

ASSOCIATION · OF

# **COMMUNITY HEALTH COUNCILS**

FOR · ENGLAND · & · WALES

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THE DEVELOPING ROLE

OF

COMMUNITY HEALTH COUNCILS

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#### THE DEVELOPING ROLE OF COMMUNITY HEALTH COUNCILS

#### INTRODUCTION

- 1. Community Health Councils (CHCs) were set up by the National Health Service Reorganisation Act 1973. That Act laid a duty on each CHC "to represent the interests in the health service of the public in its district." This is an extremely broad remit and the intention that the remit should be broad is evidenced by the statements made in the subsequent guidance (HRC(74)4 January 1974), which said that CHCs might wish to direct their attention to "the effectiveness of services being provided in the health district and their adequacy in relation to health care needs .... the planning of services .... changes in services .... standards ...." etc..
- 2. The major changes in the NHS contained in the National Health Service and Community Care Act 1990 were not intended to alter this remit. Indeed, Government Ministers went on record as saying that there would be "no change in the fundamental role of Community Health Councils". Nevertheless with so much else within the NHS changing it was inevitable that new demands would be placed on CHCs and inevitably CHCs have had to adapt to the new environment within the NHS and their role has been refined in response to new structures. The Association of Community Health Councils for England and Wales (ACHCEW) recognised this in 1991 by endorsing the paper "Core Activities of CHCs". The Department of Health and the NHS Management Executive also began to consider

these issues: in January 1992, the NHSME issued "Local Voices", which considered how the views of local people might be fed into purchasing decisions; in February 1992, Stephen Dorrell MP (the then Parliamentary Under Secretary of State for Health) wrote to the Chairmen of Health Authorities, encouraging them to facilitate the "development of CHCs as the consumers' representatives in the purchasing function"; in March 1992, Andrew Foster (Deputy Chief Executive of the NHSME) wrote to all General Managers and Chief Executives reiterating and spelling out this message; and the process continues with the Patient Empowerment Group within the NHSME considering whether further developments in respect of CHCs should take place.

3. This has taken place in the context of the introduction of the Citizen's Charter in July 1991 which in the Guide accompanying it pointed out that "In the past, the inspectors of our public services have usually been members of the profession they This has made for too close a relationship. The Government wants to give people from different backgrounds a bigger say in future." This certainly presaged a larger role for community-based consumer watchdogs, such as CHCs. This was followed a few months later by the publication of the Patient's Charter in October 1991. This did not say much about CHCs as such, but laid great emphasis on the NHS being a Service that "always puts the patient first, providing services that meet clearly defined national and local standards, in ways responsive to people's views and needs" and stressed the need for better information for the public and improving mechanisms for listening to the views of service users. These developments suggest that the process of strengthening the voice of the patient within the NHS is very much in tune with the thrust of Government policy. This point

was recognised by the House of Commons Select Committee on the Parliamentary Commissioner for Administration who in their recent report "Reports of the Health Service Commissioner for 1990/91" recommended that "the health departments initiate discussions with the appropriate national associations on the role for community health councils and local health councils in monitoring the implementation of the Patient's Charter." It is therefore particularly timely for ACHCEW to present some further proposals for consideration on how the role of CHCs should develop.

4. This paper therefore follows on from ACHCEW's earlier documents, "Effective CHCs for the 1990s: Report of the Panel of Inquiry" (November 1989) and "Community Health Council Core Activities" (July 1991), and is being published for discussion in the context of the changes and developments listed above.

### THE GENERAL OBJECTIVES OF COMMUNITY HEALTH COUNCILS

5. As mentioned above, the National Health Service Reorganisation Act 1973 defines the duty of CHCs as being:

"To represent the interests in the health service of the public in its district."

This was translated by the NHSME in their booklet "Consultation and Involving the Consumer" (December 1990) into the following:

# "CHCs are there to help the public and to advise their local NHS authorities."

- 6. Many CHCs have produced their own 'Mission Statements' or statements of 'Overall Aims'. In "Community Health Council Core Activities" ACHCEW recommended the following statement for consideration by CHCs for their use:
  - "1. The CHC is a Statutory Authority which represents the interests of the local

public in the health services; and is the patients' voice in relation to those services.

- 2. The main purpose of the CHC is to influence the nature of health care provision and monitor its quality on behalf of the local population.
- 3. The CHC works by empowering users of health services and it acts as an advocate for those unable to represent themselves."

Such a statement of general objectives remains appropriate and it is commended to CHCs.

#### MONITORING SERVICE PROVISION

7. Most recent Government pronouncements have focussed on the role of CHCs in respect of purchasing. However, a prime function of CHCs has always been the monitoring of the services provided to patients. Indeed, the ACHCEW paper "Community Health Council Core Activities" last July gave the following as the <u>first</u> specific objective for CHCs:

"To monitor the quality and take-up of and the level of satisfaction of service users and the public with local health and health-related services, and to report on this to the relevant authorities and service providers."

8. A range of core activities are associated with this. First, CHCs will want to carry out a number of visits to hospitals, clinics and other units providing services to their local communities. This, together with the following up of the reports from such visits with the relevant authorities, has always been a major part of CHC work, fully involving CHC members. The introduction of the purchaser-provider split does nothing to diminish its importance.

- 9. However, the purpose of visiting needs to be clear. It is not possible for CHCs to engage in full monitoring of all the services being provided to their communities. CHCs do not have the resources either in staff or member terms to do that. What they can do is by a programme of <u>selective</u> visiting satisfy themselves about the adequacy or otherwise of the quality control processes being followed by the provider units and the monitoring arrangements being made by the purchasing authority, as well as following up areas of concern that may have been raised with the CHC.
- 10. Another important element of service monitoring by CHCs is the conducting and commissioning of research and surveys by CHCs. Again this cannot be as comprehensive as the satisfaction studies that will be carried out by provider units or by purchasers, but CHCs by selectively doing their own research work will be able to validate the work being done by purchasers and providers, indicate areas where further work needs to be done and enable the CHC to speak authoritatively on behalf of the users of service.
- 11. This will all be supplemented and informed by the work that CHCs do in arranging meetings of service users and encouraging/enabling service users to put forward their views, in considering the issues raised by complaints/representations received from members of the public, and in liaising with voluntary and community organisations with an interest in the services being provided.
- 12. To do this work effectively, there needs to be a proper recognition of the statutory responsibilities that CHCs have in

respect of health service providers, whether they are Trusts, directly managed or purchased from the private or voluntary sectors. To this end, the NHS Management Executive should make it clear to all purchasers (both DHAs and GP Fund-holders) that service contracts should require that CHCs be provided with regular reports and information from service providers, including performance indicators, reports on medical audit, and other quality-monitoring material.

- 13. In addition, for CHC monitoring activities to make sense, it is essential that CHCs are fully involved in the setting of quality standards both by providers and by purchasers. Again, this should be a requirement laid down by the NHSME.
- Self-governing Trusts should also adopt a more open approach to CHCs. Some already do this. For example, in ACHCEW's evidence to the House of Commons Health Committee inquiry into Self-Governing Trusts it was pointed out that in a survey of the relationships of 21 CHCs with their local Trusts 6 had observer status (right to attend and speak, but not vote) at Trust Board meetings. However, in a number of other cases such observer status had been rejected. Clearly, whilst it must be for individual CHCs to decide how much involvement they consider to be appropriate with their local trusts, it is undoubtedly unacceptable that there is such a wide variation between NHS Trusts in the degree of open-ness they display towards the statutory representatives of the communities they serve. In the spirit of the Citizens' Charter, it is vital that NHS Trusts should be obliged to give CHCs observer status at their Board meetings. observer status should be available whether the particular Trust

meeting is being held in public or in private. Moreover, Trusts should have a duty to make available to the CHC information on the services being provided, the quality standards adopted and those achieved, the nature of the complaints received and the plans of the Trust concerned.

#### ASSESSING THE HEALTH NEEDS OF THE COMMUNITY

15. Central to the changes in the NHS introduced in April 1991 was the stress laid on District Health Authorities as the lead purchasers for their areas in conducting an assessment of the health needs of their local population as the essential first stage of identifying the services to be purchased. CHCs have had substantial experience over the last eighteen years of advising health authorities of the services that need improving and of areas of unmet need. Indeed, the ACHCEW paper "Community Health Council Core Activities" summarised this as a key objective for CHCs as follows:

"To recommend improvements in services, to comment on the assessments made by the relevant authorities of local needs, and to seek to influence the range, type and quality of service purchased by authorities for their resident population."

16. This was reflected in the letter sent to Health Authority Chairmen by Stephen Dorrell MP, Parliamentary Under Secretary of State for Health, (ML(92)1) which pointed out that: "The purchasing function requires a health authority to monitor the health status of its resident population, and define health

targets for the future. This process of target setting will take place in the context of the wider public health objectives defined by "The Health of the Nation", but must also reflect local needs and priorities. CHCs should have the opportunity to contribute to the process of local target setting, as well as to the monitoring of performance against agreed targets."

17. In practice, this means that CHCs should work closely with the local Director of Public Health, should feed into and comment on his/her Annual Public Health Report, and should be formally consulted by local Health Authorities or purchasing consortia on their assessment of local health needs. Health Authorities and purchasing consortia should also consult CHCs about their general plans for contract placement and on the reviews of these plans that will presumably take place on a regular basis. CHCs will also no doubt wish to address issues of health needs and, in particular, unmet needs in commenting on annual reports produced by their local DHAs, FHSAs and NHS Trusts, and any purchasing consortia.

# PURCHASING AND THE CONTRACTING PROCESS

18. Ministers have identified the development of the purchasing function as the "key management challenge for the NHS." In principle, the contractual process can be divided into a number of phases: the identification by purchasers of their health gain objectives; the preparation of a general plan for contract placement; the negotiation of contracts with providers to meet the

purchasers' objectives; the setting of specific standards of service to be met by service providers under the terms of the contracts; and the monitoring by purchasers of the performance of providers in meeting the requirements of the contracts agreed.

CHCs as the local representatives of service users need to feed into each of these phases.

- 19. Of these five phases, the first two have been discussed above in the section on assessing the health needs of the community and the fifth was discussed in the section on monitoring services. However, the third and fourth phases contract negotiation and standard specification are also crucial and are central to CHC work. When a purchaser negotiates contracts to meet its objectives, it is effectively determining what services will be provided and where they will be provided. These are key issues for local people and it is essential that CHCs should have an opportunity to feed into and comment upon the priorities being decided. Similarly, when a purchaser agrees the standards of service being provided under the terms of a contract, it is determining the quality of care to be provided to patients and again CHCs, with their experience of what are the concerns of service users, need to feed into this process.
- 20. Health authorities and purchasing consortia therefore need to be active in involving CHCs in their purchasing decisions. At present, the guidance contained in EL(92)11 requires DHAs to "involve CHCs in the purchasing process. DHAs should agree locally with CHCs how they should contribute to the assessment of relative priorities, development of quality standards, target-setting and monitoring arrangements." The same document also

emphasises that CHCs should have access to information, such as DHA contracts with providers, purchasing plans etc.. This is helpful as far as it goes. However, it makes no mention of purchasing consortia, to which the same principles must apply. Moreover, all NHSME guidance about the contracting/purchasing process should make explicit reference to the need to consult CHCs at each stage of the contracting process and proper observer status (speaking, but not voting) should be restored as of right to CHCs at all purchasing authority meetings and also to meetings of purchasing consortia.

Similar arguments apply to the activities of GP Fund Holders in purchasing services. An increasing number of GPs can be expected to become Fund Holders over the next few years. will cover an even greater proportion of the population and will purchase an increasingly substantial share of UK health care. Their decisions will have a progressively more significant impact on the choices available to health authorities. CHCs, representing the local patient interest, should therefore feed into the purchasing choices made by GPs. The NHSME has already acknowledged that GP Fund Holders contracts should be made available to ... CHCs, if necessary suitably anonymised to protect patient confidentiality). Clear guidance to this effect should be given to GP Fund Holders, who should be expected to establish effective liaison arrangements with their local CHCs to enable CHCs to feed into the choices the GPs are making as purchasers. such liaison arrangements are likely to become increasingly important in the future if GP Fund Holding becomes more prevalent.

#### RESPONDING TO CONSULTATION EXERCISES

- 22. One of the key rights of CHCs has been their right to be consulted by health authorities on proposals for a major closure, a substantial development or variation of services. Inevitably, the introduction of the internal market and the purchaser/provider split has changed the nature of those items which come forward for formal consultation. The closure of a facility is now more likely to be a consequence of earlier contractual and purchasing decisions and as a result consultation when the closure itself is proposed is rather too late for any influence to be meaningfully exerted.
- 23. The NHSME paper "Consultation and Involving the Consumer", published in December 1990 set out how this might work: "DHAs are required by the CHC Regulations 1985 (SI No. 304) as amended to consult the relevant CHC on proposals they are considering which would result in substantial changes to the services in the CHC's District. This applies equally if the changes being considered as a result of changes elsewhere, such as a decision by an NHS Trust to change the services it offers." It went on to point out that, "a DHA considering proposals for substantial development or variations in services will wish to initiate the consultation process at an early stage."
- 24. In practice, however, a clearer statement is needed on consultation arrangements. The clear duty on DHAs as purchasing authorities to consult on the implications of their plans is explicit, but the same principle ought to apply to purchasing consortia, however they may be structured. Similarly, there should be an explicit requirement on providers to consult CHCs

about their plans and, in particular, NHS Trusts should be required to consult relevant local CHCs about their business plans.

25. Consultation is, of course, more than just responding to formal consultation documents. As "Consultation and Involving the Consumer" puts it, "The essence of consultation is the communication of a genuine invitation to give advice and a genuine receipt of that advice." Sufficient information must be provided and sufficient time must be allowed to enable a view to be taken. In practice, consultation should proceed both formally and informally all the time. Thus, CHCs should have the opportunity to be involved in whatever local planning mechanisms there may be, including Joint Planning bodies. The NHSME should make it clear that CHCs should normally be offered participating observer status in the planning process, so as to enable them to feed in the users' perspective at an early stage before formal proposals are formulated.

#### NETWORKING WITH COMMUNITY ORGANISATIONS

26. When CHCs feed into service monitoring, health needs assessment, the purchasing process, consultation exercises and planning, they do so as the statutory representatives of the local community. It is important therefore that CHCs themselves are close to the local communities they represent. For this to be effective, most CHCs seek to ensure that the views they are expressing are broadly based and informed from a variety of sources. Thus CHCs make use of the direct experience of their members who will be "active citizens" and themselves direct users

of local services. CHCs will also conduct and commission their own research and surveys, as well as having access to and the opportunity to comment on the work carried out by local NHS purchasers and providers. CHC visits to hospitals, clinics etc. and the discussions that will take place during them with service users and the staff on the units concerned are also an important source of information. Similarly, much will be learned from considering the issues raised by complaints from and representations made by members of the public.

27. Increasingly, however, the focus of CHC work is shifting to one in which the CHC enables service users (both individually and collectively) to put forward their views. Thus, CHCs will liaise with a wide range of local voluntary organisations and community-based groups, providing them with information about local health issues and learning from the views expressed. CHCs will also arrange and facilitate meetings of service users, bringing them together with each other, the CHC, and perhaps with the service providers or purchasers. A particular focus in this will be those groups who are often excluded for one reason or another from more formal processes of consultation, such as those involving people from black and minority ethnic groups.

# PROVIDING INFORMATION AND ADVICE TO MEMBERS OF THE PUBLIC

28. CHCs work to provide information and advice to the public on health and health related issues, so as to enable members of the public to obtain the health care they need and to act, where appropriate, as advocate for those individuals who find it diffi-

cult to obtain access to the services they need. In practice, this means that CHCs maintain in their offices a set of comprehensive information on local health and health-related services and support groups, so that information and advice may be provided to individuals. CHCs have eighteen years experience of this, and the commitment by the Department of Health and the NHSME to the provision of Regional and local Information Services provides an opportunity to improve and enhance the facilities provided by CHCs to the public. The NHSME should require Regional Health Authorities to provide facilities for CHCs to be linked by information technology to the information material being amassed by the Regional Information Services. They should enable CHCs to offer an access point for the public to this information. most CHCs have offices which are open and accessible to the public in much more locally convenient locations than a regional service could offer, this would provide a much better service to the public, particularly as individuals would be able to draw on the independent advice and support available from the CHC itself.

29. CHCs already publish an annual report and other reports from time to time which are widely circulated. They also publish books and leaflets on local services, give talks to local organisations on local services and on the CHC, participate in a wide range of local meetings and events, and maintain regular contacts with the press and media. This work is important in helping to ensure that the public is notified of issues of local concern and is kept advised of the work of the CHC and the support it can offer to individuals.

## ASSISTING COMPLAINANTS

- 30. A substantial amount of the time of CHC staff is devoted to advising and assisting people who have or may have complaints about the health service or against health service practitioners or contractors. This may range from providing information and advice on the operation of the various NHS complaints systems to providing support (almost of a counselling nature) to individuals and also to offering representation at hearings and assisting, where necessary, in the preparation of complaints by complainants.
- 31. This work was recognised in ML(92)1, which said "CHCs will continue to involve themselves in individual casework, which will provide them with valuable information about the performance of local health services". However, the NHSME should ensure that the importance of the support provided to individual patients is properly recognised and that CHCs are given the resources necessary to carry out this work effectively.

# LOCALLY BASED COMMUNITY HEALTH COUNCILS

32. The last few years have seen a trend towards the piece-meal merger of DHAs, the formation of purchasing consortia and the establishment of new functional links between DHAs and FHSAs. This process continues and would appear to be accelerating, although at no stage has any general public consideration been given to such matters as the optimum size of a purchasing unit. The result is that those bodies responsible for planning and

purchasing health services are becoming increasingly remote from the people they serve. In many instances, when health authorities have merged, RHAs have sought to merge the matching CHCs. This is not appropriate.

- 33. If CHCs are to be effective in representing the interests of their local communities, they need to be close to indeed part of those communities. It is a contradiction in terms to talk about <u>Community</u> Health Councils, if they are not individually representing a community, but are expected to cover approaching a million people spread over several population centres.
- 34. Clear guidance should be issued by the Department of Health to RHAs making it clear that CHCs should only be merged when it is clear that such a merger is in the interests of improving the effectiveness of the representation for service users. The judge of whether such a merger is appropriate or not should be the existing CHCs all of whom should be expected to agree before a merger proceeds. Inevitably, this may mean that a DHA will relate to several CHCs, as is already the case for FHSAs. If need be, the relevant CHCs may want to consider the formation of a Joint Committee, as permitted under the Regulations, to consider collectively some issues. However, the principle of CHCs being locally-based must remain paramount.

#### THE RESOURCING OF COMMUNITY HEALTH COUNCILS

35. In 1989, ACHCEW's Panel of Inquiry report "Effective CHCs for the 1990s" reached the following conclusion: "CHCs are at present under-resourced for the work that they do .... such work

in any case will become more complex as the proposals in the NHS White Paper are implemented." This has certainly proved to be the case. CHCs from all over the country are complaining that it is becoming increasingly difficult - if not impossible - to cope with the workload that they are facing. Moreover, the introduction of the Patient's Charter has had the effect of raising public expectations even further and has meant an even greater workload for CHCs, both in terms of the contact with the public and in respect of the work associated with monitoring the Charter and the adoption of local Charter standards.

- In 1990/91 CHCs in England cost about £9.6 million. This compares with total NHS expenditure of £27,502.5 million. only 0.035% of the NHS budget is devoted to independent user representation. It is not surprising therefore that individual CHCs feel themselves being increasingly stretched by lack of resources. In 1989, when the Panel of Inquiry was sitting, most CHCs indicated that their priority for resources was staffing. Thus, it was argued that the absolute minimum of staffing required (before the 1991 changes in the NHS and before the introduction of the Patient's Charter) was three full-time members of staff (or equivalent) in each office, but that the optimum level of staffing would be five to allow for a specialist complaints worker and for research/development. Such staff also need to be fairly graded to reflect the nature of the work they do and the salaries paid to people working in DHAs, FHSAs and NHS Trusts.
- 37. The case for better-resourced CHCs is now stronger than ever. The Community Health Council Regulations 1985 (SI 1985 No. 304) that it is "the duty of the establishing authority" to

provide finance for CHCs to cover "such expenses as it considers may reasonably be incurred by a Council for the purpose of performing functions conferred on the Council by virtue of the Act". This has recently been reinforced by EL(92)11 which said "Regions should ensure that CHCs are properly resourced and that adequate arrangements are made for the development of CHC staff." Yet, it is clear that many CHCs cannot perform even their core functions adequately on the resources being made available to them.

- 38. As a matter of urgency, CHC resources should be raised to a level which will enable them to operate effectively and deliver a high quality service to their local communities.
- 39. The Panel of Inquiry also heard from CHCs about the need for support structures for CHCs at regional and national level. The Panel concluded that there needed "to be some resources available at regional level to ensure that there was proper secretarial support for regional groupings of CHCs and similarly for the Welsh Association.... There is a need for funds to be available at national level to provide extensive publicity for CHCs and their work and training for CHC members—and staff."
- 40. This was followed at the 1990 ACHCEW AGM/Conference by the passage of a resolution calling for a change in the CHC Regulations to require the formation in each Region of a Regional Association of CHCs with a range of powers and duties and which should also be resourced adequately. This case was put in a detailed paper to the Department of Health in 1991 and it is understood that this is still being considered. Similarly, as

far as support services at national level are concerned, ACHCEW has submitted proposals to the Department of Health as to how enhanced support and training for members of CHCs might be provided and again it is understood that this is still being considered. Certainly, it is difficult to see how CHCs can be effective without being part of the structures already existing at regional and national level and the NHSME should make sure that RHAs provide the resources to enable individual CHCs to participate fully in these.

- There remain, of course, continuing difficulties in some cases between CHCs and their establishing RHAs. This was considered by the Panel of Inquiry in 1989 which took the view that "the very nature of the CHC link with RHAs was sufficient for there to be a perception of a lack of independence. While in many cases CHCs do not have an unsatisfactory relationship with their establishing authority, there were some circumstances in which RHAs have a conflict of interest and there is a potential for an RHA to undermine the work of CHCs as effective organs of user representation independent of the NHS. Moreover, bearing in mind those instances where the RHA was not seen as being particularly supportive to its CHCs and those where the RHA has sought to intervene in CHC activities, the Panel have concluded that the establishing authority for CHCs should be independent and separate from the health authority structure." Given the current thrust of Government policy about the need for independent monitoring of public services, the NHSME should consider this matter again.
- 42. The position of CHC members also needs to be considered.

CHC members are a vital resource. They are the "eyes and ears" of the CHC and an essential part of its links with the community. CHC members do not receive any payment or allowances for the large amounts of voluntary time that they put in, they are not entitled under statute for time off from work for their CHC duties and there are no properly resourced mechanisms for their training. If user representation is to be taken seriously within the NHS, then CHC members should be afforded proper recognition and status for the contribution they make.

#### CONCLUSION

In his speech to the fifteenth anniversary dinner of the Adam Smith Institute on 16th June 1992, the Prime Minister said: "Too often choice in public services is exercised by people who do not have to stand at the receiving end or anywhere near it. .... We must work to empower the user better in the 1990s. In education. In housing. In law and order. health. .... Our Citizen's Charter is about choice, competition, management change and responding to the users of services. ... the inspection of key public services must - and will be - independent of the services they inspect. .... There is room for good, old-fashioned commonsense, for the outside view, and for other professional skills. We need and we will deliver, independent scrutiny from outside." If CHCs did not already exist, the logic of the Citizen's Charter would require that they be invented. For eighteen years, CHCs have been serving the public and representing the public's interests. In 1992 CHCs come of age and should now be resourced and empowered to continue that work. This paper is designed to show how that should be done.