and discussions chaired by an independent person (CHC Member) who ensured fair play amongst both speakers and audience.

- Minutes of all meeting taken, including questions and answers; the report of the meeting sent to the respective organisations and individuals.

- Final and full report of the consultation sent to all participants in the process.

The lessons that can be learnt are clear and simple. Good planning prior to the start of the consultation process is essential. Everyone who is to be involved needs to have a clear understanding of why the consultation is being undertaken and what the process is expected to achieve. There must be choice and opportunities for the views of those who are consulted to be taken into account before the final decision is made.

1.10 The Media

The media are an important party in any local consultation exercise. Local journalists should be fully briefed at the beginning of the exercise, kept updated during the consultation process and told afterwards how people's comments made a difference.

The best way of achieving this is for the organisation leading the consultation to have a media strategy in place before the exercise starts.

A strategy would set out:

- arrangements for press launch.
- consistent messages to be used throughout the exercise, which make clear the organisations position on the consultation.
- a timetable of key dates during the process, which provide an opportunity for media updates.

It is also important to identify one person who will have responsibility for liaising with the media throughout the consultation. This is particularly important for the following reasons:

- If the press know that there is someone readily available to speak to them, they are more likely to approach the organisation for a comment to counter or add balance to statements from groups or individuals who may have strong views about the proposals.
- It is easier to achieve consistency if one person is dealing with the media.

It is important to recognise that even with the above approach, the media won't always see the issue from the same perspective as the organisation leading the consultation. However, if they are well briefed and know who to contact for further information, there is a much better chance of achieving balanced coverage of the issue.

Rachel Chapman
Head of Communications
NHS Executive
Northern and Yorkshire Region

2. CHCs and Consultation

Often CHCs have to assert their rights against the background of a prevailing culture in the NHS that is wary of CHCs; their independence and ability to challenge management decisions. There is rarely recognition of CHCs as equal partners in the consultation process.

Once a proposal has been put forward the CHC will need to discuss not only the content of the proposal but whether an informal or formal consultation process will be required.

What follows is mostly written with regard to formal consultation processes, although there is some relevance for informal consultations.

2.1 The Role of CHCs in Formal Consultations

Why should CHCs be involved?

- CHCs can challenge accepted precepts and can bring clarity and objectivity into the process and thereby validate the outcome.
- CHCs have extensive networks and links with groups and individuals within the local community.
- CHCs understand the NHS structure and systems within it.
- CHCs are independent and have credibility within the community and other statutory agencies. They can act as the 'Honest Broker'
- CHCs have a wealth of information about local services and can provide information that puts proposals within context.
- CHCs are able to empower and educate the public
- CHCs have developed their expertise and skills in communicating with the public over a long period of time and understand the needs of the community.
- CHCs can take a neutral stance; they do not need to promote the proposal.

2.2 What does a CHC Need to Enable it to Facilitate and Participate in a Consultation Process ?

- Good information - from a variety of sources
- Clear understanding of the issues around the proposed change
- A clearly defined, well understood and agreed role in the process
- A clear sense of its own position
- Identified resources to match the cost of the consultation

It is important that CHCs accept that involvement in a consultation exercise involves the whole of the CHC, members and staff alike. It is important that the CHC identifies the amount of time and resources that will be required to undertake the exercise meaningfully. Similarly, the impact that such an undertaking will have on work programmes has to be realistically assessed.

2.3 Preparing for the Consultation Exercise

Planning

It is worth reiterating that it is the health authority's responsibility to ensure that in formal consultation on major services changes or closures, they consult not just with CHCs but with relevant local groups and interested parties. They may sometimes choose to ask the CHC to do this on their behalf, but nonetheless the responsibility firmly rests with them rather than the CHC.

The amount of time spent planning will never be wasted. Planning should involve all members of the CHC working alongside the Chief Officer and other members of staff. The burden of active participation cannot be placed upon one Special Interest Group even if the proposal under consideration is not of direct relevance to other groups of the CHC. It is the process of the consultation and the impact of the work that will be entailed in undertaking the exercise that needs to be fully discussed and understood by both members and staff of the CHC.

CHCs need to consider whether the cost of undertaking a major consultation will be justified by the likely outcome of the exercise; ie does the end justify the means? There may be other ways of achieving the desired outcome.

Whose agenda will the CHC be responding to? CHCs should challenge themselves before launching off on an exercise fraught with difficulty. To undertake a major consultative exercise because it is expected, or because

the CHC has always done it, might not be sufficient reason in a world where resources are limited.

CHCs also need to consider what the implications for their future might be if they undertake a major consultation. Is it likely to do more harm than good and can the CHC maintain faith with its community? Will members be able to sustain their efforts over the consultation period? What implications will the cost of the consultation have on other areas of the CHC's work?

Every CHC is well used to setting its priorities for the year and these would have to be evaluated against the need for consultation. As CHCs become subject to performance review it will be essential that this process is not disregarded and that changed priorities are justified and notified to appropriate agencies.

2.4 Who Will Pay?

In some cases the Health Authority might be prepared to pay the CHC to carry out consultation with the public on its behalf. It has to be remembered that statutorily the Health Authority is only obliged to consult the CHC, and that the CHC has to represent its community in putting forward its response to a proposal. In practice, both Health Authorities and Trusts would nearly always wish to consult more widely than just the CHC and would be prepared to invest in the CHC for this purpose. However, the CHC would have to ensure that its position was not compromised by a financial arrangement with either Health Authority or Trust.

There is a danger that CHCs might be used by either Health Authority or Trust to achieve their desired outcome. It is essential that CHCs maintain their neutrality and that is understood by all partner agencies. It is important that members and staff are seen to be impartial throughout the process of consultation.

CHC Members are rightly proud of their independence, however, during a consultation period an individual member's personal view should not be voiced in public, unless it is clearly stated that it is their personal view and not necessarily that of the CHC. In some circumstances members might not wish to participate in the process if they felt that having to maintain a neutral stance would put them in a difficult situation or compromise their personal integrity.

2.5 Local Authority Involvement

Some consultations also involve the Local Authority as happened with the NHS Continuing Care Policy. Local Authorities have their own mechanisms for consulting with their public and do not always understand the constraints

of formal consultation procedures. Clarification of the stance of the Local Authority and its intentions regarding the consultation must be sought at the outset.

Consultation can fail if the Health Authority and the Local Authority each pursue their own agenda and consult separately on the same issue. This situation serves no-one's purpose; users of the services become suspicious of the authorities' motives; bad feeling is caused and the multiplication of meetings dilutes the message to the public and similarly, its response.

2.6 Questions that CHCs Need to Consider before Embarking on a Formal Consultation Process

Question 1: What will the CHC gain from undertaking the Consultation?

Answer Each CHC will have their own answer to this question. Some of the benefits may be intangible but will have a value; this needs to be balanced against the resources and energy that will be expended.

Question 2: Is there an opportunity for the CHC to be involved at an earlier stage?

Answer As stated earlier the CHC should try to meet with the health authority to set the parameters of the consultation and to agree a process that is best suited to the situation.

Example Leeds Health Authority met with Leeds CHC to agree the process for consulting on the reconfiguration of services between United Leeds Hospital Trust and St James & Seacroft Hospitals. This situation was more complex because both Trusts were providers of tertiary services for communities in West and North Yorkshire.

The wider group of CHCs agreed that Leeds CHC should have lead responsibility and via their offices, Leeds Health Authority offered to arrange a meeting for the West Yorkshire CHCs, together with their respective health authorities. October/November 1997

Note: It can be useful to have an earlier contribution but there are dangers: CHCs need to be careful that they are not going out to seek views on a proposal that they would be perceived as having helped formulate.

Question 3: If there are no alternative options to a proposal for change can any discussion with the public or request for their views be regarded as Consultation?

Answer This question begs another, ie. What is the desired outcome of the process; what do the relevant parties wish to achieve?

All too often an authority goes out to consult the public because that is what is expected. In such circumstances, the exercise is doomed to failure and bad feeling is created between the participants because a clear aims and objectives for the process have not been agreed at the outset.

Question 4: Is it the role of the CHC to educate the public about the wider context?

Answer The answer could pose another question - If the CHC does not do this who will? It is for the individual CHC to decide on its role and how much additional information it can give. However, the CHC does not need to stand alone and can find partners who will assist in informing the public.

Example Kirklees MBC assisted Huddersfield and Dewsbury CHCs during 1992/3 when there was a proposal to merge three health authorities covering Calderdale (Halifax and district), Dewsbury and Huddersfield: at the same time there were proposals for the establishment of three whole district NHS Trusts.

Kirklees MBC offered rooms at the Town Hall for public meeting free of charge. The Council's Policy Officer worked with the Chief Officers of Dewsbury and Huddersfield to write a leaflet that explained the issues, ie the Purchaser/Provider split and government policy. The Council also used its distribution network to circulate the leaflets and notices of meeting throughout the district. December 1992/January 1993

Question 5: Will the CHC have to carry the full costs of the Consultation?

Answer Health Authorities , Trusts and the Local Authority may be willing to help, either in cash terms or by sharing resources. The extent of available resources will help dictate the process and what it is realistic for the CHC to undertake. It is imperative that the CHC is both honest and realistic in setting its parameters.

Example There is a danger that consultation will be regarded as an add on that can be easily assimilated into existing priorities; this is not the case. The result of not recognising the amount of effort involved is that members and staff become over-burdened and the whole process collapse as a result.

One example of the impact that a major consultation will have on CHC resources is the cost of postage. In a consultation on the closure of a hospital, a CHC was asked to take the lead on the consultation exercise.

Ten public meetings were held, mostly hosted by relevant user and carers groups. Over the three month period over 2,500 letters of invitation to meetings were sent out. Over 400 reports of meetings were posted and nearly 500 final reports were distributed. In addition over 50 letters were sent to individuals acknowledging receipt of their views and opinions. A total of 3,450 items of post.

However, the cost of stamps was not the main expense, it was the cost of the hours spent stuffing, sealing and franking envelopes that really took its toll and in the main, was borne by staff who did much of this additional work in their own time. The lesson learnt was the need to realistically think through the process and divide it into tasks and component parts and then to draw up an action plan which accommodated them and build in some 'slack, to cope with some of the things that might go wrong.

See also, example given at the end of Question 4.

2.7 Proposals for Trust Mergers

At the time of writing there is much discussion about proposals for mergers between Trusts and Health Authorities. At the beginning of October 1997 a Conference was held- "Trust Mergers -Is big beautiful."

The Conference was attended by the Chief Officer of Leeds CHC, and below are listed some question that he formulated for his own CHC to ask regarding the proposal to merge Leeds General Infirmary with St James and Seacroft Hospitals.

Some Questions to ask about Trust Mergers

1) Is there a baseline from which to judge whether a merger has been of benefit?

2) How will the effects of the change be monitored?

3) What cost savings or quality gains are expected from the merger? ie what is the strategy that makes merger appropriate?

4) What is the source of these benefits and what is the process to achieve them?

5) What impact will the merger have on access to services for patients?

6) What will a merger achieve that could not be achieved by increased co-operation and collaboration? (Evidence says very little!)

7) Have costs in terms of staff time spent on implementation, time for staff to adjust to a new structure, culture and work patterns, redundancies and general disruption been taken into account?

8) Are estimates of management costs savings realistic? (Evidence says that little real savings are achieved).

9) How will the merger improve services to patients and avoid disadvantaging particular care groups (eg mental health) in the larger structure?

10) If economies of scale are exhausted at the size of a 100-200 bed unit and diseconomies of scale develop at the size of a 300-600 bed unit level how much more costly will it be to run the merged trust than it would be if the trusts remained separate?

11) Do managers want to do it? Do clinicians want to do it? Do staff want to do it? It won't work unless they do![7]

2.8 The Process of Consultation

The process has to be transparent: participants and particularly those being consulted must feel confident that there is no hidden agenda underlying either the proposal or the reason for the consultation.

> "Health Authorities should have a strategic plan for, and be engaged in early, systematic and continuing communication and consultation with local people, users and carers' groups, CHCs,...etc...about plans to respond to local health 1.10.97(7) needs and to develop local

services. They should be able to demonstrate the impact of that consultation on their plans and how its outcome has been fed back to the community"[8]

Meetings

It is more useful to target meetings and have discussion with those who will be most directly affected by the proposed change. However, meetings should be open and publicised so that everyone in the community is offered the opportunity to participate and express their views.

Meetings and discussions need to be controlled and the role of the Chairman or Facilitator at such meetings is crucial. There has to be a balance struck and speakers from opposing or differing viewpoints should be given equal opportunity to put them to the public. Similarly, the Chairman/Facilitator has to maintain fairness when dealing with the audience and their questions and should not allow the discussion to be highjacked by any one individual.

Focus Groups

Focus groups are a good way of obtaining views; similarly asking established groups to host open meetings is another useful way of obtaining an informed opinion. There is much scepticism about the usefulness of the large public meeting. There is a need to be pragmatic and flexible the secret to success is to use a variety of methods and forums for meeting with the public in order to obtain their views. It is important to go out and meet the public and not to expect them to come to you.

Public meetings

Upon occasion, the large public meeting might be the most appropriate way of meeting with a community. For example if a service is to be provided in a community setting it is important that the community has an opportunity to hear about the proposal and to express its view. It is for the proposing authority to explain its position and to bring the community on board. If as happened on one occasion, 500 people at a public meeting totally oppose the proposal is it no use condemning that type of meeting, or saying that it was dominated by professional activists; the proposal has to be looked at. Why were so many people opposed to the proposal? Was the proposal wrong in concept or merely wrong for that community? All too often if the public's response is not to the consulter's liking they will condemn the process that brought about the negative reaction rather than reappraising their proposal.

Feedback

Feedback about the consultation is equally important and needs to be ongoing. Reports of meetings need to be prepared quickly and distributed to those attending the meetings. The full report of the whole consultation process similarly needs to be distributed to all who participated so that organisations and individuals are assured that their views and concerns have been recorded for consideration. The decision that is made at the end of the process should also be relayed to all participants and should demonstrate how the views and opinions expressed influenced that final decision.[9]

Example 1

A consultation exercise in respect of a reconfiguration of services within the Wakefield District has involved both Wakefield and Pontefract CHCs, plus other interested agencies right from the very beginning, in an attempt to reflect the views of the full range of stakeholders in the final document. This process once completed (still ongoing at time of going to print), will have taken about a year.

This is a good example of openness and total involvement on the part of Wakefield Health Authority in dealing with extremely contentious issues. The Health Authority has worked closely with the CHCs to determine the best approach to consultation.

It is true that at various stages through the consultation process there has been some scepticism on the part of members as to the value of this extended exercise when it is believed there has always been a 'master plan' anyway. Time will tell the outcome, but the approach has certainly been groundbreaking and one that should be considered by others as a transparent and open approach.

Example 2

Also under the heading is an example of where the process is not necessarily open and transparent. This involves a consultation in respect of the transfer of neurosurgery services from Pinderfields Hospital to Leeds General Infirmary.

A very thorough exercise was undertaken, involving information giving, public meetings etc. There was a great deal of opposition to the proposal from Wakefield CHC Members, the public and indeed many other CHCs. It was recognised, however, that because of the strength of the clinical support to the proposal, it was extremely unlikely that Wakefield's opposition, despite very good reasoned arguments having been presented, would be upheld.

Wakefield CHC Members accepted the transfer but with specific provisos that certain action be undertaken to safeguard other services at Pinderfields Hospital. Despite a minuted agreement to Wakefield CHCs provisos by the then Yorkshire Regional Health Authority, these were never upheld by its successor body. This experience has left a bitter taste in the mouths of Wakefield CHC Members, leading them to believe consultation is merely a sham.

2.9 Risks, Health and Safety

CHC members and staff are used to being in the front line and there is a risk that issues concerning health and safety are overlooked. Chief Officers would be able to recount from their own experiences, times and events when they realised that they had been 'at risk'.

Members have to be protected and similarly staff should not be put into situations where their health or safety would be compromised. Risk assessment is a term that is more commonly associated with large organisations but it is an exercise that CHCs should undertake, particularly when going out to seek the views of the public.

Example:

A Community Service Trust proposed to establish a new move on facility for Mentally Disordered Offenders on the site of a disused geriatric hospital close to a school. The Trust wanted to generate income and its business case rested on the fact that there was a shortage of places for this client group and a new facility would be used by offenders from the wider West Yorkshire area, as well as bringing others closer to their homes.

The Trust had held two meetings at which there had been a large number of attenders, heated debate and feelings had run high; the situation had been described as one of 'near riot'.

The CHC wished to hear the views of the local community and instructed the Chief Officer to arrange a meeting in the same school hall as the Trust had used for its meeting. The Chief Officer sought advice from the Police and Local Authority; both authorities advised against the meeting and said that it would be unwise to proceed because of the potential risk of violence. The CHC's members were so committed to seeking the views of people in the locality that they did not accept the advice of the Police and Local Authority and insisted that the meeting should take place.

The Chief Officer sought further advice and wrote to the members of the CHC saying that she refused to take responsibility for the health and safety implications and that they would be personally liable for any damage to property and any injury sustained by any-one attending the meeting.

Members reconsidered the position and decided not to go ahead with the meeting.

The views of local people were sought and gained by alternative means. The Chairman and Chief Officer of the CHC were invited by Local Authority Councillors to attend a meeting in the Local Working Men's Club. This was a low key meeting at which people were able to discuss their fears and views on the proposal. However, it is worth noting that both the Chairman and Chief Officer were advised not to wear suits as there was such antipathy towards officials and officialdom.

The CHC also used a room in the Civic Hall for a full day to give any interested member of the public an opportunity to express their views.

The outcome was that the Health Authority did not accept the business case or the need for such a development in the district.

2.10 Opposition to the Proposal

The closure of a hospital is often an emotive issue and the views of the public might be different to those of the users of the hospital: nearly every CHC in the country will have had an experience of this.

Example 1

The consultation to close Killingbeck hospital in Leeds was an emotive issue and was opposed by the local community around the hospital as well as a consultant who was well known both locally and nationally. The consultant was successful in arousing local feeling against the closure of the hospital and used the media effectively in putting his message across to the public. Much emotion was generated by the location of the site, which was away from the city centre and thus afforded a pleasant environment, for patients and their visitors.

A wider consultation was held across West Yorkshire with users of the services as Killingbeck was a tertiary centre for cardio-thoracic surgery. The users of the services provided by Killingbeck were far more concerned that services should continue to exist and be there when they needed them as well as providing them with the best chance of survival and recovery. For users, coming from a wider area, the issue of the location of the service was not an important factor.

The CHCs of West Yorkshire made individual responses and fully supported Leeds CHC's decision not to oppose the closure of the hospital.

Example 2

CHC Members do not always have easy decisions to make when for example there is a huge groundswell of opinions against the closure of a hospital, in this case a maternity hospital, yet from the information obtained by the members, there are concerns about health and safety issues.

In the case of the transfer of maternity services from Manygates Maternity Hospital to Pinderfields Hospital, Wakefield CHC Members had to face a great deal of criticism from the local population and local politicians when they did not oppose the transfer. Their decision at the end of the day was determined by the fact that the old unit was isolated and did not have on site anaesthetic cover with the obvious dangers to both mothers and new babies.

However as part of this consultation process, Members were able to suggest many improvements to the original proposal in respect of facilities at the new site which were taken on board by the Health Authority.

3. Bibliography and Useful Sources of Information

1) 'Consultation Counts'. Guidelines for services Purchasers and Users and Carers based on the Experiences of the National User and Carer Group - Department of Health

2) 'Healthy Dialogues'. Practical Ways of Involving Local People in their HealthCare - South West Thames Regional Health Authority

3) 'Listening to Local Voices'. A Guide to Research Methods - Nuffield Institute for Health Services Studies

4) 'Local Views'. The Views of Local People in Purchasing for Health, January 1992 - NHS Management Executive

5) 'Priorities and Planning Guidance for the NHS: 1997/98 - NHS Executive

6) 'Priorities and Planning Guidance for the NHS: 1998/99 - NHS Executive

7) 'Involving the Community'. Guidelines for Health Service Managers - National Consumer Council

8) 'A Resource for Commissioners'. Encouraging User Involvement in Commissioning - Department of Health 1996

9) 'Community Service Users as Consultants and Trainers' User Involvement' - Department of Health 1996

10) 'Consumer Audit Guidelines' - NHS Management Executive

11) 'The People's Health Service?'. Research Paper - The NHS Confederation

12) 'Involving the Community' - Guidelines for Health Service Managers. National Consumer Council.

13) Priorities and Planning Guidelines for the NHS 1998/99

14) Leeds Community Health Council - Consultation with Leeds CHC

15) Mergers: Going with the Flow - Greg Kent, Health Service Journal, 18 September 1997

16) 'No Case' Made for Major Trust Shake-up in Wales - Lyn Whitfield, Health Service Journal, 4 September 1997

Appendix 1: The Lynton Judgement

Heard by Mr Justice Moses in the High Court on 4 August 1997

The case brought by a number of patients of two North Devon community hospitals threatened with closure. Their application for judicial review of the Health Authority's decision to close these hospitals, without prior consultation, was supported by a community group. The application was successful and the authority's decision to close these the hospitals, was quashed by the court. North Devon Health Authority were directed to carry out consultation with the CHC and local community, before reaching any final decision on the future of the hospitals. The court took into account the Health Authority's argument that the closures were in order to save money, so as to allow them to meet their statutory obligation to balance their budget.

The applicants based their case upon the provisions of Regulation 18 of the Community Health Council Regulations for 1996. The fact that they were successful, is a shot in the arm for CHCs, as these Regulations give CHCs more explicit rights to be consulted.

The transcript of the judgement was available from October but below are listed some of the points made by Mr Justice Moses, which will have general relevance for CHCs, particularly those expecting to be consulted on proposed changes to services in their districts.

- Consultation is a process whereby the Health Authority and CHC should jointly seek to reach a solution to a problem.

- The North Devon Health Authority could not seek to avoid consulting on the ground that the consultation exercise might provoke anxiety, or was pointless, or that it would provoke protestations of opposition to their plans, or because the authority considered that there was only one practicable solution.

- The fact that information about the closure had been in the public domain and that the public and CHC had made their views known, does not remove the duty to consult.

- The authority were at fault in failing to consider that the consultation process could produce alternative solutions to those which they had identified.

- Whether proposals are for a temporary or permanent solution, the duty to consult remains where the proposals are substantial.

- The Authority should consult on proposals and not wait until proposals have evolved into a final decision. The time for consultation is when proposals are still in a formative stage. It is not appropriate for an

authority to reach a decision and then put it out for consultation, because the process of a consultation requires that the consulter have an open mind.

- The Health Authority were under a duty to consult with the CHC when they became aware of proposals for substantial changes to services and the fact that those proposals had not been considered by the Board of the authority, was not good reason to delay the consultation.

- The Health Authority's argument that they need not consult, due to the urgency of their need to make savings, in line with the provisions of Regulation 18(3), was criticised. The duty to consult cannot be undermined by a reliance on this exemption, when an authority allowed time to pass to the point where matters became so urgent that there was not time left for consultation.

North Devon Health Authority were granted leave to appeal to the Court of Appeal but did not do so.

Marion Chester,
Legal Officer, ACHCEW

Appendix 2: Training for CHC Members

The Training Process

The following exercises were used at a Member's Training Day for North and South Tees CHCs. Members were split into group and each group were given an exercise to work through. Briefing papers had been prepared a to give background information about the hypothetical locality and the main issues that would concern a CHC having to make a decision on whether the CHC would undertake Formal Consultation on any of the proposals.

Each of the group was ask to make an initial decision on whether they would want to undertake a Formal Consultation on the proposal that they had been presented with. Once the group had made its initial decision, if they were going to undertake a consultation exercise, the group was asked to devise a strategy for the consultation process. If the group had initially made a decision not to consult, members were asked justify the decision by examining the process that they had used to reach it. Prepared papers (pages 33 and 34) were given to each of the groups to help them in either devising their consultation strategy or justifying their decision not to consult. Members were asked to identify what they thought would be the major costs and risks consequent on their initial decision.

After a given period of time, the groups were asked to report back on what they had identified as the main issues, whether they stood by their original decision or had changed their minds and had any doubts about what they had done.

The results of the feedback session are tabled overleaf.

The main issues highlighted by Members involved in the Training Exercises

- Who takes responsibility for the decision? - This has to be the whole of the CHC
- Designation of spokespeople - Training issues
- Opposition to the stance of the CHC
- People power
- Individual/members who usurp authority
- Deflection - shift the blame

Feedback from groups participating in the training Exercises

Group	Trust Merger	Rationalisation	Rationalisation	HAs Merger
Initial decision	**Yes** - Would formally consult	**No** - Would not formally consult	**Yes** - Would formally consult	**No** - Would not formally consult
Justification of decision	1 Implications for the delivery of services. 2 Need to maintain the credibility of the CHC	1 Health Authority's responsibility to consult 2 Insufficient resources to consult with a population of 200,000 3 Costs outweighed benefit to the CHC	1 Implications for the delivery of services 2 Benefits - an opportunity to develop the CHC's relationship with the Community	1 CHC would want to maintain a neutral stance 2 Would use informal mechanisms to consult and inform the public
Costs	Time - Chairman Sub-group chairs and staff Venues for meetings		Would seek partnerships with the HA and use of their resources Overall time commitment from the Members and Staff	
Risks	Not Identified	Implications for the future of the CHC Decision could damage the CHC's relationship with the community		Would the CHC be asked to consult in the future Perception of the community on the stance of the CHC
Final Decision	Had no doubt that the decision to formally consult was the right one	At the end felt that they had made the wrong decision	Stood by initial decision	Stood by initial decision

Exercise 1: Rationalisation of Estate

Background

Hartees NHS Trust wishes to rationalise its estate in order to reduce both capital and yearly running costs.

Clevetees Health Authority has the responsibility to consult with the community covering the area served by Hartees NHS Trust.

The area is served by one CHC, Hartees CHC. The population served by Hartees CHC is 200,000 with one major urban (Town) centre and two smaller centres about seven miles away from the Town centre. The rural hinterland covers an area 10 miles (north to south) by 15 miles (east to west). There are other major town centres to the north and east of Hartees which are also part of the area covered by Clevetees Health Authority.

Hartees Trust

Hartees Trust is a whole district Trust which includes four hospital sites and the community services. The largest hospital, the General, provides acute services and has an accident and emergency department it has 450 beds but was originally built in the 1960s with accommodation for 600 beds. The building requires extensive renovation and there will be a major refurbishment and centralisation of the Operating Theatres over the next three years, for which money has been allocated. The General hospital is sited within the Town Centre approximately two miles from the main bus and railway stations.

The Midway hospital, is also in Town centre, again two miles away from the bus and railway station but in the opposite direction; ie four miles away from the General. Midway caters for elderly long stay patients, mostly suffering from Alzheimer Disease, and has a respite facility for patients with dementia as well as patients with severe physical handicaps. The building also houses a day-hospital which takes 20 to 25 patients each day. Again the day Hospital is mainly used by elderly patients with moderate to severe dementia problems.

The hospital is mainly single storey with long corridors connecting the various parts of the hospital. The hospital is run down and was created from a series of Nissen hut type buildings. The hospital has accommodation for 300 patients but over a period of years this has been reduced to 100 beds. There is pressure on the respite facility and the day hospital facility was opened five years ago.

St. Anne's hospital is in Town Centre, two miles to the South from the bus station. St Anne's houses 4 Acute Mental illness Wards, 72 beds; an assessment ward for EMI patient, 14 beds; two long stay/rehabilitation wards

for elderly patents, 28 beds; there are also 10 respite care beds for older people with learning disabilities. In addition the hospital has diagnostic facilities for x-rays, ECGs, etc. In addition there is a day hospital for patients with mental illness. There is also a rehabilitation facility for Patients recovering from stroke or amputation. The Rehab Unit was purpose built, has its own dedicated transport and houses other associated clinic/specialities such as speech therapy, physiotherapy, occupational therapy and bathing facilities.

The hospital occupies a large site with adequate parking facilities; it is surrounded by housing estates and there are good transport links to the centre of Town.

Teesvale hospital is situated 7 miles from Town in the midst of a small urban centre serving a largely rural community. Links to Town are good but the buses run only hourly and it is necessary to catch a second bus from Town to any of the other hospitals; there are no cross routes or bus services.

Teesvale is really what most people would regard as a cottage hospital, sited in its own grounds. The local GPs run a minor injuries unit, and there is a GP Unit which the GPs use for respite care. There are various out reach clinics. In addition there is a 24 bedded Unit for the care of ESMI patients who also have challenging behaviours.

The Proposal

To rationalise nearly all the services from Midway and St Anne's hospital onto the General hospital site. The rationalisation would take place in two stages. Teesvale to become a GP managed hospital with 6 in-patient beds, with a day hospital for elderly patients with dementia. The ESMI facility to move initially to the St Anne's site and then as space becomes available onto the General site; as this move is effected the St Anne's site will also close.

Issues for the CHC

The General Hospital is on a closed site where there is little room for expansion. The site has no grounds as such, there are no gardens and there are already problems due to the lack of adequate parking; the local residents have formed a protest committee about this problem.

The CHC has had concerns about the cramped facilities in the Radiography department. Similarly, other areas, particularly the out-patients departments are very cramped for space.

Midway hospital is no longer regarded as a suitable environment for the patients it houses; several very critical reports have been written over the past two years. However, the respite care unit and the day hospital have

had glowing reports. There is a local action committee supported by the MP for Town who have heard rumours about the hospital closing and who have started to raise money to campaign to keep the hospital open.

St Anne's hospital is highly regarded for the services its provides some of which have been visited by Health Ministers as models of good practice in caring for patients with mental illness.

The rehabilitation Unit provides a superb service, the Amputees committee are agitating to remain on the St Anne's site; they do not want to go back to the General ever again.

Teesvale hospital was built with monies raised by public subscription. To cater for war veterans with injuries(ie. a War Memorial Hospital). The local community believe that they should decide on its fate. They do not want the hospital sold off and they do not want patient from other parts of the district to have use of it. Some years previously there had been a public meeting held to decide on the future of the hospital; over 300 people had attended, the meeting had been very noisy and the health authority had been forced to revise its plans. The CHC had been very involved and some members f of the CHC are still members of the CHC now, including the local authority councillor for that community.

Will the CHC want to hold a Formal Consultation on this proposal?

Exercise 2 - Trust Mergers

Background

Clevetees health Authority covers three districts; Hartlees, Clevepool, and Teesdale. Hartlees is a whole district Trust (ie. Acute and Community Services), Clevepool has an Acute Hospital Trust as does Teesdale; Clevepool and Teesdale are also served by a Community Trust, Teespool Community Trust, which covers both districts.

Hartlees has always achieved a balanced budget since its inception. Clevepool Acute Hospital Trust has two major hospital sites and a third hospital for EMI patients. A PFI scheme has already been consulted on and the contractors have signed up for the building. The PFI scheme is to replace the two old acute hospitals with a new building with a facility in the grounds to replace the EMI hospital. The actual content of the hospital is still under discussion. The scheme is expected to realise savings of £2 million a year but not until the Year 2,000. The trust have always achieved a balanced budget.

Teesdale Acute Hospital Trust serves the smallest population of the three districts, it has one hospital, built within the last ten years. There is overcapacity at the hospital due to several factors, one the poor reputation of clinical services has meant that patients have preferred to go to another hospital which is a tertiary centre for the Region. Secondly, since the hospital was originally conceived changes in the provision of health care has meant that the hospital has always had more beds than needed to serve its population. The running costs of the Trust are higher than the other two hospitals and it has been unable to achieve a balanced budget; at present it has a deficit of £1.2 million.

Teespool has had difficulties in its relationship with t he two Acute Trusts and has been faced with having to respond to different protocols and expectations. Whilst the Trust has balanced its budget it has had to give warning that it cannot continue to meet the demands placed upon it without significant investment in new community facilities.

Clevetees Health Authority is faced with am overall deficit of £2 million and no promise of additional funding to address the issue of the overspend by Teesdale Acute Hospitals Trust.

The Proposal

To merge the Acute Hospital Trusts with the Community Trusts and the whole District trust in order to save money (mainly administrative costs) and to reconfigure services in line with Calman-Hine recommendations.

The issues for the CHCs

The Acute hospital trusts have refused to collaborate to provide single clinical management in minor specialties and the health authority has become increasingly frustrated with the competitiveness of the four Trusts. The health Authority has also found it difficult to control the development of services in some specialties eg intermediate cancers. Hartlees Trust is regarded as particularly aggressive.

Exercise 3 - Health Authority Mergers

Background

Clevetees Health Authority is faced with an overall deficit of £2 million; in addition one of its main providers has a deficit of £1.2 million. Locally, 10% of GPS are fundholders, there is a preponderance of single handed GPs. The authority covers a population of 280,000.

Next door, Castlefield Health Authority is facing a deficit of £3 million, there is 100% GP fundholding and Locality purchasing in operation. Locality purchasing and commissioning has imposed a serious threat to some hospital services and if this continues the health authority will have to look seriously at the viability of hospital in its area. The authority covers a population of 200,000.

Newford Health Authority has a predicted overspend of £6 million. The authority covers a population of 400,000 people. There are tertiary services provided within the area of Newford but these are few in number and it is not regarded as a Regional centre.

There are 7 CHCs in the area covered by these three health Authorities.

Just to the North of the three Health Authority area there is a large district with a population of 700,000 people. This area has one Health Authority and two Trusts which are major providers of tertiary services for the whole of the Region. These Trusts are expected to merge before April 1998.

The Proposal

To merge the three health authorities to save on administration costs and to form an authority that will have sufficient power to counter the threat that is posed by the merger of the two tertiary centres to the North of the area covered by the present three health authorities.

Issues for the CHCs

The merger of the two major providers of tertiary services is perceived as a major threat to local services.

Clevetees health authority is not regarded as performing well and there are already tensions between it and its respective CHCs.

Castlefield Health Authority has excellent relationships with its respective CHCs. The Chief Executive is held in high regard by all 7 CHCs.

The threats posed by Locality Purchasing are not well understood by all the CHCs.

Little is known of Newford Health Authority by the CHCs not in its area. (Assume that its relationships with the respective two CHCs are all right and thus there is a fairly neutral feeling towards the authority.) However, the Chief Executive is well-known for his views which are fairly radical, he is outspoken and caused a lot of ill feeling and upset when he was the Chief Executive of a Provider Unit elsewhere in the Region.

The seven CHCs have a good working relationship with each other and have a healthy respect and understanding of each others position. There is a sub-regional association of CHCs which has been existence for six years, at which both Chairman and Chief Officers meet on a quarterly basis.

YES

If the answer is yes:-

The CHC needs to devise a strategy for the Consultation process.

What will be the aim and objectives of the Consultation?

What does the CHC want to achieve for itself?

What risks are there for the process and the CHC?

What can be done to deflect or minimise these risks?

Key players have to be identified.

What will be the role of members a) as an organisation?
b) individually?

Devise a timescale for carrying out the Consultation.

Try to estimate how many meetings will be necessary.

What type of meetings will be held and who with.

Try to estimate the cost in financial terms eg.
Hire of rooms
Publicity
Postage

Estimate the cost in human resource terms:
Chairman's commitment
Members' Commitments
Chief Officer time
Support staff time

How will this change the CHC's Priorities?

How will the Chief Officer's objectives be altered?

What is the bottom line for the CHC, both member and staff, ie what will you be able to accept as an outcome of this Consultation? What would be unacceptable?

NO

If the answer is no:-

How will the CHC justify this answer?

Does it need to justify its position?

Draw up a brief statement that explains the process that the CHC used to arrive at the decision.

What were the main factors that influenced the CHC?

Who was involved in making the decision?

How will your decision not to consult be made known to the public?

What risks are there to the CHC?

Do the perceived risks fall within the parameters of acceptability to the CHC or what the CHC will be able to balance and live with?

Who will take responsibility for the decision not to consult?

Infoleft: workarea\ben\cons1197

References

[1] R v Secretary of State for Social Services, ex parte Association of Metropolitan Authorities (1986) 1 All ER 164
[2] "Mergers - The new cure all?". ACHCEW. Health Perspectives. November 1997
[3] Cleveland CHCs and Tees Health Authority, July 1997
[4] Northern and Yorkshire RHA Position Paper, August 1994
[5] Marion Chester, Legal Officer, ACHCEW. Letter re: evaluation of legal services SLA, 21 July 1997
[6] Cath Broderick, Health Director, May 1997, pages 14 and 15.
[7] Ideas from a Conference "Trust Mergers - Is Big Beautiful" held on 1.10.97
[8] The Priorities and Planning Guidance for the NHS: 1997/8. NHS Executive
[9] Listening to Local Voices - A Guide to Research Methods. Nuffield Institute for Health Services Studies (University of Leeds). The Public Health Research and Resource Centre (Salford) 1992

Published by:

ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES
30 DRAYTON PARK LONDON N5 1PB

TEL: 0171 609 8405 FAX: 0171 700 1152

Copies available from:

MRS C.L. HUNTER
CHIEF OFFICER
HUDDERSFIELD COMMUNITY HEALTH COUNCIL
12 NEW NORTH PARADE
HUDDERSFIELD HD1 5JP

TEL: 01484 544676 FAX: 01484 535142