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"Self Reviews in Community Health Councils"

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A Report on a process of Self Review and Objective Setting in CHCs

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"Self Reviews in Community Health Councils"

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Introduction

Empowerment of CHC members

This report is the outcome a year long pilot study to develop a yearly planning process for use by Community Health Councils, by means of 'Self-review'. It contains an argument for introducing a process of 'Self-review' into CHCs and provides a model that has been tested and can be readily used in similar organisations.

CHCs have been overwhelmed with work as they have tried to meet their responsibilities to represent their local communities in the health service. The impact of the NHS and Community Care Act is still being felt and, following in its wake has been the 'Patient's Charter' and 'Local Voices' - statements about the need to set standards relevant to patients and involve consumers in the NHS. All of these changes have placed major demands on CHCs, some of whom were already becoming daunted by their daily workload.

In 1990, King's Fund College anticipated this problem and were concerned that users of services and their representatives were not be left behind in the sweeping changes. They decided to organise a Management Development Course - which has since proved to be a valuable source of inspiration for CHC staff. For participants it has provided an opportunity to crystallise problems and set the demands being placed upon CHCs in a wider context.

The authors of this report attended the first Course, which was held in October 1990. During the Course we were helped to remember that CHCs are small organisations, whose job it is to make demands and to influence the decisions of professionals, managers and Health Authority members. But demands which are placed upon CHCs can also be seen as opportunities - which can be chosen to be acted upon if we wish. One of the most significant problems is to learn how to choose which opportunities are in the best interests of those whom CHCs are set up to represent - service users and the public.

Many of the participants of the first Development Course came away with a feeling of empowerment and the authors, along with Paul Etherington (former Chief Officer - North Beds CHC), decided to progress ideas further to help empower CHC members . One area in which the culture ofthe Health Service was to be dramatically affected by the NHS & Community Care Act was in relation to more explicit forms of contracts being established. CHCs needed to address this question and ideas were formed about how to clarify roles locally, as part of a consensus building and priority setting exercise.

When we reviewed how CHCs were already establishing Workplans we found two main models in existence. Neither of these models were being widely utilised and they were used by CHCs in isolation from one another. In the first model one person, or a small group of individuals, was given the task of writing a paper, for approval at a formal meeting of the full Council. The other model was initiated by the CHC Chief Officer, who started the process by facilitating a Review in which members had an opportunity to discuss priorities.

During our development of the process it was recognised that Reviews needed to accomodate the agendas of everyone working within the CHC, including members and staff. In order to make the process safe, proposals were made for facilitation of Reviews by two external people with practical experience of CHCs. And for the sake of efficiency, Reviews needed to be undertaken within the framework of a one-day programme. The Review Day now employs well tried elements, in a systematic process, helping CHCs to discover their own priorities, which may then form the basis of Workplans for the year ahead.

This report argues the need for the introduction of a Self Review process, after piloting the method amongst 20 CHCs across the country and shows how it has helped differing CHCs to overcome stumbling blocks and address the challenges facing them.

The first section describes the background to CHCs, their current role, and why some CHCs have developed a sense of disempowerment. The second part reveals the power of a Review Day for organisations with voluntary members and provides examples of the effects of a Review Day in different settings. This section also emphasises the value and importance of a Review day in being part of a continuing process of objective setting and evaluation. Finally, a 'Model Review Day' is proposed, describing how to employ the process and the purpose of each element in the process.

Background

Community Health Councils (CHCs) were established in 1974 as independent statutory bodies as representatives of the public interest in the NHS, relating to Area Health Authorities, and , after the reforms of 1982, District Health Authorities. CHCs are local bodies with a voluntary membership of between 18 and 24 and generally with two staff. They are set up by Regional Health Authorities, whose role is to act as the employer of the staff and ensure CHC funding. Their local nature with a voluntary membership and independent status distinguishes CHCs from statutory regulatory bodies in other public services.

What CHCs should do has never been prescribed and CHCs have been able to establish their own methods of working. Their role has been described in 'A Handbook for CHC members' as acting as a "Patients' Friend", as the "Community's Watchdog" and as the "Community's participation in the NHS". (Chris Ham, Bristol, July 1986, SAUS).

The **"Patient's Friend"** describes the work CHCs undertake with individuals who may need to make a complaint about the NHS, by putting people in touch with the right service or helping them to access a service, or by providing information on local services. As the **"Community watchdog"**, CHCs use their statutory rights to information to keep informed and comment on the local health service, and they use their statutory right to visit NHS premises to conduct visits to monitor the delivery of services from a patients' perspective. The CHC role in **"Community participation"** reflects the way in which CHCs are consulted or make proposals for change in health service provision, in order to try to represent the community's interests. Many CHCs have extended these basic roles to provide, for example, a comprehensive information service, or to conduct more systematic monitoring, or help service users to have a direct say in their local health services.

Changes in the NHS since 1974 have always prompted discussions about how to raise the profile of CHCs nationally, to improve their status as consumer representatives, and to ensure members of the public may come to expect a minimum service from any CHC in the country.

When the NHS White Paper 'Working For Patients' (HMSO, January 1989) was first published, it was seen as having far reaching implications for Community Health Councils. Before the introduction of these reforms CHCs related primarily to their District Health Authority, monitoring the service they provided and badgering them to improve these services. District Health Authorities had a vested interest in the services because they directly managed them and they played little role in monitoring these services or seeking patients' views on the quality of services being provided . Representation of the public interest in the NHS was also carried out by Local Authorities members being appointed to Health Authorities.

Post the White Paper, CHCs were seen to be faced with greater demands. With the elimination of Local Authority members from the Health Authorities, CHCs were also given additional responsibility in being the only remaining element of direct public representation within the NHS.

The introduction of the NHS & Community Care Act (1990) saw a formal division between 'purchasers' & 'providers' - with new powers being given to Family Health Services Authorities (previously Family Practitioner Committees). CHCs would now be faced with a need to relate to more independent bodies : the local Health Authority and FHSA as purchasers, and whatever providers there were in the district. Moreover, the changed role of the District Health Authority would mean CHCs needed to confirm their role existence and to demonstrate their worth to the local community and the local health service. Prior to the introduction of legislation, District Health Authorities were also being urged to become "champions of the people" (see speech by Secretary of State to Joint Conference of National Association of Health Authorities - DoH Press Release 90/308) and to take on the task of assessing the health status of the local population; assessing health needs, including perceived health needs; determining what services were required to meet those needs; contracting for these services; and monitoring these services to ensure they are provided to the highest standards. They were further charged with involving consumers in every aspect of the purchasing cycle (Local Voices ref - EL(92)1 - NHS Management Executive Letter).

On the face of it these functions seemed to subsume some of the work CHCs had undertaken in the past. CHCs would now be expected to demonstrate that their unique independent status offered anything different. A further problem with the new purchasing function was that CHCs could become enveloped in demands from the Health Authority to undertake some of their tasks - such as monitoring. Some Health Authorities would be developing these tasks from scratch, whereas CHCs have a wealth of experience in monitoring local health services and accessing local communities. A CHC has representatives of the locality within its membership; has a network of contacts in the community; and with its independence has a credibility with the community a health authority will not always be able to achieve. Most CHCs are also used to involving local people in the health service in various ways. Examples include:

* convening Conferences for particular users of health services to express their views

* helping to establish user groups

* conducting joint monitoring projects with other community groups

* convening locality health forums to feed into planning mechanisms

* conducting surveys of users' views of the health service

If patients are to be placed first and consumer views to be heard throughout the purchasing cycle, then CHCs become key players - if they are not overwhelmed with other demands placed upon them. The introduction of the Patients' Charter indicates another potential demand: a need to have demonstrable standards and for those standards to be monitored and developed. This was most recently reiterated by the Minister of Health at the 1992 Annual Conference of ACHCEW in Brighton.

Many CHCs understood these dangers, but also recognised opportunities for CHCs to develop into appropriate and powerful consumer watchdogs needed for the new NHS. The Association of Community Health Councils for England and Wales (ACHCEW), a national statutory body to which CHCs can affiliate, called for greater resources for CHCs now they were to be the only representatives of their local community in the NHS, to take on the role of more systematic monitoring, and to monitor greater areas of care as the divide between NHS, private and social care blurred. Much earlier, in 1988, ACHCEW had initiated a debate amongst member CHCs, in publishing an "Outline Scheme of Objectives for CHCs". This was followed later by a paper on "Commmunity Health Council's Core Activities" (ACHCEW - August 1991).

They did not avoid the implication that, if CHCs were to expand their role, there must be a mechanism for ensuring they provide a good service. ACHCEW concluded that 'as with health services, CHCs themselves need to be subject to quality control' (Report of the Panel of Inquiry. Effective CHCs for the 1990s November 1989 ACHCEW London), and that this quality control should be conducted by a body itself independent of the health authority structure.

Similarly, the Greater London Association of CHCs (GLACHC) also called for a strong consumer agency in the NHS as a result of the pending NHS reforms. "If that agency is to be Community Health Councils, then they are going to have to be prepared to change, to develop and systematise the service they are offering. They are also going to have to convince others that they can do it and to give them the resources to do it.' (' Post the Review - Community / Consumer Representation in the NHS with specific reference to Community Health Councils'. Fedelma Winkler - GLACHC - London 1989).

A conference held by the GLACHC in 1989 further concluded that CHCs were not well equipped to meet the demands of the NHS Review. They decided that CHCs should look at their underlying values, set priorities, establish core tasks and consider the resources necessary to undertake these tasks (IBID).

It was in this context that we attended the first Management Development Course for CHC Staff organised by King's Fund College. It was an opportunity to work together and share similar ideas as well as similar frustrations. The week-long course led us to an understanding and appreciation of the management skill involved in managing an organisation which consists of a mixed membership of volunteers and political nominees with an external environment of great complexity.

Many of the problems we were experiencing were addressed - particularly the effects of the health service reforms. We soon realised that we could not meet all the demands placed on our organisations and that our CHCs would have to make more explicit choices if they were to be an effective voice for local people. CHCs have similar core functions but there is a remarkable diversity between CHCs as to what work they do beyond these core functions. This is a strength of CHCs which should not be lost.

Developing the idea of Self-Review

We began by helping each other introduce or to improve upon the Annual Review day in our own CHCs. We worked together to begin developing a model for discussions, facilitated by two of our group for the third CHC officer so he or she could partake in the group work. Very quickly this modest project expanded as we mentioned to other CHCs what we were doing. We soon found other CHCs wanting outside facilitators, familiar with the work of CHCs but not part of their own CHC, to help them set objectives.

As the number of requests increased it was realised there was a need for more facilitators and for training. The King's Fund provided a grant to pilot the idea of a Self Review and objective setting process and to help set up training in facilitation training skills. The people invited to the training courses were both CHC Chief Officers and members of CHCs but always people familiar with CHCs. There is now a continually growing list of facilitators able to help with a review day. Over 20 CHCs have now undertaken a self-review and a model day has been devised with additional elements to suit different requirements.

A model Review Day agenda:

1. Introduction and outline of the day
2. Review of the previous year
3. As we see ourselves now and what we would like to be
4. Purpose statement
5. Demands
6. Resources
7. Core services
8. Aspirations
9. Priorities
10. Ways forward

The model programme begins with a brainstorm of **the previous year's activities** and how effective they were. It is a review of the year just past which helps everyone remember, or perhaps even realise for the first time, everything the organisation has done over the previous year.

Next comes a standard exercise such as asking the group to suggest what animal they would picture the organisation being at present and what animal they would like it to be in the future. This is surprisingly helpful as a warm up exercise and as a non-threatening way of allowing people to express their views of the organisation.

A **purpose statement** is a short sentence or two to sum up the reason for the organisation's existence. This is a useful exercise because it may be the first time members have discussed this or it may not be clear in everyone's mind. A practical result is a the nucleus of a statement which could be used in leaflets or on a letter heading.

Demands refers to what likely demands the organisation may be faced with over the next year and **resources** helps everyone to be clear of the resources available to tackle the work.

The next discussion is on basic services which members consider the organisation should always provide: its **core or essential services.** This is usually a list of no more than ten headings such as monitoring services and providing help and advice to members of the public.

The **aspirations** session adds an element of excitement to the proceedings allowing everyone to put forward their every suggestion they have for areas of work for the CHC in the next year. There is no need to think of constraints at this stage although the suggestions must fit within the purpose statement and follow on from the core services.

After these sessions there may be a long list of exciting ideas which have to be ordered into a set of priorities for the year ahead. The model programme ends up by looking at what to do following the day; the need to set objectives for the priorities and to build up a set of workplans for the organisation to work to over the next year.

There are additional elements which CHCs conducting the process in following years might want to include such as more in depth evaluation of the previous year; a reconsideration of the way the organisation works, eg its structure; or focussing on more longer term goals.

In piloting the elements of a Self Review Day, it was also found to be essential to send out a preliminary questionnaire to initiate interest in the process amongst CHC staff and members; to seek the views of those who would not be able to attend; to allow members to bring forward a list of their priority areas before the day; and to give everyone more time to prepare themselves.

The main purpose of Self Review is to help members and staff set priorities for the organisation for the next year and to assist in teambuilding. It does this in a way which engages all members and staff.

This model had to be developed to suit voluntary members from varying backgrounds with differing perspectives and with many other demands on their time. So the process has to be a consensus building exercise which takes into account all the members' and staff views and priorities. The process has to be non-threatening to encourage participation. The day gives everyone an equal say; brings members together and gives them ownership of the outcomes; enhances commitment by everyone in the organisation; and ends with a more firm consensus of what the organisation's purpose is. There should be a greater understanding by all members of the work of the organisation, a sense of teamwork and a commitment to some outlined priorities.

A review day is, of course, only part of the process. Following the day the organisation can experience great change. CHCs have reported far more member involvement in activities with better attendance and better planning to fit in with member availability; more prioritising and rejecting of work that cannot be tackled within existing resources; greater emphasis on training for members; more effective teamwork; and better understanding by other bodies of the current priorities of the CHC.

Conclusion

A self-review clearly does not solve the problems set out at the beginning of this report but it is a useful first stage. By setting priorities, being explicit about those and having everyone in the organisation signed up to these, it is possible to reject demands the organisation does not have the resources to meet. Equally it is possible to meet the demand by dropping a priority area. Self Review allows for this choice to be made with the understanding of all those involved.

Also, by having a clear set of work plans, allowing for an assessment of these plans and how they were met at the end of the year, the CHC can demonstrate more clearly its worth to the people in the community. The organisation should find it easier to be more pro-active as it will have anticipated work it wants to do and established plans to achieve this.

The value of the CHCs independence is enhanced by becoming more member led and involving more of the members in establishing the direction of the CHC.

Finally the CHC should be in a better position to respond to demands for a clear set of standards to CHC work by already having a clear set of plans. Self-review is, of course, just the first stage of developments in CHCs. CHCs are already beginning to consider how to more clearly develop detailed workplans following a day such as this, how to conduct continuous monitoring and evaluation of their work; how to set quality standards; and how to provide greater support for the voluntary members.

Hopefully, the idea of CHCs undertaking Self Reviews of their activities will continue to be popular. CHCs do have a greater responsibility to be seen to be accountable to their local communities. If CHCs can demonstrate a systematic process of self-review they will be better placed to argue the exact nature of these activities is for themselves to decide. Other attempts to establish core activities and priorities for CHCs could be seen as a top-down approach and may lose the commitment of the membership. A self-review protects the CHCs autonomy, involves all the members, and is member led. Members are the back-bone to CHCs; they go on visits week in and week out and bother to care about the falling down curtains in one ward and the cold meals in another, and they involve themselves daily in labyrinthian NHS decision making.

Self Review takes members priorities into account, enables them to say what the CHC exists for and what its core services should be. In the process it helps them to learn that CHCs have a public duty to be more explicit and professional in their way of working.

Self Review offers an opportunity to combine credibility with the local community with greater accountability developing confidence with purchaser and provider and helping to place CHCs once more centre stage in representing the voice of local people.

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The Authors of this report are all Chief Officers of Community Health Councils and have, between them, over 40 years of experience of CHCs - both as CHC members and staff. Cath Arnold comes from Manchester North CHC; Janet Finucane from South Manchester CHC; Nathan Lee from Merton and Sutton CHC; and Barrie Taylor from South West Herts CHC. They all attended the first Management Development Course for CHC Chief Officers, organised by the King's Fund College.