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REPRESENTING THE CONSUMER

COMMUNITY HEALTH COUNCILS 15 YEARS ON

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SUMMARY

Community Health Councils (CHCs) were set up because of concern that the NHS was not sufficiently responsive to its users' and patients' interests were often not protected. In the last 15 years, the NHS has changed - but the problems which CHCs were created to tackle still exist. Even with improved management and information systems, there will still be a need for an independent users body.

Although CHCs have approached their work in different ways, all CHCs share a common belief that people using health services are vulnerable and that the role of the CHC is to help them. CHCs have pursued certain common objectives which are discussed in this paper.

1. Promoting local community interests in the NHS, especially for those groups who are least able to get the best from the health service - people with mental health problems or learning difficulties, elderly and homeless people and people from ethnic minorities. Throughout CHCs campaigned for 'priority' services and their support helped managers and staff providing non-acute care to gain a greater proportion of resources than they otherwise might have been achieved.

2. Promoting improved quality in health services
In spite of the concern with the 'customer', quality assurance is not yet a central management function in most DHAs. However, CHCs have been undertaking surveys of consumer/customer satisfaction since 1975. There have been particular benefits where CHC and DHA work together.

3. Providing a link between the NHS and the public
CHCs have developed many different and innovative ways of obtaining public views on local health services. CHCs have set up networks with local groups to involve them in planning local health services and CHCs have encouraged management to be more oriented to community rather than hospital-based services.

Community interests are diverse and complex and may conflict. The CHC provides a local forum for different views to be expressed and channelled to the NHS management.

4. Promoting individual rights
CHCs have promoted individual rights and assisting complainants. An example is ACHCEW's Patients' Charter, which has been adopted as basic policy by some DHAs.

CHCs have also provided information and assistance in how people can make the best use of health services. CHCs in the 1970s pioneered the development of information leaflets, and guide books to local services. Many DHAs and FPCs have followed the example set by CHCs, recognizing that providing information to the public is the responsibility of service providers. CHCs have also been instrumental in setting up advoacy schemes to help those people who have difficulty in expressing their own wishes, whether because they have language difficulties, learning difficulties or are economically or culturally disadvantaged.

CHCs have initiated new ideas and often made management aware of possibilities. CHCs have provided examples of good practices in what can be done with very few resources. Management have followed the lead provided by CHCs - a remarkable achievement for a local voluntary committee with limited resources.

However, after 15 years it is time to look at what we can learn from our experiences of CHCs which can contribute to the current debates about consumerism in the health service

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1. INTRODUCTION

Community Health Councils (CHCs) were set up with the re-organization of the NHS in 1974 because of concern that the NHS was not sufficiently responsive to its users' and patients' interests were often not protected. Concern arose primarily from the scandals in long stay hospitals in the 1960s. CHCs were seen as a public safeguard against gross mismanagement. The establishment of CHCs was a first attempt to involve the users directly in the health service.

In spite of this, fifteen years after the establishment of CHCs, the NHS' lack of responsiveness to users is still a major concern. Sir Roy Griffiths in the Management Inquiry in 1983 observed that the NHS cannot: *"display a ready assessment of the effectiveness with which it is meeting the needs and expectations of the people it serves. Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question"*. (DHSS, 1983)

One of the key intentions of the Government White Paper *Working for Patients* is stated to be to *"make the health service more responsive to the needs of patients"* (DoH, 1989). Both the Griffiths report and the Government White paper see the answer to the lack of user responsiveness in better and stronger management.

In all the debates about the future of the NHS, everyone agrees that the NHS should be more sensitive to the needs of its users. There are, however, differences about how this is best done - we can improve the quality of management to reflect a more 'customer'-oriented approach or we can strengthen the position of users directly whether through increased consumer rights or community health councils.

The Royal College of Nursing suggests that user representation should be strengthened. *"One of the NHS' worst features is its failure to sufficiently take into account the wishes and desires of its consumers, actual and potential. All parts of the health service - professionals, administrators, health authorities and others - must alter their procedures and attitudes to facilitate the development of consumer opportunities and choices. Community health councils should be strengthened and made genuinely independent of the NHS; and a national health inspectorate should be established to monitor the quality of care"* (RCN,1988).

In the proposals in the NHS Review CHCs have been retained. The Department of Health has also recommended that regional health authorities should review the resources available to CHCs. CHCs received further Government support from Roger Freeman, MP, who at the 1989 ACHCEW AGM confirmed the commitment to CHCs: *"CHCs...have a vital and valuable role. It is most important that the voice of CHCs is not lost in the wilderness"*.

There have been many changes in the health service since 1974 and CHCs have developed in different ways than envisaged. They have been given new statutory responsibilities, without an increase in resources or a review of their effectiveness. It is, therefore, a good time to look at the work of CHCs over the last 15 years. What can we learn from our experiences of CHCs which can contribute to the current debates about how to make the Health Service more responsive to the needs of users?

2. EVALUATING THE PERFORMANCE OF CHCS

Consumer bodies or watch-dog organizations such as CHCs aim to change attitudes among policy makers and management in order to bring about change. If they are successful, the climate of opinion changes and this is reflected in the development and management of services. A DHA will only develop better community care or more sensitive services for people from ethnic minorities - if they are persuaded that this is a relevant priority. Having decided this, the DHA will then be given the credit. The role of the CHC or consumer body, the original 'irritant', which prompted the policy review, is often forgotten.

Because there is rarely a direct cause-and-effect between consumer group activities and the introduction of change, the impact of consumer activity is difficult to assess. With CHCs, this difficulty is compounded because in 1974 no clear targets were set or guidance on how they would operate. There was just a feeling that they would be a 'good thing'. CHCs were left to work out their own priorities and ways of relating to health authorities. The broad scope of CHC responsibilities and the limited resources (generally only two staff) led to wide variations between CHCs all over the country.

Although CHCs have undertaken different activities and approached their work in different ways, all CHCs share a common belief that people using health services are vulnerable and, as individuals, have little power and that the role of the CHC is to help them.

There have been certain common objectives which CHCs have all pursued. These are:

- Promoting local community interests in the NHS especially for those groups who are least able to get the best from the health service - mentally ill, handicapped, elderly and homeless people and people from ethnic minorities.

- Promoting improved quality in health services

- Providing a link between the NHS and the public in planning local health services and encouraging management to be more oriented to community rather than hospital-based services.

- Promoting individual rights and better use of health services

In the absence of more specific and objective targets, we will look at the work of CHCs in each of these areas.

3. PROMOTING LOCAL COMMUNITY INTERESTS

Power in the NHS has tended to lie with acute hospital services. In 1976 the DHSS stated that priority would be given in future to services for elderly, mentally ill and handicapped people and to primary and community services (DHSS, 1976). In the 1970s the development of these 'Cinderella' services was a national priority. However, in the 1980s this has changed. DHSS policy has given priority to high technology services and the acute sector (Hogg, 1989). This policy has favoured specialist services provided often for people from outside the local area often at the expense of local acute services. At the same time, certainly in London, services for elderly, mentally ill and handicapped people have suffered disproportionately from cuts (GLACHC, 1988). These trends are continuing, and the emphasis on partnership with the private sector and income generation, inevitably concentrates management and public attention on high technology - at the cost of basic local health services.

Throughout the 1970s CHCs campaigned for new units for mentally ill, handicapped and elderly people and their support helped managers and staff providing primary care and services for mentally ill, handicapped and elderly people to gain perhaps a greater proportion of resources than they otherwise might have been achieved.

CHCs have consistently fought for priority to be given to the less 'exciting' services for the care of chronic illness, mentally ill, handicapped and elderly people. They have rarely been involved in campaigns for the new, and always costly technology which can only benefit a few people. Their priority has been to ensure the local hospital provides a good local service, rather than to establish services with national or international reputations.

One third of CHC members represent voluntary organizations - many of whom work directly with NHS users. They know the suffering that the lack of care in the community causes for so many patients and their carers.

An example of a successful CHC initiative has been the establishment of the Community Care Centre in Lambeth. The 20 bed purpose-built unit opened in 1985. Its philosophy is patient-centred, allowing patients to be equal participants in their own health care, with control over their own drugs and involved in writing up their own case notes. Services provided by the centre include day care, rehabilitation for surgical patients and care of the dying. GPs, nurses, therapists, social workers and local volunteers and health groups work together to provide a comprehensive primary health care service. (Wilce, 1988)

Would general management be able to ensure the health service provides a comprehensive service to all parts of the local community? General management has made the NHS more concerned with public and customer relations. However, the introduction of general management has co-incided with financial cuts and has led to a climate in the NHS where income generation and savings have become central management tasks. This has oriented NHS management inward rather than to the community. (Hunter, 1988)

CHCs often have different priorities for services from managers. They see the problems for patients and their families caused by the lack of co-ordination and the fragmentation of social and health services between the DHA, local authorities, FPCs and voluntary organizations. Because CHCs are generally community not hospital oriented, they are in a position to see health services within a broader framework than many NHS staff.

The role of the CHC as Watch-dog is particularly important now that so many non-acute services are under threat. Voluntary organizations may campaign nationally but at local level the vigilance of the local CHC has afforded some measure of protection for these vulnerable services.

4. QUALITY OF HEALTH SERVICES

The Griffiths Management Inquiry pointed out that quality assurance is a task of management. Since then many DHAs have appointed Directors of Quality Assurance. However, the post of Director of Quality Assurance has not become an influential one. Without resources, status or even clear terms of reference, most have become marginalised. In general they have not initiated consumer surveys or stimulated change. They have often seemed unclear about what their role should be and have tended to concentrate on either nursing issues or hotel services.

Quality assurance is not yet a central management function in most DHAs. However, quality assurance is an area in which CHCs have been active since 1975, undertaking surveys of consumer/customer satisfaction. A survey from Edinburgh University in 1986 concluded that the great majority of consumer studies had been carried out by CHCs (Leneman et al, 1986). Some CHC surveys do not use a rigorous methodology or meet high academic standards. However, they are carried out with enthusiasm and few resources, with CHC members generally acting as interviewers. Moreover, the purpose of CHC surveys is to obtain user feedback about services and in this they have been very successful.

There are great advantages for managers in working with CHCs on consumer surveys. After all, the quality of care in the health service can only be assessed with users in terms of the **total** experience of the health services as perceived by the patient and carers - for whom the service is provided. CHCs have the independence and an awareness of the issues. The DHA has the resources and the ability to act on the results.

CHCs can, therefore, make an important contribution to a DHA's programme of quality assurance because they can provide the information whereby the DHA can validate its findings and assumptions. The CHC is independent and sees services as consumers and as lay people - it is easy for professionals to become so involved in technical issues that they lose sight of wider issues.

Such collaboration has happened in a number of DHAs and proved an excellent way of promoting better quality services. In West Cumbria the CHC and the DHA have entered into a partnership to try and improve services. They are jointly pioneering a quality assurance programme to find out how services can be improved from the patient's point of view. It is funded jointly by the RHA and the DHA. CHC members have already conducted in-depth studies of a range of services including occupational therapy, chiropody, X Ray services, dentistry, hospital discharges and accident and emergency facilities. Thousands of interviews have been undertaken, involving CHC members in 24 hour rota in each hospital. The District General Manager said: *"CHC members can get closer to patients than employees of the health service and are therefore more able to view the service from the customer's point of view. It is very largely the patient's perception which matters. It matters less what the doctors, nurses or managers think because they are not the recipients of care. For assurance of quality we need to look as near as we can through the eye of the customer".*

Working with CHCs is a way that the DHA can obtain an understanding of the quality of their services - without the high costs of buying independent survey consultants.

5. LINK BETWEEN THE NHS AND THE PUBLIC

One of the reasons behind the setting up of CHCs was the concern about the lack of accountability and public scrutiny of NHS staff and management. The NHS Re-organization in 1974 opened up the NHS to greater public scrutiny through CHCs, but did not make it more accountable. Subsequent reorganizations have perhaps increased accountability of management to Central Government but not to the public. DHA members nominated by local authorities, are caught between the need to meet management financial targets and improving local health services.

Informing the public and channelling information to DHAs

Most CHCs put considerable amount of work in publicising local issues and consulting the public. With their inside knowledge, they are able to interpret more easily the consequences of possible NHS decisions to the public and provide a channel to report back views to the DHA.

CHCs have developed many different and innovative ways of obtaining public views on local health services. Many have shop front premises, carry out opinion poll surveys and regular visits to health service units to talk to users. West Birmingham CHC maintains a permanent 'Panel' of 250 people who reflect the population of the district in terms of geographical area, age, sex and membership of minority groups. They are regularly informed about local health events and consulted on issues as they arise.

Perhaps the most useful way of maintaining contacts with many different groups and communities is to 'network'. A CHC can establish a network of contacts with key groups in the District and maintain frequent dialogue. This is an important way of making contact with groups and communities whose needs are often overlooked by most statutory services. ACHCEW has produced guidelines for helping CHCs to make their role relevant to the needs of people from Black and Ethnic Minorities (ACHCEW, 1989)

In Exeter Health Care Forums were established by the CHC in several localities to feed in information to the DHA's Locality Planning Teams. South Bedfordshire CHC initiated a Health Care Forum in Leighton Buzzard to enable local people to be involved in health care planning. This enables providers and consumers to come together on a regular basis to discuss how best to meet the town's health needs within limited resources. The CHC is working in co-operation with the voluntary organizations council, local authority, GPs and the DHA. Both the DHA and the CHC were anxious to build on momentum generated within the town for a community hospital and to gain better access to consumers so that services provided would be more in tune with their needs.

It is also easy to forget the complexity and diversity of community interests, which may conflict. For example both MIND and the National Schizophrenia Fellowship are committed to the welfare of people with mental illness. However, they often disagree about the services which the NHS should provide. Some community groups oppose the provision of services which they feel might attract problem drug users or homeless people to their neighbourhood. The CHC can provide a local forum for different views to be expressed and channelled to the NHS management.

Lay involvement in the NHS

CHCs have also brought a much wider public involvement. There are about 5000 people on CHCs in England and Wales, who give their time voluntarily to the health service. Membership of CHCs has proved an excellent way for lay people to learn about the NHS from the community's view and many CHC members have gone on to become regional and district health authority members and, as a result of their experience and training on CHCs often, have a better understanding of the broader issues than other lay members.

Innovative Community projects

CHCs see the problems of community care and the gaps between services provided by the health service, local authorities, voluntary organizations and the private sector. Many CHCs have used this understanding to act as a link between voluntary organizations and the NHS, both in helping initiate new schemes, such as medical services for single homeless people, rehabilitation and volunteer befriending schemes as part of the transfer of patients from long stay hospitals to the community. They also can help voluntary groups obtain funding through the Joint Consultative Committee from the NHS.

In the ideal of general management, the manager combines concern for efficiency and cost-effectiveness with identifying and meeting local needs. But by what means is the information acquired from the community - especially in DHAs which cover large geographical areas? CHCs provide a channel and link between the NHS and the public.

6. THE RIGHTS OF THE INDIVIDUAL

The individual in health care relies on the competence and good faith of health service staff. Individuals rarely can assess the specialist advice or treatment they are given - because they do not have the specialist information to be able to do so. However, doctors have also discouraged people from questioning their decisions. This attitude to giving information, according to Professor Bryan Jennett, lies in the origins of the profession. *"Like the church from which it has emerged the medical profession depended much on a combination of authority and mysticism or magic; also on the unquestioning faith of those to whom it ministered. That was no bad thing at a time when few medical*

interventions had any direct therapeutic benefit and the placebo effect was all important". (Jennett, 1983)

Now doctors have available some very powerful and invasive treatments, which have enormous potential to both help and harm. Miracle cures are few, all treatments have their costs and benefits. There are fashions in drugs, medical and surgical techniques which can lead to inappropriate and even damaging treatment. (CSS, 1983)

Attitudes have been changing. It is now recognized that people can only give consent to treatment if they are fully informed of the possible risks involved. Currently changes are being considered to the standard operation consent form used in the NHS to encourage discussion between the doctor and patient about the proposed treatment. The Department of Health have accepted the basic right to information: *"There is evidence that a patient who understands and has consented to treatment will benefit more from treatment. A patient has a fundamental right to grant or withhold consent prior to examination or treatment. Patients should be advised about proposed treatment and possible alternatives and be allowed to decide whether to accept the treatment". (DHSS, 1988)*

The debate about patients rights has moved in the last 15 years. The need for more explicit rights for people in health care is on the political agenda. CHCs have been instrumental in bringing this to public awareness and not without opposition. Giving patients the right to even basic information, means that health service staff must be willing to share power and decision-making.

Community health councils have helped to change attitudes in two main ways:

- By promoting individual rights and assisting complainants.

- By providing information and assistance in how people can make the best use of health services

Promoting individual rights and assisting complainants.

Patients' Charter

The Association of Community Health Councils produced a **Patients' Charter** of basic rights for people in health care in 1986. It was based on the experiences of member CHCs and discussed with health

authorities and professional bodies before publication. (ACHCEW, 1986) This has been adopted by a number of DHAs to provide the basic policy on which they manage the health services. For example, Durham Health Authority has adopted a Charter based on ACHCEW's which has been distributed to all staff and placed in patient's bedside lockers in its hospitals. The General Administrator said: *"The 15 point charter shows that the authority is striving to provide the best service and a service that is acceptable to the patient. So far, there has been nothing but support for the idea with no negative reaction".*

Complaints

When things go wrong in the health service the right to make a complaint is fundamental. The procedures are confusing, rarely independent and staff attitudes may be hostile and defensive.

In the early 1970s there was public concern about how complaints were handled and one of the original reasons behind the establishment of CHCs was the recognition that patients were vulnerable, particularly in long stay hospitals, and needed some protection. The Davies Committee in 1974 recommended a code of practice for health authorities in dealing with complaints, including provision for independent investigations and external checks on health authorities. However, no action has ever been taken on this, though CHCs were given the role of 'patient's friend'.

In 1985 Hospital Complaints Procedure Act was passed. However, this only stipulates that a hospital should have a complaints procedure and that it should be widely advertised. The subsequent Circular provides useful guidance, but no guarantee that a complaint will be properly investigated, that the complainant will be given the information asked for or that any action is taken on the complaint.

In fact, CHCs have often had to fight for the right to act as 'Patient's Friend'. CHC staff have been excluded from attending meetings with complainants in hospitals, in Family Practitioner Committee Service hearings and in the Clinical Review (Second Opinion) procedures introduced in 1981. The right of complainants to invite a CHC representative to attend meetings with them, have now been established - only after a long drawn out battle. In Oxfordshire, the Regional General Manager had refused to attend a meeting with a complainant against her because the family wanted the CHC Secretary to attend. The Health Service Commissioner expressed his concern at the decision and a Parliamentary Select

Committee called the RHA Chairman and General Manager to explain why they refused to attend the meeting with the complainant.

CHCs have often experienced hostility from health service staff about their role in helping complainants, perhaps on the false assumption that CHC support will 'encourage' and give undue importance to trivial complainants. However, in reality the opposite is true. CHC advice and support can help resolve communication problems at an early stage, preventing complainants, frustrated by apparent cover-ups, resorting to inappropriate legal action.

Many health authorities and Family Practitioners Committees have recognized the great advantages in CHC involvement with individual complaints. For example, in Wales the independent Medical Officer for Complaints considers that the presence of a CHC Secretary is helpful in Clinical Reviews. If the complainant is dissatisfied afterwards and complains that the Review was not conducted properly or impartially, the CHC Secretary present may be able to testify whether this was the case or not. In North Tyneside, the Family Practitioner Committee invites the CHC to send an observer to Service Committee Hearings. In Manchester the CHCs run a doctor/patient liaison scheme. The FPC refers patients to the CHC office when they have particular problems in securing or keeping a GP. The CHCs role is a mixture of advice, advocacy and counselling.

Information and advice on using health services

Information and Choice

Choice is an essential part of 'consumerism'. It must be based on information about the alternatives. CHCs in the 1970s pioneered the development of information leaflets, and guide books to local services - often providing 'Survival Guide' advice on how to make best use of services. Many have co-operated with the DHA and FPC in this. North West Herts CHC have produced a joint Health Resource Guide with the local district council, St Albans. The Guide provides information on health services and a whole range of other services such as childminding, adoption, marriage counselling and statutory services (i.e. social services, rights, benefits and legal advice).

The success of CHCs in this area is demonstrated by the fact that many DHAs and FPCs have followed the example set by CHCs in the 1970s. They have recognized that publicising services and improving information available to the public is the responsibility of service providers. CHCs have also worked in helping to raise awareness of

health issues. Topics covered include: smoking, diet and nutrition, women's health, sickle cell anaemia and AIDS. These meetings are often carried out in association with the local health education department and voluntary organizations. The Health Education Authority recognizes the possibilities for developing more the role for CHCs in health education. It is funding a part time worker at ACHCEW to support CHCs and increase their awareness of health promotion issues.

Public Education and training

CHCs have also run courses to help people speak for themselves and to learn about the rights and responsibilities in health care.

West Lambeth CHC has been involved in running weekly assertiveness training sessions for people with learning difficulties. Newham CHC has undertaken an education project. It was felt that the CHC needed to go out into the community to make people aware of their rights as health services users. A short course was developed for adults about the NHS, the local health service, rights as users and the process of decision making in the NHS and how local people can become involved in the process. A local school agreed to pilot the 8 week course in Canning Town, which is poorly provided with health care facilities. Sessions were discussion-led, making use of video, guest speakers and role playing. They plan to repeat the course as it is a positive step in establishing an effective dialogue with local people.

Advocacy

Advocates represent the interests of someone else as if they are their own, in particular people, who have difficulty in expressing their own wishes, whether because they have language difficulties, learning difficulties or are economically or culturally disadvantaged.

CHCs have been in the forefront of promoting advocacy schemes. They are in an ideal position to do this - because, while they have close links with the NHS, they are independent from it. NHS staff, however well meaning, are too close to the service to act as advocates.

These include the scheme established in City and Hackney for non-English speaking women having babies. The advocates are based in the hospital and offer their services to all non-English speaking women. A study found that there were improvements in take-up of antenatal care, in the nutritional status of the mothers and in the birth weights of babies among non-English

speaking women, which could be attributed to the project. In the control group of English speaking women there were no such trends - except an increase in non-attendance at antenatal clinic (Cornwall et al, 1984)

Advocacy schemes have also been developed as part of the community care programme for people discharged from long stay hospitals to the community. Mental handicap services are undergoing dramatic changes and community care programme have exposed people to stressful and new situations as they learn to live outside hospital. In Worcester and Hereford a citizen advocacy scheme was set up in 1986, jointly by the CHC and a local voluntary organization, with funding from the DHSS Opportunities for Volunteering. Volunteer advocates are matched with each person with a mental handicap before they are discharged from hospital to the community and provide long term support and help by both befriending them and representing their interests, such as helping them to claim appropriate state benefits.

Link worker schemes

Other CHCs have followed this example, by establishing link worker schemes for women from ethnic minorities having babies. These are not advocacy schemes as such, and the workers see themselves in a conciliatory rather than a challenging role - bridging the gap between professionals and the women they are helping. Haringey and Barnet CHCs both initiated such schemes. In Barnet the DHA has been convinced of the project's value and is gradually assuming financial responsibility. (Barnet CHC, 1988)

7. CONCLUSIONS

What have CHCs contributed to the NHS since 1974? There have been changes in attitudes among managers and professionals towards recognizing the rights of patients to information and choice, and in providing a customer-oriented service. Would attitudes have changed as much without CHCs? In all the four areas we have examined CHCs have initiated new ideas and often made management aware of possibilities. CHCs have provided examples of good practices in what can be done with very few resources. Management have followed the lead provided by CHCs - a remarkable achievement for a local voluntary committee with limited resources. CHCs have forced the pace of change.

Would the NHS be as aware of the local community without the constant, if at times inconvenient, reminders from CHCs? CHCs often arouse hostility from NHS staff. Regardless of how effective or not CHCs are, some conflict with management is inevitable. CHCs, by the nature of their role, may obstruct 'smooth' management and comment on professional matters, which may be considered none of their business. CHCs have different priorities from service providers. In present times, with financial crises and major change in the air, CHCs can provide a continual reminder to management and health service staff that - in all the fights for resources, income generation and efficiency - the central concern is for patients and their carers.

The case for Independent User Councils

Is there still a need for community health councils? Those bodies who are able to take a more detached and broader view, have noted that CHCs have an important counter-bureaucracy role. The Institute of Health Services Management and the Royal College of Nursing have emphasised that management or health authorities can never take on the role of CHCs (IHSM, 1988, RCN, 1988).

In spite of this, there is quite a widespread view that the problem of the lack of responsiveness of the NHS to users can be overcome by good management. Is this true?

It is perhaps useful to make a distinction between those activities which are undertaken by CHCs, because managers have not seen them as a part of their role or do not see them as a priority, such as 'user friendly' public information about services and how to use them. Other functions, such as advocacy both for individual and communities, can only be undertaken by a body independent from the service providers.

Some traditional tasks of CHCs might be taken over by managers or undertaken in collaboration with DHAs and FPCs. For example, information about services available and how to use them could best be provided through a database shared by the FPC, DHA and CHC. The DHA and FPC might contract the CHC to provide a helpline for enquiries. Health authorities might contract CHCs to look at particular aspects of services from a user perspective.

However, other CHC functions rely on the independence and direct links with the community and voluntary sector. Advocacy schemes, consumer advice, some consumer surveys and public meetings are better undertaken by an independent body - and at far less cost than if

additional NHS staff were employed to do them. Policy development and planning for local services require lay people with strong community links. CHCs unlike voluntary groups take an overall community view and are not just concerned with the interests of a particular client group.

The 'Customer' approach is essentially a management tool. Management is about managing, not about representation of diverse interests. Assuming that good management will make CHCs unnecessary takes little account of the realities of health service internal politics. It does not attempt to redress the imbalance of power between the patient and service provider, except as interpreted by management. It also does not acknowledge the diversity and competing interests and views which users of health services have. It does not enable bad management to be highlighted publicly - however well general management works out, there will always be areas of mismanagement.

Lessons for the future

The reasons for setting up CHCs in 1974 still exist - the NHS still does not provide a service responsive to its users. Even with improved management and information systems, there will still be a need for an independent users body.

However, after 15 years it is time to look at how users interests might be more effectively protected and represented in the health service. What can we learn from our experiences of CHCs which can contribute to the current debates about consumerism in the health service?

The achievements and good practices we have discussed point to the **possibilities** of what CHCs can achieve. In many DHAs there have been very great benefits from the collaboration of managers and CHCs. CHCs and health authorities can co-operate and work together to the benefit of the NHS - if both recognize their different roles and priorities.

Clear conclusions based on the experiences of CHCs can be drawn.

- CHCs need to be clearly independent of the NHS. There is an increasing conflict of interest between RHAs and CHCs, which undermines the RHAs ability to act as the establishing and resourcing body for CHCs. CHCs have put forward proposals to address these issues (ACHCEW, 1989).

- CHC activities need to be reviewed in the light of changes in the NHS; some activities will become more important and others less important.

- CHCs provide a varied standard of service to the public. Minimum standards of service need to be established, with provision for independent review and monitoring.

- There is a need for innovative mechanisms for CHCs to be accountable to the community. There are difficulties in setting up such mechanisms for consumer representative bodies, who are not directly elected. However, accountability is not normally expected, wrongly no doubt, of other state-funded consumer bodies - such as for electricity, post office or gas consumers. All CHCs need to set up mechanisms to report back to their communities.

- CHCs are under-resourced, most only have two staff. Statutory responsibilities have increased as have the number of complaints and enquiries, as the public become more aware of health and consumer issues. There has been no increase in resources to meet the changing role.

- There needs to be increased investment in training and information at national and regional level to enable CHC members and staff to develop skills to work better together to be more effective in the changing NHS.

- There is little research about CHCs and user representation on which to base developments in the future. DHAs, FPCs and CHCs could work together to pilot new ways of involving users, such as advocacy schemes, helplines for the public or trying out new ways of involving the public in policy and planning.

CHCs have learnt a lot over the last 15 years and are willing to accept the challenge of the future. However, Government and health service managers must also be prepared to work with CHCs to develop the future role and to provide the resources to enable effective and independent user representation in the health service.

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