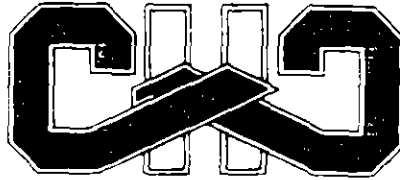

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CHC RELATIONS WITH NHS AUTHORITIES

A report of a survey of CHC relations with NHS authorities following the new Government guidance circular EL(90)185 (November 1990)

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CHC RELATIONS WITH NHS AUTHORITIES

INTRODUCTION

New guidance on the role Community Health Councils are expected to play in the reformed health service and their relationships with NHS authorities: District Health Authorities, Family Health Services Authorities, Directly Managed Units and Self Governing Trusts, was issued to General Managers on 18 September 1990 under the cover of an Executive Letter (Ref EL(90)185). The guidance, which was produced without consulting CHCs or their national Association, signals a potential shift in the access CHCs will have to local decision making by NHS authorities.

Community Health Councils are independent "consumer councils" for health, set up in 1974 in recognition that NHS care was not sufficiently patient centred, and to make a clear distinction between the management and public representation functions of the NHS. CHCs have the role of representing the interests of patients and the community to managers of the health service and they have been responsible for starting the process of opening up the NHS to the public and have kept the needs of vulnerable NHS users in the forefront of debates about resource allocation.

CHCs have the statutory rights to enter and inspect NHS premises, to be consulted on any substantial development or variation in the service and to oppose the closure of any NHS service. Moreover, CHCs have since 1981, in the case of health authorities, and since 1985 in the case of family practitioner committees, had special access to the formal meetings of authorites. Previous guidance explained:

> "Specifically, the Secretary of State expects that the CHC should send one of its members to meetings of the matching DHA as an observer. **These observers will have the same right as members of the authority to speak during meetings** but will not vote. **Observers will not be automatically excluded from those parts of the DHA meetings or committee meetings which are not open to the public....CHC observers should receive all papers to be discussed by DHAs...**"

This right of access to all parts of authority meetings, the right to speak and the right to receive papers has clearly been a very important part of enabling the representatives of the community to contribute to decisions affecting the development of local health services.

Despite public affirmations that its reforms of the health service are patient-centred and aim to promote "consumer-sensitive" management, the Government has given little positive consideration to the work and role of CHCs. Indeed, they are barely mentioned in the blue-print for the reforms, the White Paper "Working for Patients". Nor have CHCs been consulted about developing their role in the reformed NHS. However, a series of departmental discussion papers leaked to the Association of CHCs during the course of 1990, clearly indicated that civil servants,

regional general managers and ministers were discussing the future of CHCs. In September 1990, new guidance on the role of CHCs, was issued by the Department of Health and most existing guidance cancelled. Since September 1990 CHCs have only had the right:

> **"as do other members of the public to attend any NHS authority or NHS Trust meetings open to the public. It is a matter for decision by NHS authorities and NHS Trusts whether CHCs will be invited to address meetings which are open to the public or to attend meetings which otherwise are closed to the public."** CHCs no longer have an automatic entitlement to receive authority papers.

The Association of Community Health Councils for England and Wales is the national body which represents CHCs. It also has a statutory duty to represent the interests of users' of the health service at a national level. ACHCEW has condemned the introduction of the new guidance as being counter to the interests of health service users and contrary to the spirit of accountability and participation in health service management.

The first meetings of the newly constituted District Health Authorities and Family Health Service Authorities took place in the middle of September, after the introduction of the new guidance. Early indications from CHCs suggested that the introduction of the new guidance was very quickly beginning to influence the way in which authorities viewed their CHCs. Many CHCs reported feeling 'betrayed' when previously existing good working procedures appeared to be abandoned almost overnight and many others expressed a fear of 'rampant managerialism' taking over the NHS.

To clarify the situation ACHCEW surveyed its 200 members soon after the first meetings of the new authorities to assess the changes. 131 CHCs (66%) responded to the survey within two weeks of the first meetings, the results of which are produced below.

Before EL(90)185:

DHA MEETINGS *		**FHSA MEETINGS**
130 (99%)	ATTENDED MEETINGS	130 (99%)
126 (96%)	SPEAKING RIGHTS	126 (96%)
114 (87%)	ATTENDED PRIVATE SESSIONS	57 (44%)

After EL(90)185:

119 (91%)	ATTENDED FIRST MEETING	111 (85%)
103 (79%)	SPEAKING RIGHTS	89 (68%)
46 (35%)	ATTENDED PRIVATE SESSIONS	19 (15%)
82 (63%)	RECEIVED ALL RELEVANT PAPERS	57 (44%)

* Percentages based on sample size of 131 CHCs.

CHC RELATIONS WITH DISTRICT HEALTH AUTHORITIES

130 CHCs had sent observers to previous meetings of the DHA in line with the provisions of HC(81)6. (For one CHC the information about previous meeetings was unavailable.) Only 4 had not had an automatic right to speak at previous meetings and 17 had been prevented from attending all parts of the meetings, that is, including the private parts of the meetings. Formal relationships with District Health Authorities were generally felt to be helped by Authorities' recognition that CHCs had a 'right' to attend meetings, speak and receive all relevant papers.

119 CHCs attended the first meeting of the new DHA at the initation of the authority. Of the 12 which did not attend:

- 6 were explicitly excluded from the meeting
- 2 had no member available to attend
- 1 HA had not met at the time of the survey
- 3 information unavailable

Of those CHCs prohibited from attending, all reported that their health authorities wished to hold the first meeting in private to consider future relations with the CHC. Two CHCs mentioned that their health authority was cautiously waiting to see what happened in other areas before deciding. None of these CHCs has yet received an assurance that they will be invited to future meetings.

Of the **119** CHCs which did attend the first meeting of the new District Health Authority:

- 16 were prohibited from speaking
- 73 were prohibited from attending the private parts of the meeting
- 38 did not receive all the papers relevant to the meeting

These results show a clear increase in secrecy on the behalf of health authorities and some deterioration in the formal CHC/DHA relationship. CHCs fear that important decisions regarding the provision of health services will be taken during private sessions to which no CHC, press or public will have access.

At their first meetings most health authorities announced their schedule for future meetings:

- 45 health authorities are planning to meet monthly,
- 42 bi-monthly,
- 21 quarterly,
- 2 ten times each year,

One 9 times each year, One six weekly, One eight times a year and One 5 times a year. 17 have yet to decide.

With only 1/3 of DHAs agreeing to meet in public on a monthly basis, there must be some concern that health authorites will be seen to be less accountable, to the people they service, in the future.

CHC RELATIONS WITH FAMILY HEALTH SERVICES AUTHORITIES

All but one of the 131 CHCs had sent an observer to previous meetings, in line with the provisions of HC(FP)(83)2. Five had not been given an automatic right to speak and 74 had been excluded from the private parts of the meeting. Generally it was felt that relations with the old FPCs had not been as good as those with DHAs. Many CHCs feel that FPCs never really got to grips with the responsibilities they were given in 1985.

111 CHCs attended the first meeting of the new FHSA.
Of the 20 who did not attend:

- 6 had no member available
- 7 FHSA had not met at time of survey
- 7 were explicitly excluded from the first meeting
- 1 information unavailable

Of those CHCs prohibited from attending, 4 explained that the first meeting was deliberately held in private, ostensibly to discuss internal matters, but that the CHC has been given an assurance tht it would be invited in future. One CHC explained that a very long private meeting was followed by a very short public meeting to which the CHC was invited. Arrangements for the future for this CHC remain unclear. Finally two CHCs reported being denied access to the first meeting with no assurances that an invitation will be extended in future.

Of the 111 CHCs who did attend the first meeting of the new Family Health Services Authority:

- 23 were prohibited from speaking
- 92 were excluded from the private part of the meeting
- 55 were not sent all the papers for the meeting

It would appear that where relations between CHCs and FPCs were already less than excellent, the introduction of the new guidance has made the situation worse. Concern must be expressed at the apparent tendency of secretiveness amongst FHSAs which exclude CHCs from discussions held in private and which fail to give CHCs information about matters being discussed.

48 FHSAs are planning to meet on a monthly basis, 37 bi-monthly, 6 quarterly, two 10 times each year and one 5 times each year. However, 37 FHSAs have not yet decided on the frequency of meetings. Whilst few FHSAs have opted for quarterly meetings, which in itself is to be applauded, the usefulness in terms of public accountability of more regular meetings will only be demonstrated by a commitment to openness in the management of health services.

WORKING RELATIONS WITH NHS AUTHORITIES - HOW DO CHCs FEEL?

Although many CHCs (58) told us that so far the introduction of the new guidance has had little effect on their working relationships with NHS authorities, the majority felt very vulnerable:

> "Information and involvement is clearly being linked to 'co-operative' attitude of CHC officers."
>
> "No effects at all apart from the feeling that observers attend as a 'privilege' rather than by statutory right."
>
> "Our position is one based on good will and if we rock the boat too much we stand to lose out."

A further 19 CHCs told us that on the basis of one meeting, it was too early to say whether existing relationships were likely to improve or deteriorate:

> "Confused - need time for CHCs, DHAs and FHSAs to get their act together."

However, one-third of CHCs (43) did report definite cause for concern, in that relationships with NHS authorities were already begining to deteriorate:

> "We are suspicious that any controversial subjects will be discussed at the private parts of meetings."
>
> "Previously we had access to all papers and the CHC observer had access to Part II as well as access to 'seminars' on particular subjects that took place prior to DHA meetings. Now it appears these 'seminars' will take place on alternate months to DHA public meetings and the CHC will not be invited to participate. We are obviously making noises about this!"
>
> "DHA is distancing itself from CHC, Secretary does not sit at table but attends as member of public."
>
> "There are fears that public meetings of the new health authority will be mere 'rubber stamping exercises and that full discussion of issues will take place only in business meetings of the health authority with decisions being made prior to public meetings."

Set against this widespread concern, 14 CHCs actually reported that they were anticipating better relationships with their authorities in the future:

"We have chosen to use the publicity given to the 'worst case scenario' of the new CHC guidance to work out an even better arrangement with the DHA and FHSA, in future an observer and the CHC secretary will attend meetings etc."

"DHA have written CHCs' relationship into their standing orders."

"FHSA have welcomed us in a new spirit of openness."

CONCLUSIONS

Clearly it is early days - the new guidance on the role of CHCs was only issued in September at the same time as the newly constituted DHAs and FHSAs were holding their first meetings. Arguably, these organisations are still finding their feet and working out their own role. However, the experiences of CHCs at these first meetings indicates a number of areas of concern, which need to be resolved before working arrangements become established.

It would appear that very few DHAs and only slightly more FHSAs have specifically tried to exclude CHCs from their meetings. These authorities are clearly in a minority and must be encouraged to fall in line with their colleagues - exclusion is not acceptable. However, merely admitting CHC observers as members of the public is also clearly not adequate in terms of promoting participation and community involvement: rearranging the meeting room to move CHCs away from the main table is not good practice, neither is allowing CHCs to speak only to items arranged in advance. More worrying and apparently more widespread is the practice of excluding CHCs from the private parts of meetings, cutting down the number of public meetings, holding private 'seminars' to discuss strategic developments and restricting the circulation of background papers. Those CHCs who find themselves prevented from making a positive contribution to the work of authorities via formal channels are likely to turn increasingly to the local media as a means of promoting and publicising the users' view of decisions made in private.

As the public's only statutory representative CHCs must be given an opportunity to participate in the formal decision-making process, to contribute to discussions and put forward the community's view. Authorities truely committed to developing consumer-sensitive high quality services have much to learn from the experiences of CHCs and should, therefore, be encouraging their input.

Clearly, a handful of authorities have already done this. 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.