ASSOCIATION · OF
COMMUNITY HEALTH COUNCILS
FOR · ENGLAND · & · WALES
30 DRAYTON PARK · LONDON N5 1PB · TEL: 01-609 8405 · FAX: 01 700 1152

22 May 1990

BRIEFING FOR THE CONSERVATIVE BACKBENCH HEALTH COMMITTEE

REPRESENTING PATIENTS EFFECTIVELY IN THE NINETIES

The existing patients' watchdogs, Community Health Councils, are hardly mentioned in the White Paper and in the National Health Service and Community Care Bill.
Yet, CHCs have had fifteen years' experience of:

- promoting local community interests in the NHS, particularly for those groups who are least able to get the best from the health service - people with mental health problems or learning difficulties, elderly people etc.

- promoting improved quality in health services, by surveying patient satisfaction, monitoring services and assessing unmet needs.

- providing a link between the NHS and public, obtaining public views on local services and setting up networks to involve local groups in planning local health facilities. CHCs have successfully encouraged NHS management to be more oriented to community-based services.

- promoting individual rights, by assisting individual complainants, helping people to get the best use of services, and encouraging the NHS itself to be more "user-friendly".

CHCs are under-resourced for the work that they do. The average CHC has a budget of £35,000, out of which it has to pay its staff, rent its premises, service a council of 18 to 24 members and provide a service to 250,000 people. The total cost of CHCs amounts to some £7 million per year, compared with a total NHS budget of £20 billion.

The Government has said that "Community Health Councils should continue to act as a channel for communication for consumer views on the NHS. The Government however sees no need to reconsider the role of CHCs, which will remain unchanged, but are considering with interested parties whether any clarification is needed of the way in which they should exercise that role." (Government reply to the House of Commons Social Services Committee, Cm 851).

There are a large number of questions still to be resolved:

(1) Will CHCs relate primarily to the "purchasers" of health services or to the"providers" of services or both? The NHS is to be split into "purchasers" (eg DHAs and GPs with clinical budgets) who will buy services from "providers" (eg NHS hospitals, self-governing trusts etc). If CHCs are to be related to the purchasers of service, CHCs need to be able to "follow the patients" to see how well the services purchased for them are meeting their needs. Similarly, if CHCs are to relate to providers of service, CHCs will have to establish relationships with all types of providers, including self-governing trusts and non-NHS facilities (this, of course, is often done already where private beds are supplied on a contractual basis to a DHA).

(2) How will CHCs relate to GPs who opt to hold their own clinical budgets? It is the Government's intention that increasingly services will be purchased by fund-holding practices rather than via DHAs. It is important that CHCs have a clear role in respect of these practices, but it is not clear how this is to be organised.

(3) How will CHCs feed into the new NHS contracts? Contracts are going to be crucial under the Government's proposals. The contracts between purchasers of service and providers are going to be much more than mere commercial documents. The Government intends that these contracts should be the mechanism by which standards to the patient are to be specified. CHCs, as the representatives of the patients, therefore need to feed into the contractual process. There are six key elements to this:

(i) The production by DHAs of an assessment of the health needs of their resident population. This, of course, is again something in which CHCs will have much to contribute, having had 15 years of experience in looking at the community's health needs and the extent to which those are being met.

(ii) The determination by DHAs of which services are to be provided locally within the District or to be provided on contract further afield. CHCs will obviously want to comment on whether or not a service is to be

provided locally and the trade-off between local access and price/quality.

(iii) The presentation by DHAs of their plans for contract placement in a form which will enable the Local Medical Committee and local GPs to express their views before final decisions are taken. Clearly, the views of GPs are important in this but so too are the views of patients, and it would surely make sense if the CHC was given the opportunity to make its comments in the same way as the LMC and GPs.

(iv) The determination of the standards of service to be included in the terms and contracts to be agreed between DHAs and providers of service. CHCs are concerned that, once the contracts are agreed it will only be possible to resolve concerns about the quality of service if the service provider has breached a contract term. In any event, CHCs would wish to have the opportunity to make an input into the standard setting process.

(v) Once contracts are in place, DHAs will monitor how well the standards required are being met. It needs to be specified in the contract that CHCs should have a right to information, a right to visit facilities, and a right to be consulted on changes in the organisation of services by agencies providing services on contract to their DHA. Parallel arrangements would need to exist for contracts entered into by GPs holding their own clinical budgets.

(vi) Contract renewal. We would hope that CHCs will be formally consulted when contracts are renegotiated, rolled forward or renewed.

(4) Will CHCs have a role in respect of all agencies supplying health care to the people of their district? Will CHCs have visiting rights, in respect of all agencies providing services? Will this include those agencies which are within the NHS, but are self-governing, and those which are non NHS. Will they also have rights in respect of agencies outside their district but providing services to the people of their district?

(5) What will happen to the NHS planning system? With some parts of the NHS self-governing, it will be more difficult for the NHS planning system to operate. It is important that users' interests are represented in NHS planning and that CHCs can feed into the process.

(6) Who will protect the users of community care services? There is a need for the users of community care services to be protected in the same way as CHCs protect users of the

NHS. CHCs have a history of concern for 'Cinderella' services and of promoting the needs of mentally ill people, elderly people, people with learning disabilities etc and their carers.

(7) How will CHCs be managed in the future? It is important for the public that CHCs are and are seen to be independent of the health authority structure. At present, budgets are determined by Regional Health Authorities, who are also the nominal employers of CHC staff. These arrangements might mean that CHC independence could become more limited in the future. Certainly, CHCs' rights to independence need to be guaranteed - perhaps the CHC movement should become self-governing. Proper arrangements need to be made to ensure that all CHCs offer an effective service to their local communities. At present, there is no system of "quality control" of the work of CHCs themselves, and there is no mechanism for ensuring that CHC best practice is adopted by all CHCs.

This briefing is prepared by the Association of Community Health Councils for England and Wales (ACHCEW). ACHCEW was set up in 1977 to represent the consumer of health services at national level and to provide a forum for member CHCs. 198 CHCs out of the 215 CHCs in England and Wales are members of the Association. ACHCEW is mainly funded by subscriptions from individual CHCs, but also receives grants from the Department of Health and a number of other bodies.