SURVEY OF CHC RELATIONS WITH NHS AUTHORITIES 1991

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ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

SUMMARY OF FINDINGS

SURVEY OF CHC RELATIONS WITH NHS AUTHORITIES 1991

In September 1990 an Executive Letter, EL(90)185, was issued to Health Authority managers giving new guidelines about how CHCs should operate. This was later published in booklet form in December 1990 as Consultation and Involving the Consumer. This guidance lays down the way that Community Health Councils (CHCs) are expected to relate to NHS authorities in the new-style NHS. Most significantly, it removed a number of key areas of CHC 'rights' that had been included in several policy documents. There have been no changes in the legislation relating to CHCs - the statutory duties of CHCs remain unaltered.

ACHCEW has conducted a survey of CHCs to determine how the working relations between NHS authorities and CHCs have changed.

The findings from this survey overwhelmingly point to how the guidance has, as a presumably unintended consequence, heightened CHC dependence on the goodwill of local health service managers. This has resulted in some areas in CHC exclusion from participating in NHS planning, which, ACHCEW believes, is detrimental to the interests of users of the Health Service.

This summary of findings points to how, for some CHCs, their relationship with NHS authorities has improved but for others it has deterioriated. The conclusions of this study argue for revised policy statements/ guidance and additional statutory powers for CHCs so that the task of monitoring health service provision, recommending improvements and representing the interests of patients can be carried out without obstruction.

The response rate for the survey was 65.5% of ACHCEW's membership.

CHC PARTICIPATION AT DHA & FHSA MEETINGS

The guidance removed expectations on NHS managers that CHCs should be fully involved - the right to attend as an observer with speaking but not voting rights is now a matter for the DHA and FHSA to decide.

* 9% of CHCs are not invited to attend the DHA public meeting This does not represent a significant decrease in numbers of CHCs attending but it remains a cause for concern.

* A tenth of CHCs can no longer speak at DHA meetings. Of those who reported that they are allowed to speak, some have to arrange this with the DHA before the meeting identifying the topic on which the CHC observer wants to contribute. Such arrangements obviously fall a long way short of full participation.

* A tenth of CHCs can no longer speak at FHSA meetings.

* Nearly a third of CHCs cannot attend private sections of DHA public meetings.

* The number of CHCs who cannot attend private sections of FHSA meetings has nearly trebled since September 1990.

* One in ten CHC representatives/ observers do not receive background/ agenda papers for the meetings of their DHA.

* One in ten CHC representatives/ observers do not receive background/ agenda papers for FHSA meetings.

These figures would suggest that there is a significant number of CHCs who are relegated to the status of a member of the public. CHCs need to be allowed full participation at DHA and FHSA meetings in order to carry out their role of representing consumers' views.

ACCOUNTABILITY OF NHS AUTHORITIES

* Less than one third of DHAs now hold monthly public meetings.

* Only just over a quarter of FHSAs now hold monthly public meetings.

Public accountability of health service managers, instead of increasing, as those implementing the NHS reforms promised, would seem to be declining in some areas:

* Nearly three quarters of CHCs reported a suspicion that their DHAs were holding private meetings at which items of importance were discussed and key decisions made.

* Nearly half of CHCs responding felt that the FHSA holds private meetings at which key decisions are taken.

CHCs, on the other hand, encourage DHA and FHSA involvement in CHC meetings:

* A significant proportion of CHCs (70%) invite their DHAs to send a representative to their public meetings;

* Over half of FHSAs now send a representative to CHC meetings;

These figures are encouraging and serve to underline CHCs' desire to work with their matching authorities. Informal liaison arrangements are well established between CHCs and DHA and FHSA officers.

OTHER FORUMS

* The vast majority of CHCs (89%) are represented on local Maternity Services Liaison Committees, on Joint Consultative Committees (85%) and on Joint Care Planning Teams (73%).

CONSULTATION ON DHA CONTRACTS

* Nearly one third of CHCs report that they have not been invited to comment on general contract plans.

* Over half (57%) have been excluded from input into individual contract specifications.

CHCs have the necessary experience and skills to provide an important perspective in drawing up user-responsive contract arrrangements. Their lack of involvement could mean that in many districts contracts have been arranged which have scant regard for users' interests.

CONSULTATION ON CLOSURES, CHANGES IN HEALTH SERVICES.

There is a clear need for guidelines on good practice in consultation to be issued to all DHAs and FHSAs and instances of good practice to be widely disseminated.

* One in five CHCs report problems with the consultation procedures.

* Consultation exercises run by FHSAs do not seem to be smooth running operations - a significant number of CHCs did not respond to this question and many who did reported problems.

* A fifth of CHCs reported problems gaining access to information. Without information CHCs experience difficulties carrying out their duty of monitoring health services.

PERSONALITIES

* The vast majority of CHCs feel that personalities in the DHA and FHSA determine the extent of CHC involvement. It would seem to defeat the object of CHCs if their effectiveness is largely dependent on the attitudes and co-operation of the DHA or the FHSA - the bodies the CHC is monitoring.

  Additional statutory rights are needed to ensure that CHCs are not restricted in their monitoring role by unco-operative authorities.

WORKING RELATIONS AFTER 'Consultation and Involving the Consumer'

* Over half of CHCs responding describe their relationship with the DHA as being 'very good' or 'good'.

* Over half of CHCs responding describe their relationship with the FHSA as 'good' or 'very good'. However, the numbers of CHCs describing the relationship as 'very good' has dropped from 45% to 21%.

* Just over a tenth of CHCs felt that it was too early after the introduction of the reforms to describe their relationship with the DHA and the FHSA.

These figures may appear to contradict earlier statements about the problems some CHCs are having. However, there are factors that probably account for these discrepancies. First, some aspects of CHCs' relationships with NHS authorities are better than others and this makes it difficult for CHCs to rate the overall relationship. Secondly, CHCs have worked to maintain and improve good relations since the introduction of the NHS reforms.

GOOD PRACTICE

* Nearly all CHCs can provide examples of partnership with their DHA and FHSA - from joint surveys to holding joint seminars. The main report provides details of examples of good practice in working relations between CHCs and NHS authorities. The instances of good practice should be widely disseminated so that all DHAs and FHSAs can learn from each other and promote good working relations with their local CHCs.

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

SURVEY OF CHC RELATIONS WITH NHS AUTHORITIES

C O N T E N T S

SURVEY OF CHC RELATIONS WITH NHS AUTHORITIES

INTRODUCTION

The White Paper Working for Patients which was given a legislative framework in the NHS and Community Care Act 1990 sets out a model of health service management which purports to be user-centred. Much has been said about involving users of services to a greater extent in the running of the NHS. Many commentators, however, argue that the managerialism of the 'new' NHS is diametrically opposed to philosophies of health service management which give a key role to user needs and user participation at all stages in the planning, delivery and evaluation of health services.

Community Health Councils have a statutory duty to represent the user of health services at a local level and are key channels in representing the interests of users. This brief would suggest that it is axiomatic that CHCs are fully involved in the reformed NHS. However, this was not to be the case. In September 1990 an Executive Letter was issued to RHAs, DHAs and FHSAs. The attached document was published in December 1990 as Consultation and Involving the Consumer (England) and Consultation and the Involvement of Local People (Wales). Emphasising a consumer-led stragegy the guidance introduced a number of key changes to the following areas:

DHA and FHSA Meetings

* the expectation that CHCs could send observers to health authority meetings with full speaking rights and an expectation that s/he would also attend the private sessions of meetings was revoked

Consultation

* health authorities would in future determine what they considered to be "substantial" variations (for which consultation would be neccessary) in use of health service buildings or closure of services

* RHAs were given responsibility for consultation under certain circumstances

* NHS Trusts would not be required to consult on substantial service changes

* the practice whereby following a consultation the health authority would be required to submit all comments received to the CHC for final comment was cancelled

* CHCs do not have to submit a counter-proposal when responding to a consultation

* CHCs do not have to be consulted by DHAs on individual NHS contracts

Monitoring/Visiting

* CHCs' visiting rights to NHS premises are restricted to those managed by the home DHA and CHCs can only visit NHS Trusts in their own area

A fundamental aspect of this guidance is that CHC/NHS Authority working relations are to be negotiated at local level. Such a strategy of devolution however may not be in the best interests of users of the health service. CHCs nationally voiced concerns about the impact of this guidance on their role in the NHS which was about to be restructured.

ACHCEW's initial study of the effects of the guidance

In November 1990, the Association of Community Health Councils for England and Wales (ACHCEW) published findings from an initial study of the impact of the guidance, aiming to assess the extent to which NHS Authorities had acted upon it. The initial findings suggested that in many cases NHS Authorities acted almost immediately upon the changes contained in EL(90)185 and a series of reported instances of exclusion and secrecy gave rise to very real fears that, through excluding CHCs, the interests of the user of the health service were being compromised. The key findings of this initial study revealed that: -

* only one third of DHAs were planning to meet in public on a monthly basis

* a sixth of DHAs could be meeting less frequently than once every two months

* nearly one quarter of CHCs reported that they were being denied speaking rights at the first meetings of their DHAs and FHSAs

* just over one third of CHCs had been allowed to attend the private parts of DHA meetings, and only 15% had been allowed to attend the private parts of FHSA meetings.

When EL(90)185 was issued the most immediate concern voiced by CHCs was the possibility that observer status would no longer be automatically expected as the new guidance did not explicitly support CHC observer presence with speaking rights. The initial study therefore concentrated on CHC representation at DHA and FHSA meetings. The results threw into relief the contradiction between the "consumer-led" rhetoric of the White Paper and the exclusion of the statutory representatives of users from full participation in NHS Authority meetings.

Soon after the ACHCEW survey, The Community Rights Project released details of a survey which showed that a number of health authorities were breaking the law (1960 Public Bodies (Admission to meetings) Act) in the secretive way that they operated.

The results from the ACHCEW study highlighted other anxieties:

> "There are fears that public meetings of the new health authorities will be mere rubber stamping exercises with decisions being made beforehand." (ACHCEW Press Release, November 1990)

The National Association of Health Authorities and Trusts have responded to this by saying:

> "Such a survey taken so early on in the life of the new authorities may not be particularly reflective of the current situation."
> (Director of NAHAT, HSJ, June 1991)

This was certainly the case for some aspects of the CHC/authority relationship but the current study reveals the extent to which the concerns voiced by many CHCs in the initial stages of the adoption of the guidance by health authorities are still valid and that the need for more appropriate guidance to guarantee user representation by CHCs is still urgently required.

Current survey on CHC/NHS Authorities relations

EL(90)185 was issued in September 1990. CHCs were not sent this document and ACHCEW had to issue copies to its members. In December 1990, Consultation and Involving the Consumer was produced, a replica of the Executive Letter, but in booklet form.

By then, ACHCEW was receiving reports from member CHCs detailing exclusionary practices that were being adopted by their authorities in respect of consultation procedures, involvement in the drawing up of service agreements and access to private sections of DHA/FHSA public meetings. These developments suggested that it would be necessary to undertake a second study, approximately four months after the first survey, which would aim to reassess the situation regarding CHC participation in DHA/FHSA meetings, additional contact between CHCs and the authorities, CHC representation on various authority sub-committees, CHC involvement in the contracting process, consultation exercises and access to information. More importantly, the current study was particularly concerned to document instances of collaboration, of constructive partnerships between CHCs and DHAs and FHSAs following the guidance. Related to this it was also considered important to record CHCs' views on the 'mechanics' of good practice, of the extent to which the attitudes of senior health service managers can help or hinder CHCs representing the interests of the local population.

As with the earlier survey, the findings of this more in depth study are not fully conclusive but they provide us with clear

pointers to areas of both good practice and of practices which are patently not in keeping with the 'spirit of the guidance'. The situation is constantly evolving - as many CHCs have noted, a change in key personnel can have a dramatic impact upon working relationships. However, one overriding aspect which is unchanging is the fact that as a result of the guidance NHS Authorities have uncontested power to include or exclude CHCs as they so wish. (Of course, this exclusion cannot go against legislative provision for CHC involvement). This aspect should be borne in mind when considering findings from all sections of the questionnaire.

The questionnaire was sent to the 200 CHCs who comprise ACHCEW's membership in the early part of 1991; just under two thirds responded (65.5%) comparable to the response rate of the earlier survey.

PART I : CHC RELATIONS WITH DISTRICT HEALTH AUTHORITIES

DHA meetings

Immediately following EL(90)185 in October 1990 the number of CHCs who were invited to DHA meetings had fallen from 99% to 91%, 17% had been denied speaking rights and a significant 52% who had hitherto attended private sections of meetings were now excluded from these. The findings from the current study reveal how the strategy of 'local arrangements', promoted by the government, has had an adverse affect on CHCs' work for users of the health service.

* 11% of CHCs have lost the automatic 'right' to speak at DHA meetings

* The number of CHCs not allowed to attend the private parts of DHA meetings has nearly trebled since September 1990

* One in ten CHC representatives/observers are not receiving background/agenda papers for meetings

The table below records the situation both before and after the issuing of EL(90)185:

Attendance at DHA Public Meetings

	Present	Pre - September 1990
Invited to meetings	99%	100%
Speaking rights	87%	98%
Not allowed to stay for private sessions	28%	11%
Receipt of background papers	78%	92%

Overall, however, the situation has not significantly changed since the initial survey. It would seem that the findings reported here signal a 'steady state'; DHAs have settled down and some have reversed decisions about CHC observer status following negotiation. Some CHCs of course reported no change in their status and their DHAs were quick to assure them of that; as one CHC noted:

> "The good working relationship and position of trust established with the health authority in ... has... paved the way for the future. The CHC observer at DHA meetings continues to have speaking rights and is allowed to stay for the private part of the meetings."
>
> (CHC minutes 1990)

However the impact of the guidance on some CHCs and the speed at which some DHAs instituted changes cannot be underestimated. Immediately following the issuing of the guidance one DHA wrote to the CHC 'clarifying' the situation:

> The DHA "would like to set up arrangements to brief the Chairman and Secretary of the CHC before meetings of the authority. I think this might be helpful to you in considering any comments you want members to consider on reports from the CHC. I imagine you or the Chairman or some member will attend meetings as a member of the public."
>
> (Letter from DHA to CHC 1990)

The minutes from another CHC refer to the DHA's confusion as to whether or not the observer could sit at the table with DHA members. It seems that the matter was resolved in the observer's favour but such confusion suggests that some DHAs saw the guidance as an opportunity to prevent active CHC participation at DHA meetings.

A further CHC reported the farcical situation whereby the CHC observer retained speaking rights but had to sit at a table away from the main table at which the meetings were conducted. The tale was fully recorded in the CHC's minutes:

> "Following the arrangments made for the DHA meeting on 26 November which proved to be very unsatisfactory to the CHC involving the CHC Chair moving to and from the table at which the DHA were meeting on items at which we had requested permission to speak. Following discussions with the Secretary,..Chief Executive,..HA, had reviewed this procedure and now intends that **a table will be made available for the CHC at the end of the table at which the DHA is meeting albeit with a small gap to indicate that the CHC is not a part of the decision making process.**
>
> The CHC would also still be required to indicate items with which we wished to speak to but acknowledged that if in the course of discussion on a particular item the CHC then wished to make a comment we could signal this to the Chairman in the usual way and we would then be invited to comment on that particular item."
>
> (CHC Minutes, January 1991, emphasis added)

As always, the situation has not been clear cut - some CHCs must sit with other members of the public but are able to attend private sections of meetings. Also, many of those who stated that they were allowed to speak added in brackets that this is not guaranteed, so the figure given above (87%) is not fixed but rather may be expected to fluctuate according to the DHA. There were CHCs who wrote that the situation has not changed since the introduction of Consultation and Involving the Consumer but added that they did not know how long this would continue. This

response was given to a number of questions and underlines the sense of uncertainty felt by CHCs in the face of loss of 'rights' which cannot be dismissed by DHA assurances of commitment to consumer participation.

Removing CHCs' right to observer status seems to have had an effect of allowing DHAs to hold fewer public meetings. (Of course, another variable that must be considered is the effect of the new constitutions for the restyled health authorities.) A mere 29% of CHCs report that their DHA hold monthly meetings. Nearly half of DHAs are holding bi-monthly meetings with a further 12% holding quarterly meetings. These findings do not depart in any notable way from the November study although the number of DHAs holding monthly meetings has decreased. In defending this practice, the Director of the National Association of Health Authorities and Trusts (Mr Philip Hunt) has argued against seeing the decrease in the number of public meetings held as "a bad thing";

> "authorities should be judged by the effectiveness of their decisions rather than by the number of meetings they hold." ("Open up your contracts" Health Service Journal, 27 June 1991)

However, he concedes that such a practice means that an impression of "closing their doors to the public" must be avoided. (ibid.) If authorities are reducing public meetings then, as a corollary, public participation is reduced. If CHCs are not allowed access to private parts of meetings then public participation is minimal. Such a situation clearly conflicts with the new role of DHAs as "champions of the people".

We were interested in assessing any changes in DHA practice of sending a representative to CHC meetings and the level of seniority of the representative. A negligible change has occurred; 71% of CHCs now report that their DHA sends a representative to Council meetings, an increase of 1% from before September 1990. The level of seniority varied across regions ranging from the DHA chairperson, to the District General Manager to non-executive members of the DHA. Some CHCs do not invite a representative to attend their meetings. On the basis of these finding it would seem that authorities do recognise the importance of keeping track of CHC activities. Attendance at CHC meetings should be promoted, if the CHC so wishes, as it furthers contact between the authorities and the CHC. As one CHC noted in their newsletter "DHA observers at CHC meetings had traditionally taken on board any matters of concern to the CHC and referred them on to the relevant managers" (August 1991). Concern has been expressed, following the NHS reforms, that a newly established Trust did not send a representative to CHC meetings. It is felt by this CHC that such non-attendance points to a decrease in accountability.

"No limitations" - informal contact arrangements

Rather than merely focusing on the formal apects of the CHC/NHS authority relationship, it was considered that the informal relationship was vital in carrying out the duties of a CHC. Virtually all CHCs responding said that they had informal contact with DHA officers, with a further third reporting additional formal (i.e. minuted) liaison arrangements. The emerging picture points to a great deal of informal contact between CHCs and DHAs. The following comments highlight the informal relationship that exists between CHCs and DHAs:

> "Whenever the need arises"
>
> "Presentation of annual report by Director of Public Health, talks to CHC by relevant officers on contracts, projects, NHS and Community Care Act; informal meetings between Chair, Chief Officer and executive members and unit general managers."
>
> "As before, very regular [contact] at all levels. New contact with Director of Quality re contracts on a regular basis."
>
> "The DHA operate an "open door" policy whereby the CHC can arrange meetings with the Chairman, GM and/or senior officers as and when required."

A sense of good working relations emerges from these comments - regular contact, keeping both parties informed about various health service developments, represents an area of good practice which other CHCs and DHAs should seek to emulate.

"Rubberstamping" - Private Meetings

The practice of DHAs holding private meetings at which CHCs should be present points to areas of the health service in which there are 'dark corners'. A massive 73% said that their DHA held private meetings with a further 16% of respondents unsure as to whether such meetings were occurring. 'Considered with the dismal CHC representation on DHA planning committees, (discussed below), predictions of increasing health service secrecy seem to have been borne out.

CHCs noted in response to other sections of the questionnaire that DHA meetings appear to have shorter agendas than before September 1990. One Council believes that currently "most business is now carried out in private". Another wrote of how such meetings "happen in the months when there is no public meeting".

The significance of private meetings and the adjusted public meeting schedules of many DHAs indicates how 'public accountability' could in some health authorities become meaningless. Still another referred to their fears that at such meetings important discussions and policy decisions take place.

Allied with responses concerning CHC attendance at private parts of public meetings such practice cannot be accepted. One Council's minutes spoke of : the HAs agendas were much shorter than they had been and it was suspected that "substantive policy items" were now placed on the private part of the agenda.

Some CHCs have confronted their DHAs about this practice and they have responded by stating that "What is discussed is not relevant to the public interest" or else deny that this practice exists.

Representation on DHA sub-committees

Membership and/or representation on DHA working parties and sub-committees constitutes a significant part of some CHCs' work. Such involvement is considered by some CHCs to be vital in effectively carrying out the tasks of monitoring local health services and advising health service managers on strategies aimed at making services more 'user-responsive'.

Respondents were asked whether the CHC has a representative on DHA sub-committees, ranging from Maternity Services Liaison Committees to Joint Care Planning Teams. They were also asked about their membership status, i.e. whether they had speaking and voting rights. Four main committees were listed and CHCs asked to list other committees to which they sent a representative.

If it is accepted that it is vital for CHCs to participate fully at all levels of the planning process then it seems vital that they are accorded either observer or full status on these statutory bodies. The lack of representation on such committees is worrying - consider the following:

* 11% of CHCs are not represented on Maternity Services Liaison Committees

* 15% have no involvement with Joint Consultative Committees

* 27% of CHCs have no representative on the district Joint Care Planning Team

Where CHCs did participate in these groups, they did not always have full membership; in the case of the Maternity Services Liaison Committees (MSLC) only half of those CHCs responding had full membership status. The significance of this figure is unclear as many CHCs do not want full status, preferring observer status as they feel that the former compromises their position as independent bodies.

The above figures suggest a slightly lower level of full membership. In ACHCEW's Annual Report 1989/90, it was reported that 67% of CHCs had full membership on Maternity Services Liaison Committees.

A concerted effort on the part of DHAs to secure CHC involvement on such committees with appropriate status ought to be part of

any strategy which aims to promote consumer involvement in health service management.

CHCs were asked what bodies they were involved in apart from the specified four. The range and number of DHA committees on which some CHCs had observer and/or full member status is astounding. The following list provides a sense of the variety of committees to which CHCs give their time: accident & emergency group; monitoring group; out-patient forum; public health group; audit committee; district policy groups; health promotion group; contracting group; cervical cytology; drugs advisory group; black and ethnic minority group; HIV/AIDS advisory group. This list illustrates CHC involvement but also how CHCs truly represent all members of their local communities.

The reported activity of CHCs vis a vis DHA committees ought to be considered in conjunction with responses given to the question about which groups CHCs wish to have involvement in, many repsonding that they had pressed for years to gain access to some committees. Not surprisingly, a high proportion of those repsonding stated that they wished to have representation on joint planning teams. This reported lack of involvement on committees sits uneasily with the role of CHCs as defined in SI(1985)304, Section 18:

> "It will be the duty of each council to keep under review the operation of the health service in its district and make recommendations for the improvement of that service."

Being denied access to key DHA sub-committees does not make it an easy task for CHCs to fulfil this role. It cannot be argued that CHCs do not have the 'expertise' to contribute to such groups - the evidence is not there as the list of groups above shows. ACHCEW's Panel of Inquiry which was established in 1987 to consider possible changes to the role of CHCs suggested that:

> "CHCs should have the rights to observer membership of DHA/[FHSA] committees (including sub-committees and working parties) of health service planning teams...and to participate in local ethics committees."
>
> (Effective CHCs for the 1990's ACHCEW, 1989)

In the light of the above findings, it seems even more urgent that CHCs are accorded such rights. However, official responses to such requests display characteristic ambiguity; .."It must be for the DHA to decide whether and when they might wish to open CHC involvement on medical audit committees which are seen as "professional groups aimed at securing an improvement in professional standards and **lay involvement would impede the individual professional participation.**"

> (leaked DoH internal document, "The future role of CHCs" February 1990, emphasis added).

ACHCEW's view, however, is that there should be a lay element or oversight of professional audit.

Contracts for managers? Contracts for patients? Involvement of the CHC

The NHS & Community Care Act 1990 has transformed the working culture of the NHS, introducing an internal market. The purchaser/provider split raises issues about how CHCs are to operate in the new environment. The new remit accorded to DHAs, that of assessing health needs of the local population, purchasing appropriate health services and monitoring provision, gives consumer involvement a high profile; in assessing health needs the DHA will need to ensure that the voice of the consumer is clearly heard. The relevant guidance states that "DHAs should consult CHCs ... at an early stage of the decision making process." (DoH, correspondence to ACHCEW January 1991) It is recognised that "an input by CHCs will be needed at an earlier stage than that of formal DHA meetings". This stance falls a long way short of the view of the Association which noted in Working for Patients? The Patients' View (1989) that:

> **"it is essential that CHCs are fully consulted by their DHAs on the definition of core services, on the range and location of the contracts the DHA intends to place, on the detailed content."**

The proposed service specifications which were to emphasise quality issues seemed to guarantee a key role for CHCs with their vast experience of monitoring the quality and level of provision from the user's perspective and of recommending appropriate changes.

Asked about their involvement in the contracting process nearly two-thirds reported that they had been invited to comment on general DHA plans with a further third having opportunities to comment on specific service agreements. Significantly nearly a third had not had access to general contract plans. Over half of those surveyed (57%) stated that they had not been invited by their DHA to comment on individual specifications.

These figures highlight the extent to which many CHCs are being excluded from the contracting process and suggest that user representation in the drawing up of contracts has been, in a significant minority of DHAs, at best minimal, at worse non-existent. By not making use of CHCs' knowledge of the local health service and users' views on specific areas valuable resources are being wasted through duplication.

Comments about the level of CHC involvement serve to highlight some of the specific problems CHCs faced in attempting to become involved and ensure that users' interests were being taken up by those drafing service agreements. The comments can be grouped into distinct groups from CHCs having to negotiate for access to contracts papers to full involvement.

"After much prodding" : Access to contract information

Many DHAs displayed a reluctance to provide information:

* "The only information gained about the contracting process came to the CHC when it invited an officer along to a meeting to speak specifically on this subject."

* "Very little direct involvement so far - we have had draft copies of the 'mechanics' of contracts for comments. More importantly, soon we shall have copies of specific contracts"

* Contract papers "not available yet"

* "Sent details but not involved as yet to any great extent"

* "We were not given much time for considered comment but the new contracting manager said there would be fuller involvement next year."

* "Meet with the purchasing consortium - chief officer only - this meeting was only arranged because of CHC pressure. Have been told that the CHC has no involvement in contracts"

* "Limited involvement"

It seems amazing that on the eve of the introduction of the 'contracts culture' some CHCs had not even had access to general service agreements which are, of course, public documents. The reported level of CHC input into individual service agreements was not extensive - 57% had not been involved. CHCs were asked whether they had been involved in commenting on individual contract specifications; one CHC stated that it did not wish to be involved as members "feel it is principles which are our role, not individual contracts." Few CHCs responded to this question and the responses given reflect problems CHCs are having on a general level. Only two CHCs listed contracts in which they had had an input: "non-emergency ambulance transport and general quality specification" and "cervical cytology and breast screening". Other CHCs who responded stated that they have been asked to comment on draft specifications. As some DHAs have placed a number of contracts with providers outside the district, the 'home' CHC has not been involved to any great extent.

In general terms then, most DHAs would see a role for CHCs in commenting on general contracts but not for commenting on individual service agreements. Some CHCs would feel that they have a role to play in both areas.

As Ealing CHC in Contracts in the NHS: A Practical Guide for CHCs (1991) states:

> "The opportunity to be involved in laying down specific consumer standards for health services is not one to be missed. Each Community Health Council will have to carefully think through the appropriate level of involvement for them in the local contracting process. **In order to represent the consumer Community Health Councils will certainly need to have input into the Contract/Service Agreement."**

A further relevant point that is made is that if the commissioning agency has an "inaccurate view" of the health needs of the local community, then the CHC must "push to be involved in the standard setting process". The CHC involvement provides a perspective which can ensure that "unsuitable/inadequate contracts (are not) being placed on the decisions of health professionals alone."

It would appear that some DHAs with their lack of experience in consulting different communities within districts are not concerned to 'get it right', and that rather than drawing upon CHC experience, some are prepared to draw up service agreements which reflect their concerns rather than those of the local community. Of course those DHAs who have involved the CHC are aware of the benefits that accrue to the DHA in its task of health needs assessment as the following excerpt from a DHA document indicates:

> "It will be to the mutual benefit of the Health Authority and consumers represented by the CHC for the CHC to have a role in assisting the Health Authority to identify Health Needs and have input to Health Investment Planning...In undertaking its purchasing role the DHA recognises that it will be beneficial to involve the CHC as user representative particularly in the following aspects of contracting:
>
> 1) consultation on planned patterns for contract placement
>
> 2) consultation on the range of quality issues to be addressed by the purchaser
>
> 3) ...provision of relevant monitoring information
>
> 4) consultation when contracts are renegotiated, rolled forward or renewed.
>
> (Great Yarmouth and Waveney Health Authority Obtaining the Consumer Views (1991))

Other DHAs throughout England and Wales have produced similar statements reflecting their commitment to commissioning the most appropriate services for the local population.

Asked about problems experienced, nearly half said that their involvement had not been problematic, with one third stating that they had experienced problems. A selection of the comments raise a number of issues which have been of concern to CHCs for many years. Many of the comments represent bad working practice with respect to collaboration and DHAs working in partnership with CHC and contrast with comments below dealing with CHC involvement.

* "reluctance to involve CHC"

* "they are resistant to our involvement"

* "difficulties acquiring contract details on a systematic basis"

* "say they are not far enough into process to involve us"

* "They won't tell us anything until the contracts are published"

* "Short timescale makes it difficult to comment meaningfully"

* "Specifications drawn up with scant regard for quality issues, dismiss (CHC's) comments"

A common complaint was related to the time given for CHCs to comment on service agreements. Also the volume of work posed problems for many CHCs. Related to both of these themes is the feeling expressed that if CHC comments are not going to be considered it seems like a lot of work for what is in effect a tokenistic exercise on the part of the DHA; "many papers to wade through, suspect that it is too late to make any changes."

One CHC made reference to problems of confidentiality with respect to CHC involvement. In Contracts in the NHS it is recognised that too close a relationship with a purchasing authority can cause problems for a CHC's autonomy.

Other CHCs report that they have had informal liaison with health authority directors responsible for contracting or have had seminars with DHA officers at which they are invited to give comments. Some mention that they have been sent details about general service agreements both draft and published:

* "We have reviewed contracts but it was after publication"

* One CHC described how it had met with the Director of Planning to discuss the future role of the CHC but although "suggestions were offered from the CHC (they were) not taken up re: contracts".

This latter comment illustrates the importance of formal involvement as one CHC noted:

* "the DHA is not aware that informal discussion does not mean consultation"

Some CHCs reported positive developments despite having had initial "teething problems" and referred to current high levels of participation: "tentative negotiations first, since Christmas very cooperative".

User-friendly contracts: "We ripped the document to bits"

Those DHAs who consulted CHCs on general and individual service agreements were assured of comments that would reflect the concerns of the user of the health service. The time given over by Councils in providing constructive comments on such documents must also be appreciated.

* "Have commented on the purchaser/provider draft contract for health services. Have also been involved in inviting the comments of users from the voluntary sector on the purchasing requirement document"

* The CHC has had "three meetings with the Director of contracts and staff. Several CHC suggestions were accepted and incorporated."

* One CHC reported that the general principles of the ACHCEW Patients' Charter were inbuilt into all service agreements.

* One respondent referred to how the DHA "will be talking about our contribution towards monitoring, particularly quality issues and the providers also want to involve us more."

CHCs' 17 years' experience in monitoring existing provision can be and is used in such a way as to guarantee better services for their local community. This is to be welcomed although the issue of adequately resources for CHCs to do such work must also be reviewed.

Consulting the watchdogs

Among other things, "Consultation and involving the consumer" brought changes to consultation procedures. The definition offered in West Birmingham CHC's paper (1990) on consultation is useful in directing attention to good working practice in this area:

> "Consultation is joint consideration of a matter. The consulting body must make a full and frank disclosure of its view and provide such supplementary information as ... reasonably [requested]. The consulting body must be receptive to the views of those consulted and be willing to change its tentative plans." (Good Practice in Consultation)

Approximately one in five CHCs reported problems with DHA consultation procedures following the introduction of the guidance and their experiences indicate the need for stronger statutory powers for CHCs with respect to consultation. The DoH statement that "Our guidance requires Health Authorities to secure full, effective and early consultation with CHCs but the manner in which they do so is largely for their decision." (Correspondence with ACHCEW, Jan 1991). Leaving DHAs to determine the manner of consultation can often have negative consequences as the following statements from CHCs show:

* "We rely more and more on our 'other sources' to alert us to proposed changes."

* "One temporary closure to take place without consultation on grounds of insufficient time. Closure has been talked about internally (in DHA) since March 1990!"

* "Timescale with bi-monthly meetings is a problem. Also providers have attempted substantial change without consultation."

* "We have had to request consultation on several closures and changes of use - one of which was not granted (as being not a 'substantial' closure - 14 beds lost in a ward)"

Part of a motion put to ACHCEW's Annual General Meeting ten years ago (1981) succinctly puts forward the view of ACHCEW's membership with respect to time scale of consultation exercises.

> "....To enable councils to undertake this response (to the consultation) adequate time must be given to ensure that they are able to study the document, ...consult the public and obtain reactions and prepare a meaningful response..."

(Of course CHCs can appeal to RHAs if they feel insufficient time has been allowed.)

Consultation ensures that the patient's voice is heard, that her/his concerns are placed on the agenda. If, as another AGM motion (1988) stated, consultation procedures are being abused in some authorities, the rhetoric of user involvement sounds rather hollow. The need for strengthened statutory rights to protect those CHCs who are not consulted is evident. This has been proposed many times, however it is even more urgent in the 'new' NHS of purchasers and providers with the added dimension of NHS Trusts who do not have to consult. One CHC was particularly concerned about this and wrote: "With the Trust as the main provider, we have limited power and need a detailed agreement with the DHA which we have drafted." Government statements repeatedly emphasise that things should be managed at local level, this is clearly not adequate for over a fifth of CHCs with the result that they are excluded from acting as effective channels of users' views to health authorities.

"In the teeth of the health authority" - problems getting access to information

Access to information is central to good consultation practice. A fifth of CHCs mentioned that they were experiencing problems with the flow of information from their DHA. Expressing the effect of this one CHC has written "The CHC is endeavouring with increasing frustration to perform its function as patients' watchdog in the teeth of a health authority who will not provide adequate information.." (letter from a CHC to its RHA March 1991)

Lack of information stymies the work of any CHC - informed decisions cannot be taken without having all relevant information. One CHC spoke of how information at the DHA meetings had become progressively more patchy, the agenda quite tame, omitting complaints reports and concludes that such business is most probably being carried out in private. .

However, peppered amongst comments about lack of information and increasing secrecy were comments praising DHA openness. Such openness is often due to changes in personnel rather than the changes instituted by EL(90)185. A new District General Manager who believes in openess can have a profound impact on increasing CHCs' access to information.

Personalities

"If CHCs are to be a help rather than a hinderance, this will require good working relations between HAs/FPC and CHCs. **This will largely be a question of local personalities..."** (Leaked Department of Health document "The role of CHCs" Feb 1990)

One of the prime concerns voiced when EL(90)185 was issued was that CHCs would be increasingly dependent upon the personal whims of NHS managers in the working out of statutory rights. It seemed important to document the extent to which such a concern was well founded - patchy anecedotal evidence regarding the importance of personalities in determining the CHC/NHS Authorities relationship is in plentiful supply, however there has never been any systematic collection of CHCs' views on this matter. As mentioned above one of the main aims of this paper is to demonstrate that CHCs require more far-reaching statutory rights or more directive guidance in order that they can effectively carry out their functions unhindered.

Asked whether they felt that their working relationships with DHAs were dependent upon personalities rather than upon statutory rights the majority of CHCs stated that personalities are of paramount importance; the reorganisation of DHAs which resulted in a number of key personnel changes has had, generally speaking, a positive effect. However, those CHCs who at the time of response enjoy a good working relationship, are acutely aware how easily this can deterioriate with a change of personnel. The responses to this section of the questionnaire underline how the guidance is being used by some DHAs to undermine the position of

CHCs. Overall though, CHCs appear to be more aware of personalities following the removal of some of their statutory rights.

If CHCs are to be true to their nickname 'patients' watchdog' then that means that they must be able to criticise health service managers without having to suffer repercussions such as denial of access to information. A number of CHCs report that following CHC action DHAs have distanced themselves and that they have experienced subsequent problems gaining access to meetings and so on. Such comments underline how, in the absence of sufficent statutory rights/directive guidance, the situation has become such that CHCs are almost entirely dependent upon the whim of individual DHA managers. As one CHC noted while currently the relationship was good "with all personalities getting on, it will be interesting to see what happens when the CHC rocks the boat." Independence from DHAs and FHSAs (formerly FPCs) was a central tenet of the founding legislation; removing key aspects of CHCs' statutory powers places this 'independence' in a very vulnerable position indeed.

The following comments highlight the above points and come from CHCs in different parts of England and Wales. Commenting upon the importance of personalities CHCs have commented:

* The relationship is "very dependent upon personalities. The District General Manager hides behind statutory rights when it suits him".

* "very much so, our involvement is based on good will, it could change"

* "to a high degree, at present there is a lot of respect on both sides, it could change, statutory rights are a must"

* "a great deal. When there was publicity prompted by the CHC against the DHA, they put up shutters"

* "personalities play a part in how rigidly statutory rights are implemented"

* "The relationship is determined by whether the DHA want us out of discussions"

* The relationship between the CHC and the DHA is very "dependent upon personalities; CHC lack of involvement in the contracting process is due to the DHA person".

Good relations where there is mutual respect and trust are seen by many CHCs to be vital to fulfil their role. One CHC stated that the good relationship currently enjoyed would continue even if all statutory powers were revoked. Another felt that all relationships are dependent upon the personalities involved and the imposition of statutory rights breeds illwill. However, these last views do not in any way represent the prevalent feeling amongst CHCs. Broadly speaking, CHCs seems to be very much aware of how dependent they are upon the 'goodwill' or

otherwise of DHA managers. References to DHA suspicions of the CHC and its activities were frequently made as were comments about DHAs mistrusting CHCs. The following excerpt from one CHC's annual report gives a sense of what can happen in the course of a CHC fulfilling its duties:

"It is a sad fact that criticism of our local health authorities frequently results in their accusation of unfairness/inaccuracy mostly without justification (if we are inaccurate, it is because we get inaccurate information). More unhappily still since it bears onerously on an individual, there have been occasions when the substance of the criticism has taken second place and the secretary has been accused of 'hostility', political bias and of conducting a personal campaign against the ... HA." (CHC Annual Report, 1990)

Another CHC has been in contact with ACHCEW to tell of how the DHA has made threats that the good relationship between the CHC and authority would be terminated if the CHC acted in a way which was supportive of a complainant. It is in the light of such cases that the need for safeguards for CHC independence is clear.

Ministerial statements have been consistent (and persistent) in insisting that guidance for CHC-DHA relations must be flexible and that it would be unacceptable to bind DHAs to a definite form of working with CHCs. While this in itself is perfectly valid the actual practice in many districts would appear to fall into a category of working against the intended spirit of legislation and guidance. Leaving local health service managers to decide the form of CHC involvement, if any, is extremely successful in some areas where forward thinking DHA personnel are in post, conversely it is not successful in others.

Working together after EL(90)185

Many commentators suggested following the issuing of EL(90)185 that relations between CHCs and their matching authorities would become progressively strained in the absence of statutory rights. However, CHCs responses to the question asking them to describe their relationship on a scale of very good to very poor both before and after the guidance provided some interesting results in the face of the previous predictions.

CHCs describing ther relationship with DHA before/after EL(90)185:

	before	after
very good	28%	23%
good	38%	37%
satisfactory	27%	25%
poor	05%	01%
very poor	01%	00%
too early to say		14%

The results laid out in the above table are not at all surprising, especially when responses given with regard to areas of good practice are considered. However, they do seem to contradict the instance of bad practice described elsewhere in this paper. This may be explained as being due to CHCs' continued efforts towards working for partnership with their DHAs. Almost all CHCs were able to provide examples of joint working with their DHA. Instances of good working partnerships ranged from communication issues (liaision, sharing information), to joint projects on a range of health service issues and to the DHA giving the CHC unannounced visiting rights to DHA premises. A selection of comments serves to affirm the above figures on CHC perceptions of their relationship with the DHA; -

* "Involvement on quality issues, monitoring, constructive relationship with senior officers"

* "CHC/DHA officer meeting, district general manager not involved."

* "Support for new standardised monitoring, patients' charter"

* "Top relationship with Director of Public Health, joint survey, joint working group."

* "Access to sensitive information before it's published"

* "DGM easily accessible to secretary especially re complaints or services."

* "Working together on discharge policy, joint leaflet on nursing homes."

The tremendous range of examples of partnership between CHCs/DHAs illustrate how effectively both parties can work for the benefit of users of the local health services.

Assessing the impact of the guidance

* "new guidance has not significantly altered our relationship"

* "had a problem at the first meeting, hasn't reoccurred"

* "higher profile on quality issues, DHA recognition of the role the CHC can play"

* "cannot think of anything we are presently doing that is affected"

The above represent the plus side of a continuum. Some CHCs do not perceive any change in their relationship. For others the impact is felt in particular areas of CHC relations with DHAs. One CHC commented the DHA does not regard the CHC as an overall 'voice' of the local community and does not consult the CHC on

issues which affect it. Interestingly, this attitude mirrors that emanating from the Department of Health in its defence of Consultation and involving the consumer. The view of the Department of Health is that ACHCEW's attempt to delineate the role which CHCs can adopt is misled:

> "In setting out how they see the role of CHCs the Association should not mislead themselves into thinking that the monopoly in representing the public rests with the CHC movement."
>
> (Correspondence, DoH to Director, ACHCEW January 1991)

Of course, CHCs are not the only bodies to represent "the public". They are though the only bodies within the NHS who have statutory responsibilities to monitor the health service and represent the interests of the users of that service. CHCs act as enabling resources for local voluntary groups, in many instances facilitating and coordinating local initiatives. The responses to this question suggest that it was rather naive to ask it in the first place. A number of CHCs point out that the introduction of the internal market has had a far greater impact on CHCs working relations than the guidance:

* "guidance less important than the purchaser/provider split, need to establish as power brokers"

* "it cannot be emphasised too strongly, the purchaser/provider split is the cause of the change."

PART II: CHCs RELATIONS WITH FAMILY HEALTH SERVICES AUTHORITIES

In the past CHCs' relationship with FHSAs has not received the level of attention given to their relationship with DHAs. This is so for a number of reasons, not least due to the lack of statutory powers CHCs hold vis a vis GPs, dentists, pharmacists and opticians. CHCs have long argued for rights to visit GPs' premises as part of their brief "to keep under review the operation of the health service in its district and make recommendations for the improvement of that service" (SI 1973 2217, paragraph 19) In view of the reforms, especially GP fund holding, its seems vital that CHCs' relations with FHSAs are fully documented.

A separate questionnaire dealing with Family Health Services Authorities was sent to all CHCs. It was basically similar to that dealing with DHA relations as much of the guidance applied equally to FHSAs as to DHAs.

FHSA meetings

Those CHCs who responded (128, 64% of ACHCEW membership) stated that in the past nearly all (98%) sent an observer to FPC meetings. At present all are invited to FHSA meetings. The following points illustrate how the guidance has affected CHC involvement at meetings:

* 90% of CHC 'observers' have speaking 'rights'

* The numbers of CHC representatives at FHSA meetings who cannot attend private parts of those meetings has doubled since September 1990

* Over one in ten CHC representatives do not receive background/agenda papers for meetings

The findings suggest that, for some aspects of CHC involvement at FHSA meetings, there have not been significant changes, for example, there was little difference in the results concerning receipt of relevant background papers (84% before EL(90)185, 85% now). This is not to say that there is no cause for concern. A recent report in the Health Service Journal told of how CHCs in one district are concerned about FHSA cuts in agendas and in the number of organisations agenda papers are sent to. Two CHCs will now receive only one set of papers between them. This action aimed to cut FHSA costs but as a CHC deputy chief officer remarked "While cost cutting is obviously necessary, we do feel that public accountability should be protected." (HSJ, 15/8/91)

Before September 1990 less than a third of CHCs reported that the FHSA sent a representive to Council meetings. Significantly this has changed, now in half of the districts FHSAs send a representative to Council meetings. This is quite an encouraging display of interest in CHC matters by FHSA and should be promoted.

A less positive change concerns FHSA meeting schedules. As with DHAs, monthly and bi-monthly meetings are no longer the norm amongst FHSAs. The table below compares the responses of the ACHCEW November 1990 study with the current situation and provides evidence of a trend which is not encouraging.

	NOVEMBER 1990	MARCH 1991
Bi-monthly	37 (28%)	19 (15%)
Monthly	48 (37%)	33 (26%)
Quarterly	06 (4.6%)	48 (37.5%)

The very obvious shift towards quarterly meetings gives cause for concern. This frequency of meetings a year hardly signifies openness nor does it provide much opportunity for close contact with the public. The decrease in number of meetings should be considered in the context of the doubling of those CHCs who report that they are denied access to private parts of meetings.

Informal contact

Informal contact appears to be well established - four-fifths of CHCs report that it occurs frequently. However, in stark contrast to the findings from the DHA questionnaire, a mere 15% of FHSAs have set up additional formal liaision arrangements with CHCs. Coupled with the responses to the question which asked about CHC formal status on various FHSA sub-committees, an overwhelming 92% stated that they had no formal status on such bodies. In addition to these results, nearly half of FHSAs hold private meetings and a further 43% of CHCs are not sure as to whether or not such meetings are taking place. Secrecy appears to be the norm.

"Not since September 1990" - Consulting CHCs

95 CHCs did not respond to the question regarding consultation arrangements. The comments are taken from the 20% of CHCs responding. On the basis of their responses it seems that consultation exercises with the DHA are more frequent and have a higher profile. Also, as a CHC commented, contact with the DHA is more frequent than with the FHSA. As with the findings from the DHA/CHC questionnaire, CHCs complained about the short time scale allowed for consultation exercises. Those who gave details about the consultation procedure were not complimentary, indeed the mood can be summed up in the following response : "What consultation procedure??!!!".

One of the striking aspects of the responses is the extent to which FHSAs are not consulting CHCs. It further appears that CHCs experience problems in their attempts to obtain full information necessary to carry out a competent and informed response. Some CHCs are more optimistic than others - one talked about how "real information" has not been made available since

the formation of the FHSA but added that it was still too early to come to a conclusion. Amongst other serious complaints made by CHCs was the statement that "almost always the FHSA asks for urgent decisions before the next meeting of the CHC".

Two CHCs raised important points regarding the result of a consultation exercise. One pointed out that it seems unclear as to what routes are available to pursue the results of a consultation and another, expanding on the topic of late receipt of consultation documents, mentioned that while comments were welcomed there appears to be little opportunity to alter the proposals. Of course, consultation exercises should be precisely about amending/deleting aspects of a proposal; it is the raison d'etre of a consultation document. This comment hints at inherent tokenism which some CHCs must suffer vis a vis FHSA consultation arrangements. It does not seem unreasonable to suggest that FHSAs need guidelines on good practice in consultation practice as a matter of urgency. In this context, the statement that the FHSA does not accept the CHC as the consumers' voice, preferring to deal with voluntary sector groups, echoes one official viewpoint. CHCs as the key users' representative in the NHS cannot and do not hope to ascribe to being the only voice. CHCs' expertise and experience cannot be matched by many voluntary organisations. CHCs' statutory powers place them in a different position to voluntary organisations.

It seems that the national picture with respect to FHSA consultation practices is rather grim. The following comments illustrate this adequately:

* "no consultation recently"

* "failure to consult on annual plan"

* "on occasions not consulted and only learn results in the minutes"

* "they forget to do it"

* "documents published late, little apparent opportunity to alter but OK to comment".

There are few examples of good practice in consultation procedures between FHSAs and CHCs. But of course, there are FHSAs who do consult : "exceptionally open". This comment stands in contrast to the other comments which can, for the most part, be summed up in the following statement:

* "not applicable because we have not been involved at all".

The former comment is the only positive comment made out of the 33 CHCs who replied to this question.

Behind closed doors : "Seminars and training workshops"

Nearly half of the CHCs responding stated that their FHSA held private meetings. Some CHCs feel that such meetings are the place where crucial decisions are taken.

* "Sub-committees meet and only recommendations come to the main FHSA meeting"

* "Some sub-committees are making major decisions"

It should be borne in mind that CHCs are by and large not members of such committees. One CHC noted that it is certain that such meetings are taking place as there is a distinct lack of continuity in the agenda for the formal meetings, while another mentioned how much of the "important stuff" seems to be conducted in private. This practice appears, on the basis of CHC comments, to be relatively well established and one of the implications identified is that "the CHC cannot maintain continuity when it attends alternate meetings."

Some CHCs appeared to be resigned to this practice and see it merely as something which has always been there. Other CHCs expressed a wish to attend such 'seminars' and indeed when this was put to the FHSA, they were invited to attend. Other CHCs are invited on an ad hoc basis. However often this invitation is extended to CHC persons the FHSA wants to attend. ACHCEW was recently alerted to the case of a CHC whose chair is invited on a regular basis to FHSA private meetings. As the chair was taking annual leave it was suggested that the vice chair attend in her/his place. This was not acceptable to the FHSA. So yet again it seems that favoritism on the part of the FHSA determines CHC involvement.

"A bit of both" - Statutory rights and personalities.

The Department of Health's comment about the importance of local personalities suggests an acceptance that CHCs' work will be influenced by the personalities at the FHSA. As with responses dealing with the CHC/DHA relationship, most CHCs commented that personal relationships are "really significant", some regarding them as having less importance than with the DHA. Again a sense of vulnerability was evidenced in such comments. As one CHC wryly observed: "personalities are important but if statutory rights were in place the CHC would be consulted".

Comments were made which serve to underline the extent to which CHC involvement is determined significantly by the attitude of certain FHSA members towards the CHC; "Chair of FHSA favours a good working relationship with the CHC" as against "The general manager (former DHA officer) doesn't see CHCs as having a future".

Shifts in personnel at the FHSA have an immediate impact - a number of CHCs reported how ex-CHC staff or members are now senior FHSA officers "so relations are good". As with the DHA

section, changes in personnel have brought positive changes in personnel have brought positive changes in the working relationship between the two bodies. There was general agreement that statutory rights "are vastly important, new appointments have made a great improvement (but we) still need statutory rights"

Changing relations?

CHCs were asked to evalutate their relationship with their matching FHSAs both before and after the guidance. The responses given suggest that the nature of the relationship has indeed changed, although in many ways these figures must be considered in conjunction with cases of good practice between CHCs and FHSAs.

CHCs Relations with FHSAs

	BEFORE 1990	AFTER SEPTEMBER 1990
VERY GOOD	45	21
GOOD	34	33
SATISFACTORY	13	24
POOR	05	07
VERY POOR	02	01

(FIGURES IN %)

As can be seen nearly half of CHCs regard themselves as having a good to satisfactory relationship with their local FHSA. 12% stated that they thought it was too early to characterise the relationship on this scale. Of course the table indicates a dramatic decrease of those CHCs who previously have described their relationship as very good which is significant.

Partnerships

CHCs have commented upon the willingness of FHSAs to involve them in a range of capacities. Such a development is to be welcomed. However it is also necessary to be aware of how this increased involvement impacts on the workload of on average two full-time staff in a CHC office. It also needs to be acknowledged that there is a possibility that some CHCs are being exploited in their willingness to share expertise and resources. One CHC mentioned that their "FHSA seems to think that the CHC is a department of theirs and try to give us work".

Issues relating to CHCs' independence are raised in this context. Questions such as who determines the research agenda and who decides what the procedure for dissemination of research findings will be, need to be considered by CHCs taking on joint projects with FHSAs. The following section details examples of good practice as described by CHCs. It indicates the extent to which, even in the context of lack of full powers and 'rights', CHCs are

working with FHSAs to the benefit of users of the local health service.

A striking aspect to the comments relating to good practice is the number of CHCs who said that the complaints procedure, both informal and, to a lesser extent, formal, has been improved over the last year due to increased liaison between the CHC and FHSA. Of the 59% who responded to this question, 16% specifically said the work on complaints had improved.

The sheer scope of cases of good practice cited is tremendous: from joint surveys, joint training and publicity, monitoring, quality assurance initiatives, joint work on specific areas such as community care to more effective liaison arrangements between officers, all point to how CHCs are working to fulfil their role as patients' watchdog. The range of examples provided illustrate how, with sympathetic FHSA officers in post who encourage CHC involvement, CHC expertise can be fully utilised to inform health service planning and management to the benefit of users. It would appear that there have been many positive developments in the CHC/FHSA relationship but as with the DHA whether this is directly due to EL(90)185 is difficult to ascertain.

Assessing impact of guidance

CHCs were asked to describe the impact of the guidance and interestingly nearly two-thirds (66%) did not respond, further the responses given sit uneasily with the examples of good practice above. Those who did respond painted a bleak picture of the negative way in which the guidance has been used by FHSAs:

* "Disappointing, the good relationship which had been built up now being distanced"

* "new chair doesn't want CHC members around the table at formal meetings"

* "Initially the FHSA tried to reduce CHC participation.."

* "CHC observer excluded from first meeting, since then the minutes etc have been very brief"

Others noted the "continual inability/refusal to accept the role of the CHC" which of course has been legitimised to some degree by the guidance sanctioning the removal of key expectations. One CHC reported how their observer is no longer allowed to sit at the main table althought she/he is given a "spot" at the end of the meeting. Another described how the Council was refused access to parts of the meeting which they had traditionally attended. The characterisation of EL(90)185 as a "ludricuous blockage" seems quite appropriate in the light of CHCs' comments.

However, as with all other sections, where there are examples of bad practice they are counterposed by examples of good practice, of improving relationships between the two bodies. A pertinent aspect to the relationship which must be addressed is the

historical backdrop to the CHC/FHSA relationship - one comment noted that while the relationship was improving the baseline was poor to begin with. Past good relations are clearly an important factor: "the last meeting was very satisfactory - (the CHC) used to share offices with the old FPC".

Notable is the persistence of CHCs in seeking to improve the relationship; consider the following statements of intent:

* "we intend this year to break down the barriers"

* "we are hoping to start regular meetings which will aim to improve the relationship"

As with the responses dealing with consultation, regional patterns are clear. While in some areas Consultation and Involving the Consumer has had a negative effect on the relationship between CHCs and NHS authorities, in others the opposite is true. CHCs from one region reported their experiences following this guidance:

* "a joint meeting was arranged, seen as encouraging for the CHC following past experiences"

* "improving due to managerial attitude towards the CHC"

* "FHSA trying much harder to consult"

* "much more friendly and open body than former one, mainly due to new chief"

As with CHCs reporting on how EL(90)185 affected their relationship with the DHA, it seems that personnel changes must be considered as key factors in assessing how this guidance is used by NHS Authorities.

PART III: OVERVIEW

CHCs and NHS authorities

As noted earlier, the immediate impact of the guidance Consultation and Involving the Consumer (entitled Consultation and the involvement of local people in Wales) was that it removed CHCs' 'right' to observer status at NHS authority public meetings. This was contrary to ministerial assurances that observer status would be protected in the NHS reforms in the interests of CHC independence. Currently CHCs have a right to meet with their matching authorities once a year, otherwise they "have rights as do other members of the public to attend any NHS authority or NHS Trust meetings open to the public." (Consultation and Involving the Consumer). Access to DHA meetings is now deemed a "matter for local discretion by health authorities" (Virginia Bottomley, House of Commons, 30.10.90)

Whilst at present a majority of CHCs have speaking rights at NHS Authority meetings, this right is not guaranteed. In February 1991, Stephen Dorrell responded to a question about CHC rights by saying that "whether or not they are allowed to speak or allowed to attend confidential parts of such meetings has always depended and will continue to depend upon the decision of the chairman of the meeting." (House of Commons, 5.2.91) While this is so, observer status was expected and this was explicit in relevant guidance and there was an expectation that the CHC observer would attend private parts of public meetings. Following the guidance, the number of CHCs who cannot attend such parts has more than doubled.

Also, CHCs are experiencing problems obtaining agenda papers for meetings. Meeting schedules have been significantly revised by both DHAs and FHSAs - only a quarter are holding monthly public meetings, which in many ways validates fears that health service managers are becoming increasingly remote from their local communities.

In addition, local accountability would appear to be under threat - following the reorganisation of health authorities there is now no local authority representative on DHA boards.

Informal contact, for example, day to day contact, ad hoc meetings and so on, appears to be very well established throughout England and Wales. In districts where it is not currently standard working practice, efforts should be made by both CHCs and NHS authorities to promote it. Minuted informal arrangements (rather a contradiction in terms) are not common.

Collaborative ventures (projects, producing information materials and so on) are widespread in many areas and illustrate the benefits that accrue to users of the health service as a result of such efforts. Such initiatives are to be welcomed as being true to the spirit of the reforms in promoting user-centred services.

In contrast to the positive nature of this aspect of CHC/ NHS authority relations, CHCs report that their matching authorities are holding private meetings at which it is suspected that key decisions are being taken. A significant number of CHCs are not being involved in any meaningful way in DHA/FHSA sub-committees. CHCs' expertise and knowledge about the state of the local health services ought to be utilised for the benefit of users of those services. These practices prevent this happening.

The responses to involvement in the contracting process apply only to DHAs as, despite government statements that the CHC is to relate to commissioning agencies, the Department of Health's view is that CHCs have no remit in respect of GP fund-holders. Whilst the guidance allows for DHAs not to consult CHCs on individual contracts, a third of DHAs are not even consulting CHCs on general contract plans and a significant number of those who are 'consulting' are not doing so adequately.

CHCs, despite their experience and knowledge have no special status as consultees. The Minister of Health has stated that "DHAs are responsible for placing contracts with providers including NHS Trusts. They will be expected to seek the views of all interested parties, including Community Health Councils on their overall contracting plans." (House of Commons 29.01.91)

A leaked Department of Health document concerned with the role of CHCs in the reformed NHS spoke of how "The purchaser/provider contract will be fundamental to the new arrangements and, if CHCs are to play any sensible part their role must fit the new environment." (Feb. 1990) The 'sensible' part allotted to CHCs would appear to be quite small , pointing to the lack of any special status for CHCs despite their being the statutory body representing users' interests. There are some CHCs whose DHAs have sought to involve them fully in the contracting process and it is encouraging to note this active participation.

Consultation on substantial developments of the health service and on proposals to make any substantial variation in the provision of such services has historically raised problematic issues for CHCs. Now, DHAs and FHSAs themselves determine what criteria are to be applied to determine what is a 'substantial' change in provision. CHCs reported problems gaining access to relevant information and the timescale of consultation exercises. FHSAs in particular do not appear to be consulting CHCs. This is true across all regions. Where DHAs are consulting, one in five CHCs report problems.

The net effect of the guidance, and some would argue the reforms themselves, has been the deterioration in the overall relationship between CHCs and NHS Authorities. Of course this is not a fixed picture, some CHCs report that their relationship has improved dramatically but typically this was connected with change of personnel at senior level.

"Local personalities" emerged throughout as a significant factor in the CHC/authority relationship. The government's position is that all guidance must allow for flexibility at local level, that

local personalities will determine the nature of the working relationship and that to impose statutory obligations would be to straitjacket authorities. The logic here is particularly myopic - if a good relationship exists because personalities are conducive, then there is no need for statutory rights for CHCs.

The problem is that this nowhere acknowledges the consequences for CHCs (and thereby for the users of local health services) should local personalities conflict. Most CHCs saw statutory rights as a last resort, something to safeguard their involvement should a relationship break down. Christine Hogg points out that by the very nature of the CHC role they "May obstruct 'smooth' management and comment on professional matters which may be considered by some to be none of their business. CHCs have different priorities from service providers." (Representing the Consumer - 15 years on 1989:14) Many CHCs reported that if they are 'obstructive' they encounter problems and the DHA/FHSA distance themselves. And as Roy Jobling, the Chairperson of Cambridge CHC states "Making CHCs constantly conscious of their dependence on the grace and favour of those they may have to criticise is no recipe for useful consumer representation." ("Reins to tighten up for future CHCs", Health Service Journal, 22 February, 1991)

Recommendations

The central recommendation based upon the findings of the current study is that statutory rights and guidance relating to CHCs require urgent review and that the emphasis of such powers should be centrally concerned with CHC independence - working for improvements in the health service ought not to have repercussions of exclusion. The findings outlined above point to areas of concern which have been addressed by ACHCEW's Panel of Enquiry and are laid out in Effective CHCs for the 1990s (1989). Regional Associations of CHCs have also drawn up lists of recommendations in considering how they are to perform their role within the NHS. In 1984 the Liaison Committee for CHCs in NWT Region produced a series of proposals which would be instrumental in promoting good practice between DHAs and CHCs. These proposals include the following points:

* CHCs should receive all published DHA papers in good time for effective comment;

* CHCs should receive background and supporting papers..necessary to the full understanding of health issues and decisions affecting the NHS consumer in the district;

* CHCs to have membership of all district planning groups; to have observer status on all relevant JCCs; to have observer status on all FPCs;

* More frequent opportunities should be found for joint seminars between DHAs and CHCs on topics of mutual concern

(NWTRHA 1984)

To these, ought to be added the Oxford RHA recommendations which were drawn up following the issuing of the guidance.

* The 'right' to full involvement in the planning of services, including consultation on contractual documents. Involvement also requires that CHCs will need the information to have appropriate input in the contracting process and to organise monitoring of provider services.

* The 'right' to nominate observers from the Regional group of CHCs to the RHA, its committees, subcommittees and working parties where the interests of service users are involved;

* The 'right' to send observers to DHA and [FHSA] meetings, who may speak but not vote.

* "It should be the responsibility of RHAs, DHAs and FPCs (now FHSAs) to ensure these 'rights' are fulfilled.
(Oxford RHA 1990)

* The Community Rights Project, in its 'Secrets File No. 17, includes 'Guidelines for Health Authorities on Open Government' which covers public participation (such as access to agenda documents) and should be consulted as the guidelines aim to promote public involvement in health authority business.

Such recommendations ought to be seen as "CHC Charters" and the rights specified above should have legal status. As one CHC commented in respect of EL(90)185, "we are disappointed to find what appears to be a further 'chipping away' of CHCs' rights which appears to us inconsistent with repeated ministerial statements underlining the importance of CHCs in the 'new' NHS as a means of ensuring that the interests and views of the service's users are kept in the forefront." A significant number of CHCs have worked with their matching authorities in the run up to the 1st April 1991 demonstrating beyond doubt that CHCs do have a crucial role to play in the 'new' NHS. The findings from the current study can only reiterate ACHCEW's recommendation as made following the November 1990 study:

"ACHCEW would recommend that all authorities look again at the contribution their local CHCs can make, the experience they possess and adopt the practices of their more forward thinking colleagues in involving users' representatives in the planning and design of services" (CHC Relations with NHS Authorities, 1990)

Conclusions

The findings from this current study underline the diversity and multifaceted nature of the working relationships between CHCs and NHS Authorities. Instances of bad practice on the part of DHAs and FHSAs in terms of excluding CHCs from discussions on health service planning are widespread in some districts. However, as stressed throughout this report, this is not nor has it been the experience of many CHCs; as one CHC asserted:

> "Much has been written during the past few months about the 'diminished' powers of Community Health Councils (CHCs) and of their apparent inability to represent patients' interests with any significant degree of efficacy in the market forum of the reformed NHS. In one corner of the country at least, however, these assumptions are wide of the mark."
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> (CHC Newsletter August 1991)

To acknowledge the existence of working partnerships between CHCs and authorities in no way diminishes the urgency of calls for a review and strengthening of statutory rights of CHCs - it serves to underline the potential for effective user representation in the NHS via councils. Firm statutory rights and appropriate guidance would enhance relationships where good and ensure relationships where currently there are none.

Of course, a related issue is the funding of CHCs. Provision of adequate resources for CHCs to fully carry out their role would signify a commitment on the part of the government to the opening up of the health service, to increased consumer participation.

Discussing the future role of CHCs in the restructured NHS, Kirk and Owen argue "To play an effective role in representing the user's view of services and ensuring their rights are incorporated in service contracts and applied to those services it is essential that CHCs have good working relationships with with their District Health Authority and with the provider units." (1991:9) The existing legislative framework within which CHCs carve out a relationship with their matching authorities does not guarantee their participation; exhortions in guidance to openess and partnerships are not enough and have clearly failed in some areas. With sufficient statutory powers CHCs will as the Department of Health have stated "continue to play a key role in representing the interests of the local community and will act as an effective channel of communication for consumer views to health authorities."

ACHCEW welcomes such statements and will continue to monitor what is a constantly changing picture of CHC/NHS Authority relations following the guidance. Of particular concern is the need to disseminate information about good practice regarding working relations between CHCs, DHAs and FHSAs. Those authorities who aim to plan and deliver services which are appropriate to the needs of the local population, a strategy central to the White Papers, should seek to draw upon the experience and knowledge of CHCs. As this paper has

demonstrated, some authorities are involving CHCs and recognise the contribution they can make in the planning, delivery and evaluations of provision. ACHCEW has campaigned on a national level for recognition of the valuable work CHCs perform as "Patient's Friend" and will continue to press for statutory powers for CHCs which protect the voice of the user in the NHS.