ACKNOWLEDGEMENTS

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I would also like to thank Pam Aldren and Julie Platt for their assistance in producing this edition.

GLOSSARY OF ABBREVIATIONS

Below is a short list of the more commonly used abbreviations in the National Health Service.

ACHCEW	Association of CHCs for England and Wales
AHA	Area Health Authority
CHC	Community Health Council
DGH	District General Hospital
DGM	District General Manager
DHA	District Health Authority
DHSS	Department of Health and Social Security
DMT	District Management Team
DPT	District Planning Team
FPC	Family Practitioner Committee
HAS	Health Advisory Service
JCC	Joint Consultative Committee
JCPT	Joint Care Planning Team
NAHA	National Association of Health Authorities
NHS	National Health Service
RAWP	Resource Allocation Working Party
RGM	Regional General Manager
RHA	Regional Health Authority
UGM	Unit General Manager

1 HOW THE NHS WORKS

This paper sets out some of the main things you need to know about the National Health Service (NHS). It is divided into two parts as follows:

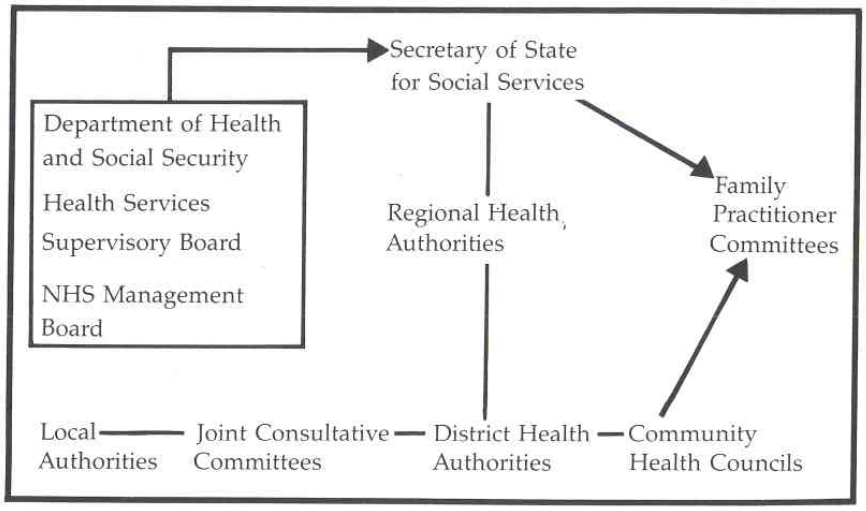
1. The organisation of the NHS
2. Finance

The paper concentrates on the organisation and financing of the NHS in England. An appendix sets out the different position which exists in Wales.

1 THE ORGANISATION OF THE NHS

The National Health Service (NHS) is organised like this:

Diagram 1



At the top of the structure is the Secretary of State for Social Services in the Department of Health and Social Security. Lower down are Regional Health Authorities (RHAs) — there are 14 of these in England — and they are responsible for planning and providing services for populations ranging from under two million to over five million.

Regions are divided into District Health Authorities (DHAs), of which there are 191 in England. DHAs are the basic units for management and planning in the NHS, and they each have to relate to three other bodies: Community Health Councils (CHCs) who represent the views of the community to the managers of health services; Family Practitioner Committees (FPCs) who administer the contracts of general practitioners, dentists, opticians and pharmacists; and Local Authorities who provide related services such as personal social services, housing and education. Joint Consultative Committees (JCCs) provide a formal link between local authorities, DHAs and FPCs.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY (DHSS)

DHSS carries national responsibility for three services:

- Social Security
- Personal Social Services
- The National Health Service

The Department's political head is the Secretary of State for Social Services, who is a member of Parliament and a member of the Cabinet. He or she is appointed and dismissed by the Prime Minister and is accountable to Parliament for the work of the Department and the NHS. The Secretary of State is supported by a number of junior ministers, including a Minister of State for Health, and by around 5,500 civil servants. Of these, some 2,000 work mainly in the field of health and personal social services. The most important of these civil servants are the Permanent Secretary, who is a general administrator, and the Chief Medical Officer, who is a doctor.

Following the Griffiths Inquiry into NHS Management, which reported in 1983, a Health Services Supervisory Board was set up in the Department to advise the Secretary of State on the strategic direction of the NHS. Members of the Board include Health Ministers; the Permanent Secretary and Accounting Officer; the Chief Medical Officer and the Chief Nursing Officer; Sir Roy Griffiths and the Chairman of the NHS Management Board. The NHS Management Board was set up during the course of 1984. It carries out, under the direction of Ministers, those management functions in respect of health authorities which the Department must carry out eg finance, information and performance review. Like the Supervisory Board, the Management Board is located within the Department, and it reports to the Supervisory Board on health authorities' performance.

The two main functions of DHSS in relation to the NHS are:

- allocating resources to regions
- making policy and issuing advice.

Each year DHSS has to share out the NHS budget between the 14 RHAs. In doing this the Department tries to ensure that each region receives a fair share of the money available, in line with the recommendations of the Resource Allocation Working Party (RAWP) which reported in 1976 (see Part Two for more details of finance). At the same time DHSS informs health authorities of the way in which it thinks the money allocated to them should be spent, through policy documents like Care in Action issued in 1981. The Department also gives more specific advice through health circulars.

Individual Members of Parliament are able to raise issues through Parliamentary questions and debates, and a Social Services Committee of the House of Commons investigates various aspects of the work of DHSS. This select committee, which takes oral and written advice from Ministers, civil servants and others involved in health policy and the provision of health services, was set up in 1979. The Committee has so far produced a number of important reports, including studies of perinatal and neonatal mortality and the planning and expenditure systems of DHSS. The Public Accounts Committee of the House of Commons also examines the NHS from time to time, paying particular attention to the way in which the money voted by Parliament has been spent. The Committee is supported in its work by the Comptroller and Auditor General and the National Audit Office.

There are many channels of communication between the DHSS and the National Health Service. These include the professional advice available through statutory advisory committees and comment from professional associations. Also, trade unions and voluntary bodies regularly make their views known and are consulted. The Secretary of State meets chairmen of RHAs from time to time and there are frequent contacts between DHSS officials and the staff of health authorities. The National Association of Health Authorities offers advice to the DHSS and is consulted on policy issues. Individual CHCs as well as the Association of CHCs for England and Wales are also part of the consultative machinery.

The Secretary of State receives advice from a number of formal advisory bodies, including the Health Advisory Service (HAS) and the National Development Team (NDT) for Mentally Handicapped People. Between them HAS and NDT visit and report on hospital and community health services for the mentally ill, the mentally handicapped, the elderly and children receiving long-term hospital care. From 1 January 1985, reports on HAS and NDT visits have been published.

REGIONAL HEALTH AUTHORITIES (RHAs)

Each Regional Health Authority comprises about 20 members appointed by the Secretary of State after consultation with interested organisations including professional groups, trade unions, local authorities and voluntary bodies. All members are unpaid apart from the chairman who receives an honorarium. RHAs normally meet monthly, and each authority is served by paid officials headed by the Regional General Manager (RGM).

RHAs provide a few services themselves - for example, blood transfusion — but their main task is to plan the development of health services and allocate resources to districts. This they do by issuing guidance to DHAs; by co-ordinating the plans of DHAs; and by monitoring their implementation. Of increasing importance in recent years have been the annual accountability review meetings between RHAs and DHAs. These meetings enable RHAs to assess the performance of each DHA and to ensure that DHAs are held to account for their actions. The meetings are also a means by which DHAs can explain to the RHA the problems they are facing in providing services locally.

Other functions of RHAs include responsibility for designing and arranging the building of major capital projects like new hospitals, and for employing senior medical staff in non-teaching hospitals. In addition RHAs are the bodies responsible for setting up Community Health Councils (CHCs) and keeping their running under review.

DISTRICT HEALTH AUTHORITIES (DHAs)

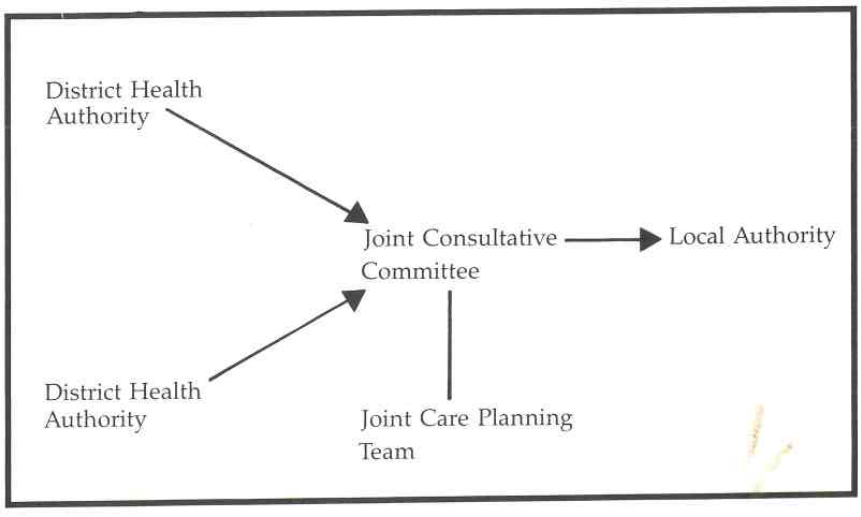
Each DHA comprises about 16-19 members, some appointed by the RHA after consultation with interested organisations, and some nominated by local authorities. The DHA Chairman is chosen by the Secretary of State and receives an honorarium. Members are unpaid, and should include a hospital consultant, a general practitioner, a nurse, midwife or health visitor, a nominee of the appropriate university with a medical school in the region, a trade unionist, and normally 4-6 members appointed by local authorities. Those DHAs which contain a university medical school and teaching hospital facilities include additional members with medical school or teaching hospital experience. DHAs usually meet monthly in public, and CHCs are allowed to send observers to the meetings with the right to speak but not to vote. Each DHA is served by paid officials headed by the District General Manager (DGM).

The services provided by the DHA are organised through units. Unit General Managers (UGMs) are responsible for managerial performance within the unit. There are many different ways of organising units and examples include a large single hospital; a group of smaller hospitals; and client care services, for example a mental illness hospital with psychiatric community services and the psychiatric service of a district general hospital. As part of the implementation of the Griffiths Report, DHAs have reduced the number of units.

JOINT PLANNING

One of the most important functions of DHAs is to work with local authorities to ensure that services are provided in a co-ordinated way. To assist collaboration, DHAs and local authorities are required to set up Joint Consultative Committees (JCCs) of their members to review and co-ordinate plans and to advise on the operation of the two services. JCCs usually draw their members from one local authority, one or more DHAs, and the family practitioner committee. Since 1984 three places on each JCC have been set aside for representatives from voluntary organisations. In London, arrangements are more complex and sometimes involve one DHA relating to two local authorities. JCCs are supported in their work by a Joint Care Planning Team (JCPT) bringing together officers of the two types of authority.

Diagram 2: A Joint Planning Framework



One of the main functions of the JCPT and JCC is to make recommendations for the use of joint financing money (see Part Two). In addition to these arrangements most authorities appoint officers with specific responsibilities for joint planning. These are usually the health services liaison officers in the local authority personal social services department, and community physicians in DHAs. The local authority councillors who are appointed as members of DHAs provide a further potential channel of collaboration.

A report, Progress in Partnership, published in 1985 made proposals for strengthening joint planning. A draft circular issued by the DHSS in 1986 endorsed a number of these proposals and suggested that JCCs should be required to produce annual reports.

FAMILY PRACTITIONER COMMITTEES (FPCs)

The contracts of general practitioners, dentists, pharmacists and opticians are administered by Family Practitioner Committees (FPCs). The members of FPCs usually number 30 and are appointed by the Secretary of State. Half the members are professional and half are lay. Family practitioners are not salaried employees of the NHS but are independent contractors who contract with the FPC to provide a service to the local population. Because of this the FPC has no managerial authority over practitioners — it simply handles contracts with them and arranges for them to be paid.

FPCs were given independent status as employing authorities on 1 April 1985. In administrative terms, this represents a further separation of family practitioner services from other health services. On the other hand, it has secured a direct line of accountability from FPCs to the Secretary of State. A joint working party on collaboration between FPCs and DHAs reported in April 1984 and recommended that FPCs should develop their planning role. Specifically, the working party proposed that FPCs should compile a Profile and Strategy Statement every five years and an Annual Programme. The working party also suggested that collaboration might be helped through regular contacts between FPC and DHA chairmen and through links between members.

These proposals were welcomed by ministers and detailed guidance was issued in HC(85)20. The guidance stated that the role of FPCs was concerned with administering, managing, planning, monitoring, investigating and adjudicating. This reflects the view of ministers that FPCs, as independent bodies, should take on greater responsibility for family practitioner services, including undertaking collaboration with DHAs. However, as practitioners are independent contractors, FPCs have to work through a process of information, consultation, persuasion and influence. FPCs are held to account by DHSS through comprehensive reviews conducted every five years interspersed with less detailed annual scrutinies.

Complaints against family practitioners are heard by sub-committees of FPCs, known as Service Committees, made up of professional and lay members. The Health Service Commissioner (or Ombudsman) is another channel for complaints, though services covered by FPCs are outside his jurisdiction. In the main he investigates complaints about hospital services (excluding grievances involving the use of clinical judgement by doctors) after the health authority has had an opportunity to reply to the complainant.

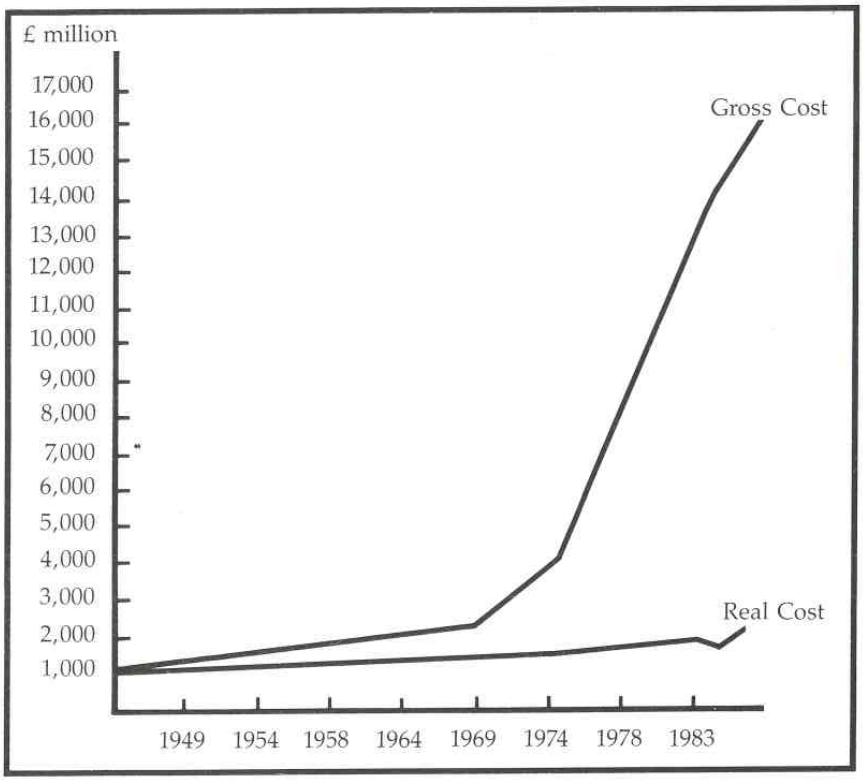
FURTHER READING

HEALTH POLICY IN BRITAIN
Chris Ham, Macmillan, 2nd edition 1985.
NHS MANAGEMENT INQUIRY REPORT
DHSS, 1983.
IMPLEMENTATION OF THE NHS MANAGEMENT INQUIRY REPORT
DHSS Health Circular HC(84)13.
MANAGEMENT ARRANGEMENTS FOR FAMILY PRACTITIONER COMMITTEES
DHSS Health Circular HC(85)20.
NHS HANDBOOK
NAHA, 1985.
FAMILY PRACTITIONER COMMITTEES: a guide for members
NHS Training Authority, 1985.

2 FINANCE

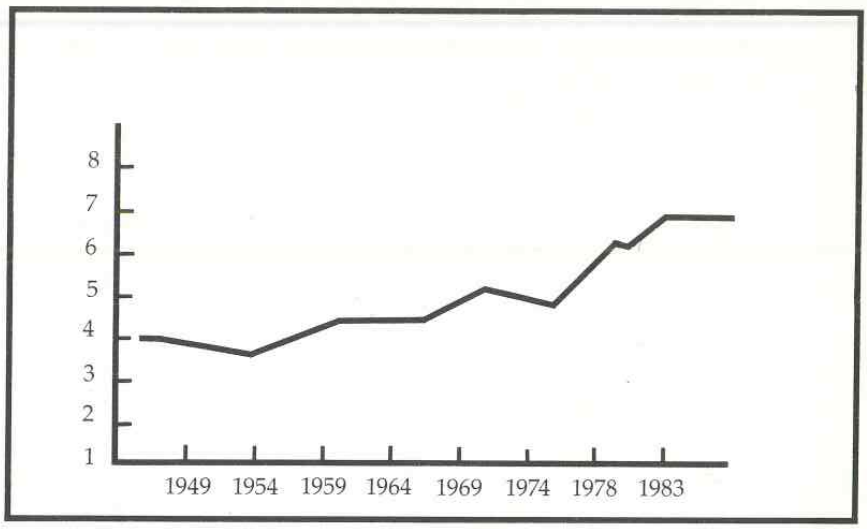
Expenditure on the NHS in the UK has increased from about £450 million in 1949 to a planned £17,700 million in 1986. Rising prices account for a large part of the increase, but even allowing for this the NHS still costs more than three times as much as it did when it was set up.

Diagram 3 : Cost of the NHS



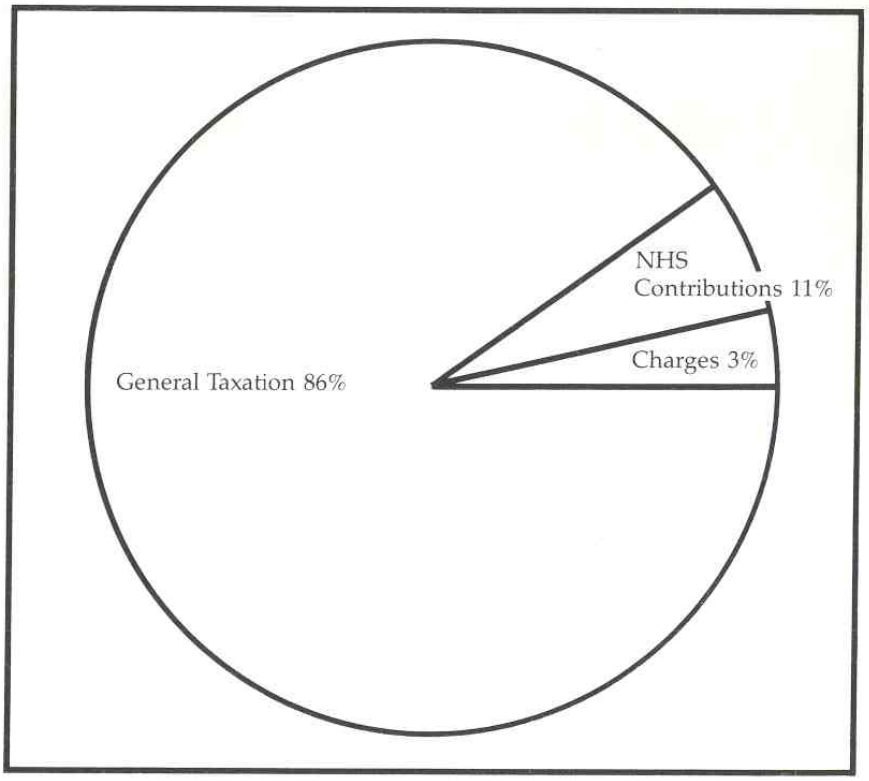
Expressed as a proportion of gross national product, which is a way of measuring the amount of wealth produced in the United Kingdom in any one year, expenditure on the NHS has increased from 3.9% in 1949 to 6.2% in 1984.

Diagram 4 : Cost of the NHS as % of GNP



The largest part of the cost of the NHS is met out of general taxation, the remainder being financed by National Insurance contributions and charges paid by users of certain services.

Diagram 5 : Sources of NHS Finance 1985-6



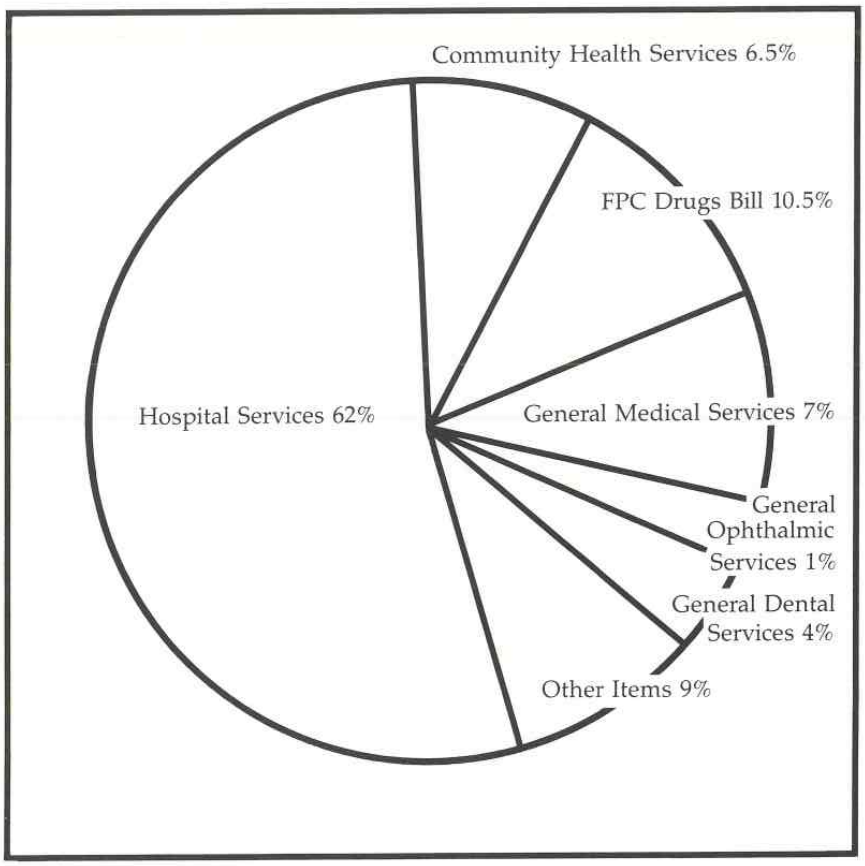
Where does the NHS budget go? There are four main ways of examining the distribution of the budget:

- by type of service
- by item of expenditure
- by client or patient groups
- by geographical areas.

TYPE OF SERVICE

Figures for the United Kingdom for 1983 show that Hospital Services accounted for 62% of expenditure, Community Health Services for 6.5%, the FPC Drugs Bill for 10%, General Medical Services for 7%, General Dental Services for 4%, General Ophthalmic Services for 1%, and other items for 9%.

Diagram 6 : Distribution between services



ITEM OF EXPENDITURE

Staff salaries and wages are the biggest single item of expenditure for the NHS as a whole - about 75% of the total. This is because health care services are labour intensive. About 1 in 20 of the total working population are NHS workers. Nurses are by far the largest group of NHS staff comprising almost one half of the total.

Diagram 7 : NHS Staff — England

	1985	
DIRECTLY EMPLOYED STAFF	**No.**	**% Total**
Nursing and Midwifery	401,000	49
Medical and Dental	41,000	5
Ancillary	147,000	18
Administrative and Clerical	110,000	13
Professional and Technical	73,000	9
Maintenance	20,000	3
Works	6,000	1
Ambulance	18,400	2
TOTAL (DIRECTLY EMPLOYED)	816,000	100

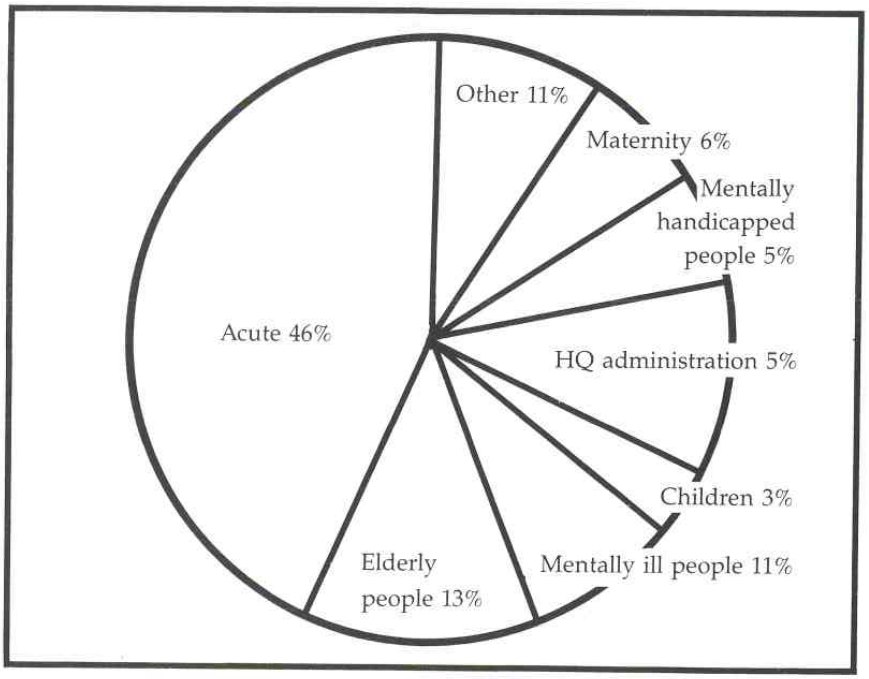
As well as these directly employed staff, 37,000 general medical and dental practitioners were employed as independent contractors.

In 1983 Manpower Targets were introduced into the NHS, requiring health authorities to make cuts in staff employed of 0.5% on average during the year, although within this overall reduction some authorities were allowed to take on additional staff. Tight controls over staffing continue to be exercised: the target set for March 1985 maintained nationally the March 1984 level, and by March 1986 a further reduction of 2,000 staff occurred.

CLIENT OR PATIENT GROUPS

Expenditure on different client or patient groups is shown below in Diagram 8. This shows the largest share of expenditure (46%) going on acute services, and the smallest share going to services for children and mentally handicapped people.

Diagram 8 : Health Authority expenditure by patient group 1983/84



GEOGRAPHICAL DISTRIBUTION

The distribution of health services expenditure between different geographical areas varies widely. The four Thames RHAs are the most favoured, and the Wessex, Trent and West Midlands RHAs the least favoured. There are even wider variations in expenditure between DHAs. In 1976 the Resource Allocation Working Party (RAWP) made proposals for reducing these variations, involving the use of a formula designed to allocate resources according to the need for care. Some progress has been made in implementing the Working Party's proposals but it will take a number of years before the RAWP target shares are achieved.

The RAWP policy arose from the concern that the previous budgetary method used in the NHS was only perpetuating geographical inequalities by allocating automatic annual increments. RAWP covers all health services apart from those administered by FPCs, and the resource allocation formula is based on the size of each region's population. For the largest part of the NHS (non-psychiatric in-patient services) the population is weighted for age and sex to take account of the heavier demands made on services by the young, the old and women. Populations are also weighted for morbidity (experience of ill health) to take account of the need for medical care, and mortality (death) rates are used as a proxy for morbidity.

Using the RAWP formula, a target revenue allocation was calculated for each region, and the Secretary of State for Social Services decided the targets would be progressively worked towards over a period of years. At a time when national growth rates in NHS expenditure have been low or non-existent, this has meant increases in regional allocations ranging from around 2% in below-target regions to zero growth and in some cases reductions in the above-target regions.

RHAs have sometimes amended the formula in calculating sub-regional allocations. This is consistent with the RAWP report, which recommended that discretion should be used in the local implementation of the policy. RAWP has had more impact within than between regions, and has aroused opposition from those areas, particularly in the Thames Regions, which have suffered most from the formula through sharp reductions in allocations for growth.

CASH LIMITS

There have been significant changes since 1974 in the way the finances of the NHS are managed. A new accounting system is being developed and health authorities have been given greater powers (though within specified limits) to carry forward over- and under-spendings from one financial year to another and to switch funds between capital and revenue allocations. Cash limits have also become an important factor in the management of health authority finances.

Until recently health authority budgets were calculated on the basis of the previous year's expenditure plus an element of growth and full allowance for inflation. The significance of cash limits is that they make available a fixed amount of cash based on the Government's estimate of likely movements in pay and prices and improvements in efficiency. In so doing they may make inadequate, or occasionally over-generous, provision for inflation. If the Government's forecast of inflation is too

low, then health authorities have to make up the difference from their own budgets. And whereas in the early years of cash limits this shortfall was made up in the following year, this is no longer automatically done. The budgets of health authorities have been squeezed further by the requirement that they should make 'efficiency savings' of 0.3% in 1982/83, and 0.5% in 1983/84.

In 1984/85 efficiency savings were replaced by Cost Improvement Programmes under which health authorities were required to demonstrate how they intended to improve the efficiency of their services and release resources for improvements and new developments. Ministers estimate that cost improvements of £105 million and £153 million were achieved in 1984/85 and 1985/86 respectively. The overall effect of these measures has been to limit severely the amount of additional money available to health authorities. This has meant that new developments have often had to be funded from savings made in established expenditure programmes.

EFFICIENCY INITIATIVES

In the context of resource constraints, the Government has, since 1979, promoted a series of initiatives designed to increase the efficiency with which services are delivered. The initiatives include:

Performance Indicators: A range of statistical indicators has been developed and published by the DHSS. The indicators cover clinical services, finance, manpower, ambulance services and estate management. They enable health authorities to compare their performance with other authorities, for example in terms of length of stay and costs per case.

Rayner Scrutinies: A number of studies have been carried out by NHS officers covering areas such as transport services, recruitment advertising, and the collection of payments due to health authorities under the provisions of the Road Traffic Act.

Competitive Tendering: Health authorities have been asked to test the cost effectiveness of laundry, catering and cleaning services by seeking competitive tenders both from existing staff and outside contractors.

Most important of all, the Griffiths Inquiry into NHS Management (see Part One) is likely to have a significant impact in the emphasis it gives to increasing efficiency, cutting costs and introducing a more dynamic management approach into the NHS.

JOINT FINANCING

Joint Financing between health and local authorities was introduced in 1976. This is a scheme whereby the Secretary of State allocates funds to health authorities, and the money is spent mainly on local authority personal social services projects like old people's homes and home help services. One of the aims of joint financing is to encourage and improve joint planning between health authorities and local authorities, and the use of joint financing money is discussed jointly by DHAs and matching local authorities at Joint Consultative Committees (see Part One). Joint financing may also be used for schemes concerned with primary health care, community health and prevention, and voluntary sector initiatives. Voluntary organisations achieved representation on JCCs in 1984 and three places on each JCC are set aside for the voluntary sector.

The amount of money made available nationally for joint financing has grown from £8 million in 1976/77 to £105 million in 1985/6. Support may be given to capital or revenue projects,and may meet all or part of the cost of these projects. However, joint financing tapers off over a period of years as the local authority assumes responsibility. The normal maximum period of support is seven years, although this may be extended to nine years with the agreement of the Secretary of State.

In 1983 the Government announced that the process of moving people out of hospital would be speeded up by an extension of joint financing to housing schemes and education for disabled people, and by increasing the period of support available through joint finance. At the same time health authorities were encouraged to make lump sum payments or continuing grants to local authorities to care for people moved from hospital to the community, and a small programme of pilot projects was launched as a way of exploring and evaluating different approaches to moving people and resources into community care.

For schemes which enable people in hospital to move to care provided by local authorities or voluntary organisations grants may be given for a period not exceeding thirteen years. The main client groups to benefit from joint financing have been the elderly and the mentally handicapped.

FURTHER READING

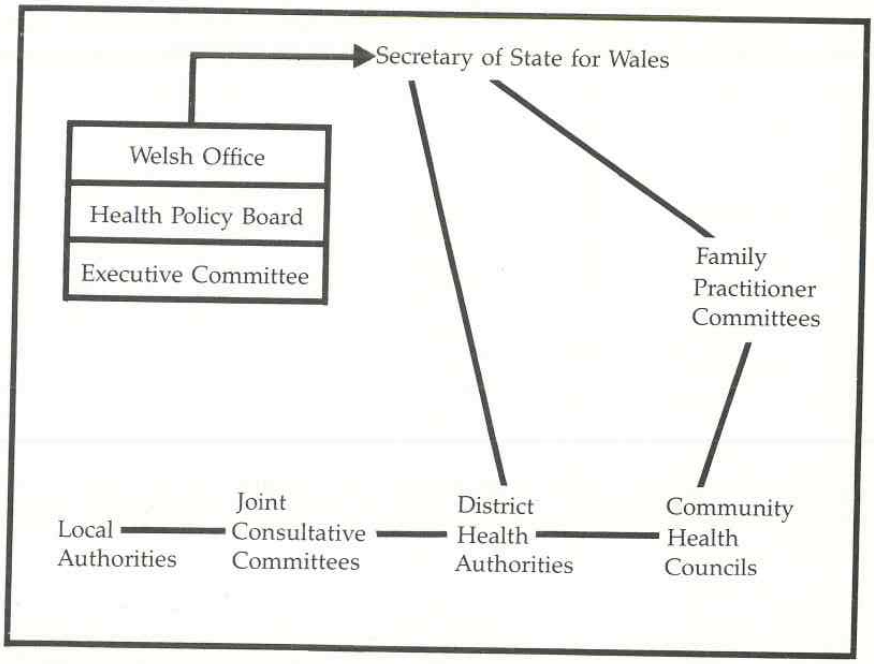
COMPENDIUM OF HEALTH STATISTICS
Office of Health Economics 5th edition, 1984.
THE HEALTH SERVICE IN ENGLAND ANNUAL REPORT 1985
DHSS, HMSO.
SHARING RESOURCES FOR HEALTH IN ENGLAND
Report of the Resource Allocation Working Party, HMSO, 1976.
HEALTH CARE AND ITS COSTS
DHSS, HMSO, 1983.
THE GOVERNMENT'S EXPENDITURE PLANS
HM Treasury, HMSO, 1986. Cmnd 9702.

APPENDIX

There are a number of differences between England and Wales in the organisation and financing of the NHS. Some of the key differences are set out in this Appendix.

The NHS in Wales is organised like this:

Diagram



At the top of the structure is the Secretary of State for Wales in the Welsh Office. The Secretary of State discharges his statutory responsibilities for the provision of health services through nine District Health Authorities (DHAs) and eight Family Practitioner Committees (FPCs). The Secretary of State exercises some functions in relation to major capital works, computers and prescription pricing through a special health authority known as the Welsh Health Common Services Authority.

The absence of a regional tier in Wales means that the Welsh Office combines the functions of the DHSS and RHAs in relation to the NHS. A number of committees and groups exist at the all-Wales level to advise on the development of policy and services. These include the All-Wales Health Forum, the Wales Supply Policy Group, the Manpower Steering Group and the Information and Technology Steering Group. In addition, the Welsh Health Authorities Chairmen's Committee is developing as an important forum for representing service views to the Secretary of State.

Following the Griffiths Inquiry into NHS Management, a Health Policy Board was set up in the Welsh Office to advise the Secretary of State on policies and priorities. The Board is chaired by the Secretary of State and includes in its membership the Parliamentary Under Secretary of State with special responsibility for health matters, the Chief Medical Officer, the Chief Nursing Officer, the Chief Social Work Services Officer, the Director of the NHS in Wales and other senior policy officials of the Welsh Office. The Executive Committee of the Board is responsible for carrying into effect the policies and priorities of the Secretary of State and is chaired by the Director of the NHS in Wales.

The chairmen and most of the members of DHAs are appointed by the Secretary of State for Wales. The composition of DHAs is much the same as in England and includes a hospital consultant, a general practitioner, a nurse, midwife or health visitor, a nominee of the University of Wales, a trade unionist, and members appointed after consultation with appropriate organisations. In addition, at least one-quarter of all members of DHAs are appointed directly by local authorities. Each DHA is served by paid officials headed by a District General Manager. Management arrangements at unit level are similar to those which exist in England.

The distribution of health service revenue between DHAs is carried out using the formula developed by the Resource Allocation Working Group (RAWG). RAWG is the Welsh equivalent of RAWP (see page 9).

There are 22 CHCs in Wales based on the health districts which existed between 1974 and 1982. Most DHAs now relate to a minimum of two CHCs. The absence of a regional health authority in Wales is important because in England RHAs are the bodies responsible for setting up CHCs and enabling them to function. In Wales, this task is the responsibility of the Welsh Office. Among other things, this means that the budgets of CHCs are approved by the Welsh Office and CHC Secretaries are formally appointed by the Welsh Office, although in practice the CHC itself chooses its Secretary. These points should be borne in mind in reading the following paper, How CHCs Work.

FURTHER READING

THE NHS MANAGEMENT INQUIRY REPORT — IMPLEMENTATION IN WALES
Welsh Office, Welsh Office Circular WHC(84)15.
WALES TODAY
J.H. Button, Hospital and Health Services Review, May 1984.

2 HOW CHCs WORK

This paper sets out the main things you need to know about Community Health Councils (CHCs). There is a separate list of suggestions for further reading at the end of the Handbook if you want more details.

CHCs were set up in 1974. They are statutory bodies - this means their existence and functions are established by an Act of Parliament and official regulations. The operation of CHCs was reviewed as part of the reorganisation of the NHS which took place in 1982. As a result of the review the Government decided to retain CHCs.

The following pages cover:

1. Who's who in CHCs?
2. How long do members serve?
3. How long do Chairmen and Vice-Chairmen serve?
4. The national picture.
5. What do CHCs do?
6. Resources.

1 WHO'S WHO IN CHCs?

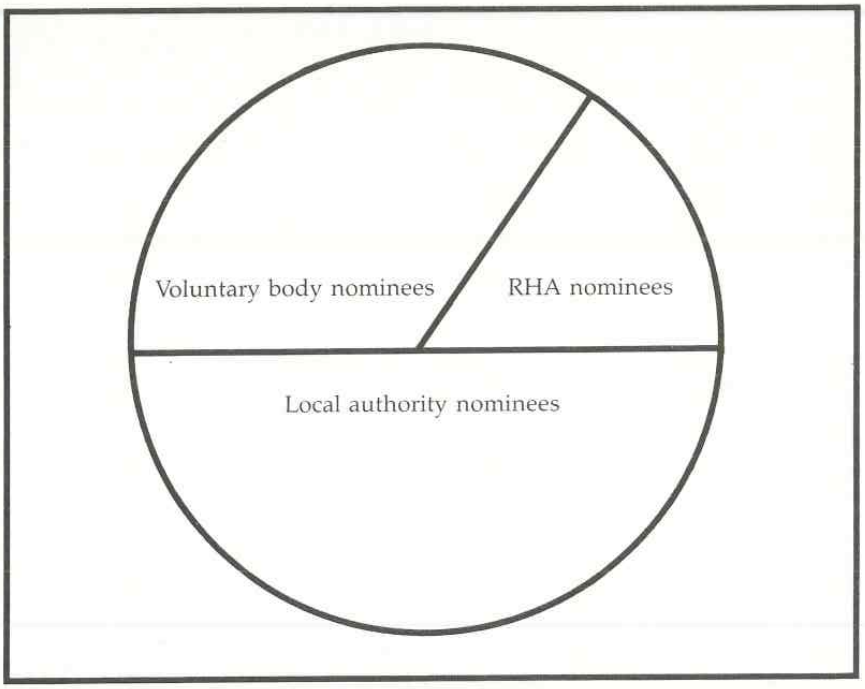
Community Health Councils (CHCs) normally have 18-24 members.

ONE THIRD of the members (8 out of 24) are nominated by voluntary organisations, eg Red Cross, Society for Mentally Handicapped, Age Concern.

ONE HALF of the members (12 out of 24) are nominated by the local authorities eg district council, borough council, county council.

ONE SIXTH of the members (4 out of 24) are nominated by the regional health authority (in Wales by the Welsh Office), and may include a disabled person and a representative from a trades council.

Diagram 1



There is a Chairman and at least one Vice-Chairman for each CHC, chosen by the members from their number.

The Secretary of the CHC is a paid employee of the Regional Health Authority chosen by and accountable directly to the CHC for all the work he or she undertakes on their behalf. In Wales the Secretary is formally appointed by the Welsh Office.

There are usually one or two Assistants to the Secretary. Assistants are also paid workers.

Some CHCs have Co-opted Members who are appointed by the CHC to help with particular work.

2 HOW LONG DO MEMBERS SERVE?

The normal term of office for CHC members is four years. Members can then serve another term of four years as soon as the first is over, making a total of eight years. However, there must be a gap of at least four years before members can be appointed again (a third time). Service on CHCs before 1 September 1982 does not count towards the eight year period.

If a member resigns or leaves the CHC before the end of the four years, another person can be nominated to fill the vacant place, and hold it until the original four year term is up. Members who fill casual vacancies in this way may go on to serve two full terms of office (that is, a further eight years).

Not all members serve the same four years. Normally, half of the members complete a term of office every two years in order to allow for continuity among the membership.

If a member fails to attend any CHC meeting for six months, the RHA will, after consultation with the appointing body concerned where that body is a local authority or voluntary organisation, declare the place vacant unless satisfied that absence was due to a reasonable cause. The term of office of a member may also be terminated if the RHA, after consulting the appointing body, is of the opinion that a member has been guilty of misconduct.

3 HOW LONG DO CHAIRMEN AND VICE-CHAIRMEN SERVE?

Chairmen and Vice-Chairmen are chosen by their CHCs for a period that the CHC itself decides. In most cases this is one year, and then the same people can be reappointed or others chosen.

Some CHCs have in fact had the same person as Chairman for as long as four consecutive years.

Some CHCs automatically 'promote' a Vice-Chairman to be Chairman each year.

Whichever method councils use, their aim is to combine the continuity of experienced leadership with the freshness of introducing newer people to these responsible posts.

4 THE NATIONAL PICTURE

As a general rule there is one community health council for every health district. The only exceptions to this rule are in three districts (Liverpool, Bristol and Weston, and Cornwall and Isles of Scilly) where there are two CHCs. This means that there are 194 CHCs in England. Wales has 22 CHCs, and, at the time of writing, Scotland has 45 similar bodies called local health councils.

Regional Health Authorities (RHAs) are, in England, the bodies responsible for setting up CHCs and enabling them to function. RHAs have the power to alter the total number of CHCs, the number of members and staff of each CHC, and to approve the administrative arrangements (premises, staff, budget) of the councils. They may review these matters periodically. In Wales these matters are the responsibility of the Welsh Office.

Regional associations of CHCs provide a means by which CHCs can get to know each other and discuss matters of common interest, including their relationship with the RHA. These associations operate with varying degrees of formality.

Since 1977, CHCs have had their own national organisation: the Association of Community Health Councils for England and Wales, known as ACHCEW. This promotes CHCs' views nationally and undertakes work on projects to do with the public interest in the National Health Service. Most CHCs belong to the Association and the work of ACHCEW is governed by a standing committee composed of representatives from CHCs in each region and Wales.

CHC Secretaries keep in touch through their own informal links or through regional associations. Nationally there is a Society of CHC Secretaries to which some, though not all, secretaries belong.

5 WHAT DO CHCs DO?

Officially, it is the job of CHCs to represent the interests in the health service of the public in the district. This means that CHCs are one of the channels through which the public's voice is heard in the NHS. In the main CHCs deal with district health authorities and family practitioner committees, although they may also relate to regional health authorities, local authorities, the DHSS and other bodies with an interest in health and health services.

In relation to DHAs and FPCs, CHCs have various *rights* and *duties*.

The *rights* of CHCs comprise:

- the right to *information* from DHAs and FPCs
- the right to be *consulted* by DHAs and FPCs on any proposals under consideration for any substantial variation of or development in services
- the right to challenge *closures* or *changes of use* of health buildings, and if CHCs object to have the matter referred to the Secretary of State via the regional health authority
- the right to send *observers* to DHA and FPC meetings. Observers may speak but not vote
- the right to *visit and inspect* premises under the control of DHAs. This has been extended by agreement to include private hospitals where NHS patients receive services under contractual arrangements. This right does not extend to premises controlled by FPCs or contractors' premises

The *duties* of CHCs include:

- the duty to publish an *annual report*
- the duty to *meet annually* with the DHA and FPCs
- the duty to submit a *detailed and constructive counter-proposal* when objecting to proposals to close or change the use of health buildings.

FPCs and DHAs are required to comment on CHC annual reports and to make their comments known to the public.

Another way of looking at the work of CHCs is that they act as

1. THE PATIENTS' FRIEND
2. THE COMMUNITY'S WATCHDOG
3. PARTICIPATION

THE PATIENTS' FRIEND

This means giving help to individuals who are having difficulty finding out how to obtain a service, or who want to make a complaint. The Secretary of State has said that he does not think that acting as patients' friend at service committee hearings is a formal role for CHCs. However, there is no official objection to individual CHC members or officers

providing such assistance if they are asked and wish to do so, and this frequently happens.

THE COMMUNITY'S WATCHDOG

This means that CHCs have to find out for themselves what local health services are trying to achieve and how they are organised, so that the CHC can comment on the range and quality of the services provided, from the community's point of view. To do this, most CHCs divide up into small working groups to study in more detail the needs of particular patients or specific problems. These groups may examine the needs of groups such as mentally handicapped people, or they may focus on issues like finance or planning. Many CHCs find it useful to carry out surveys to discover what the community thinks about local services.

PARTICIPATION

CHCs have the right to be consulted about plans to change and improve local health services. This involves reading DHA and FPC planning documents, investigating alternatives, and joining in planning team discussions. When hospital closures are being proposed, CHCs have to find out from the public what views should be expressed. It is important that CHCs should be involved early in the consultation process before firm decisions are made (see Policy Guide for further information on CHC participation in health planning).

Altogether, these three kinds of work done by CHCs can be very time consuming and need a great deal of commitment from the members if they are to function effectively. So what resources do CHCs have?

6 RESOURCES

There are four sorts of resources available to all CHCs:

1. The members
2. Staff
3. Money
4. 'Free' help.

MEMBERS

Obviously, the most important thing about CHCs is the time, energy, commitment, enthusiasm, knowledge, experience and concern that each member brings to the CHC. The more each member can offer, the stronger that CHC will be. It is difficult to be a good CHC member, especially if you already have a lot of other interests and demands on your time. But for those people who can whole-heartedly join in the work of their CHC, the experience can be extremely rewarding and exciting.

STAFF

Each CHC has people working for it (usually) full-time. The Secretary of the CHC has a demanding and varied job, acting partly as a committee secretary preparing and circulating papers, taking minutes, etc; partly

as a helper for members of the public who call in for advice or who want to make a complaint; partly as a researcher, planning and carrying out surveys and investigations; and partly as a press officer keeping the press, radio and TV well informed and interested in the CHC. The Secretary has a particularly important role as an adviser to CHC members on matters of planning and policy. The Secretary is the key link between members, co-ordinating their activities and helping them to plan their work and achieve the CHC's objectives. It is a very responsible position, and it requires the ability to work efficiently on your own, with quite long hours and to be able to cope with all sorts of demands.

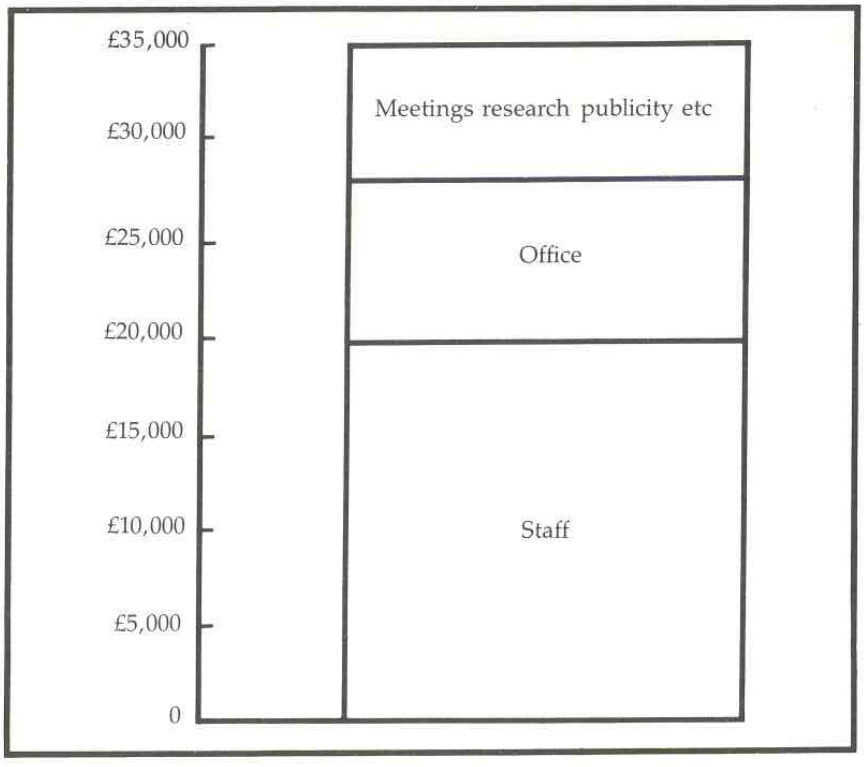
People from all walks of life have become CHC Secretaries — not only those who have worked in the NHS before but businessmen, voluntary organisation workers, servicemen and ministers, and all kinds of others. Men and women, younger and older, have become involved. The job is graded as a middle-level administrative position with a salary of around £10-11,000 per annum.

The Secretary has an assistant (some have more, often part-timers) who helps with the typing, clerical work and other activities, and may be asked to deputise for the Secretary.

MONEY

Even with the vital contribution from members, CHCs still need a little money to keep things functioning effectively. Annual budgets for CHCs are worked out between the regional health authority and the CHC and currently most CHCs receive about £35,000 from their RHA. (Some get less, some get more, depending on local arrangements.) The Welsh Office approves the budgets of CHCs in Wales and the budgets are allocated to CHCs via DHAs.

Diagram 2



The money is needed to:

a pay staff — the Secretary and assistant are paid employees, and the annual salary bill is roughly £20,000;

b pay for the office - most CHCs have to pay rent, rates, heat, light, telephone and other bills for their offices; the amounts vary considerably, but, for example, could be £8,000 in a year;

c this leaves about £7,000 to do the work of the CHC, and that includes holding meetings, going on visits, publishing reports, advertising, training members, going to conferences, etc etc.

FREE HELP

So it can be difficult to afford everything a CHC would like to, given the relatively small amount of money in the budget. But all sorts of free help exist and can be used by CHCs, such as

'free' staff, provided through Government schemes to create jobs for people out of work

'free' researchers in the form of college students who can help with projects to find out about needs and services in the community

'free' advertising by taking part in local radio and TV programmes to spread the word about what the CHC is doing to a wider audience

'free' publicity from local newspapers that follow CHCs' activities, especially if the reporters are well-briefed by the CHC

and there are many other examples that you will be able to think of yourself.

CHC NEWS

Beginning in 1975 a monthly magazine, CHC News, provided information to CHC members and staff about developments in the NHS and among CHCs. However, the withdrawal of the DHSS grant which supported CHC News forced the magazine to cease publication in March 1984. The information bulletin published by ACHCEW, Community Health News, has since been expanded to include more information relevant to CHCs.

3
CHCs IN ACTION*

*This paper was written by Christine Hogg who was formerly Secretary of a CHC in central London.

This paper discusses the work that CHCs have done in seven areas:

1. Participation in planning
2. Consultation on changes of use and closures
3. Monitoring existing services
4. Identifying unmet need
5. Information and advice to the public
6. Complaints and acting as a patients' friend
7. Health education and health promotion

Much of the material is presented as case studies. These have been selected because they indicate some of the ways CHCs have developed and show possibilities for the future.

1 PARTICIPATION IN PLANNING

Planning of services is a management function. DHSS envisaged that CHCs would be involved in the planning process, but arrangements were left to local negotiation. In 1980 a study showed that just under half of health districts were in favour of CHC membership on planning teams. There was a significant difference between regions in the North and regions in the South of England, ranging from 21% of districts favouring a CHC presence in the Northern RHA to 75% in South East Thames RHA. 84% of planning teams with a CHC representative considered their presence to be beneficial and were also more likely to be satisfied with their effectiveness.CHC representatives had a better than average attendance rate on planning teams and most CHCs had sub-groups which shadowed the planning teams in their health district. The study concluded:

"By including a representative from the relevant CHC sub-group in their membership, planning teams can obtain consumer views on a regular basis and at an early stage in the discussions. Major benefits could be:

a a saving in time and money by finding out sufficiently early on an informal level, whether certain planning options are as likely to be acceptable to the local community as others;

b increased understanding on the part of the consumers of the difficulties faced by the 'professionals' in planning health services;

c consumers and professionals combining their experience and channelling their energies into providing a better service for patients."

In 1985 CHCs were given the same rights and duties in relation to FPCs as to DHAs, including observer status on FPCs,consultation rights and annual meetings between FPC and CHC members. Family practitioner services are fundamental to community care, with which CHCs are particularly concerned. It is important, therefore, that CHCs and FPCs learn to work together. In Lancashire a joint agreement has been negotiated between the CHCs and the FPCs, which attempts to define issues requiring consultation and lay down procedures.

There are difficulties both for CHCs and FPCs in building up a relationship:

- FPCs cover larger areas than District Health Authorities. One FPC may have to relate to up to seven CHCs;
- the requirement for FPC members to meet formally with members of each CHC once a year may be unrealistic for FPCs covering many CHCs. CHCs may need to combine in relating to FPCs;
- FPCs and CHCs have not been given any additional resources with which to undertake planning and consultation. This may cause difficulties for FPCs who may not have enough staff to undertake public consultation and strategic planning;
- FPC members may see their role as administering an existing service rather than being involved in policy making and planning. FPC membership is largely made up of professionals rather than lay people or managers;
- FPCs have less authority to plan and develop their services than DHAs. The family practitioner services are provided by doctors, dentists, pharmacists and optical practitioners who are self employed independent contractors and the local professional committees exert strong influence.

2 CONSULTATION ON CHANGES OF USE AND CLOSURES

In 1974 CHCs were given a special role in relation to hospital closures. Until 1974 all closures were referred to the Secretary of State for a decision. After then, where a CHC agreed, this was no longer necessary. If a CHC opposed a closure, it had to make detailed and constructive alternative proposals and the matter was referred to the Secretary of State for a decision.

Consultation on closures and changes of use has become a major part of the work of CHCs. Resource allocation and public expenditure cuts have led to more closures and changes of use of NHS buildings than envisaged when CHCs were set up. CHCs have not used their delaying powers indiscriminately. A survey in 1980 found that 44% of CHCs consulted on closures and change of use had opposed the proposals, 32% agreed and the remainder opposed some proposals but agreed others. Of those opposing, one in six had not put forward counter proposals, half the CHCs had worked out alternative proposals and a third had put forward counter proposals in some cases but not others. In six years, between May 1979 and June 1985, 50 proposals which had been opposed by the CHC were sent to the Secretary of State for a decision. In these cases the Secretary of State found against the health authority in only five cases.

In spite of the obligation to consult CHCs, health authorities have not always done so and problems have arisen:

- some health authorities have evaded consultation by reporting a closure as 'temporary' and so exempt from the procedure. Consultation then proceeds with the unit already closed, so it is difficult to get it re-opened;
- consultation procedures are open to various interpretations. How do you define 'substantial'? 'Substantial' relative to what or whom?
- the amount of information given by the health authority often is insufficient to be called consultation;
- the time allowed for consultation may be too short in which to undertake a major public consultation;
- if a CHC opposes the health authority's plans it must put forward detailed counter proposals, within the same financial constraints. It is difficult for a CHC with limited resources to produce properly costed alternatives, particularly as it may have to rely on the health authority for information to do this.

Consultation: a cautionary story

The Grange Maternity Hospital in Ely was a small unit run by local GPs. In December 1976 a local newspaper carried a story saying that the Grange would soon have to close because the landlords, the Ministry of Defence, wanted the premises back. In February 1978 the DMT recommended to the health authority that the unit should be closed in July 1978, depending on the Ministry of Defence issuing formal notice to the AHA, the publication of the consultation document and the agreement of the CHC to the closure.

The consultation document was not issued until April 1979 and the Ministry of Defence did not give notice to quit until February 1980. Meanwhile the Grange had been under threat of closure for almost two and a half years. Bookings had slumped and GPs had lost interest in the unit, while the other maternity unit for the area, Mill Road Maternity Hospital, was under serious pressure on its beds. The CHC pointed out that there was extreme pressure on maternity services in the district and it did not make sense to dismantle an excellent unit. They proposed that the unit remain

open for at least a further three years and that local GPs should be encouraged to make referrals there. In December 1979 the GP who had kept the unit going during the years of uncertainty committed suicide. The unit now had no medical cover and was temporarily closed in January 1980. In February 1980, the Ministry of Defence issued a notice to quit and the CHC withdrew its opposition.

Although the CHC responded 'speedily and constructively' to consultation, adequate response was rendered almost impossible by the inadequacy of the information presented by officers in support of their proposal to close. The guidance on consultation with CHCs, set out in the DHSS Circular, was not followed through. Further, AHA members and officers seemed to take the view that in objecting to the closure, the CHC had simply indulged in time-wasting, causing 'unnecessary and expensive delays'.

Consultation: the birth of a Community Plan

In 1978 the Area Health Authority consulted the Paddington and North Kensington CHC on its long term plan to rebuild the teaching hospital, St. Mary's, Praed Street and to close St. Mary's, Harrow Road. Following lengthy consultations with the public the CHC rejected the plan and then obtained a three month delay in order to formulate an 'alternative' strategy.

The CHC conducted a random survey based on the electoral register, asking people to consider four alternative plans and say which they preferred. The vote was overwhelmingly for the CHC's own plan to rebuild St. Mary's teaching hospital in Paddington and replace the general hospital at St. Mary's, Harrow Road, with a community hospital on the same site. GPs would admit their own patients to the new community hospital which would also provide facilities for pre-convalescents, the elderly, mentally handicapped adults, young chronic sick as well as a health centre and minor casualty centre.

In April 1979 the AHA agreed to adopt this plan in principle and to explore with the CHC how it might be implemented. Following this the CHC canvassed local GPs and local community groups and social services to obtain their support and involvement to the idea of a community hospital. In September 1979 a Joint Working Party was set up with membership from the CHC, DMT, GPs, RHA and local authority social services.

The Paddington Community Hospital opened on a trial basis in January 1982, with 25 beds. An appraisal was undertaken in 1984 which recommended that the hospital become an established part of the District.

3 MONITORING EXISTING SERVICES

CHCs often mount surveys to ask for users' experiences and views on services. According to a study in 1980 75% of CHCs had carried out at least one survey between 1977 and 1980. The average number was two,

but many had done far more. Many CHCs indicated that they would like to do more research but were caught up in responding to consultation documents. The following are examples of what some CHCs have done.

Healthcare needs of Chinese people in Bloomsbury

The area around Soho is well known for its Chinese restaurants, shops and meeting places. In 1984 pressure from the Chinese community led Bloomsbury CHC with the Bloomsbury Community Services Unit to see how services could be made more appropriate to the Chinese community. In depth interviews were conducted with 80 Chinese families. The aim was to find out whether local Chinese people knew about the services available and how to use them; whether they were satisfied with the services they use and which services they do not use and why not.

The findings revealed that 'the Chinese community knew very little about available health service provision. In every area of health care examined communication - about treatment, diagnosis, prognosis, prevention and day to day care and so on - was the major problem experienced by most people'. The recommendations included the recruitment of a Chinese health visitor/community nurse, staff training and development of health education material in Chinese. A Chinese health visitor was immediately recruited.

Services for people with hearing impairment in Cumbria

In 1979 South East Cumbria CHC conducted a survey on the problems of people with hearing impairments. The survey highlighted a number of issues:

1. the service for the manufacture of hearing aid moulds was inadequate. After local measuring these moulds were made in the South of England. Many were ill fitting and poorly made, causing delays to patients waiting for an aid;
2. new recipients of hearing aids need counselling at home. Many aids were being discarded because of inadequate advice about how to use them;
3. communicator devices with 'loop' systems and headphones were needed to enable doctors and others to hold confidential conversations with patients;
4. hard of hearing people complained about the problems of watching TV and called for clearer speech, less background music and more programmes with subtitles.

As a result of the survey:

- a domiciliary counselling service staffed by trained volunteers was established by the audiology department at Beaumont Hospital, Lancaster;

- Cumbria Deaf Association organised the gathering of hundreds of signatures on a petition to the broadcasting authorities seeking better provision for the hard of hearing;
- plans were drawn up to manufacture ear moulds adjacent to the audiology department;
- Kendal Lions Club raised money for a communicator device for hospital clinics.

Consumer attitudes in Dorset

East Dorset Health District covers a large area, which includes five local authorities covering both urban and rural areas. Since 1975 East Dorset CHC have monitored consumer attitudes to health services. Initially the surveys were small and experimental to determine the best way of eliciting information from the public with limited staff and resources. Methods included interviews, group discussions,interviews with community leaders and professionals and questionnaires to local organisations and individual households.

In 1980 the CHC settled on a system of distributing information packs (containing introductory letters, leaflets and questionnaires) to as many households as possible in representative areas or rural parishes. From 1980 to 1983 five areas were surveyed, with an average response rate of 35% (2828 completed questionnaires 1980-1983).

The surveys involved local people in identifying existing and potential problem areas. These have provided the CHC with information to advise on improvements and extensions in services, including the establishment of GP branch surgeries and a service to deliver and collect prescriptions.

Complaints are a useful source of information, indicating areas requiring further investigation. Many changes have been brought about through CHC action arising from a single complaint. Some CHCs regularly audit schedules of all complaints made to the health authority. This assists in identifying trends and recurring difficulties and can give the public more confidence in the DHA's impartiality and thoroughness in investigating complaints.

The main sanction of the CHC is to publicise what is happening. Health authorities may be aware that things are wrong but may not be prepared to take action. The problems of Normansfield Hospital in 1976 and Stanley Royd Hospital in 1984 only came to public attention following major incidents. In both cases the CHC was commended for speaking out.

Normansfield

Late in the evening of 4 May 1976 an informal meeting of certain members of the Confederation of Health Service Employees was held at Normansfield Hospital, Teddington, Middlesex. That night the hospital housed 202 mentally handicapped patients of varying ages, many of them suffering from multiple handicaps to the point of complete helplessness. Those present at the meeting were

members of the nursing staff and they were angry that the health authorities had apparently failed to take full notice of their grievances against the Consultant Psychiatrist in Mental Subnormality in the hospital. After some hours of discussion they decided to go on strike from seven o'clock next morning with a view to persuading the SW Thames Regional Health Authority to suspend the doctor from duty.

Shortly after daybreak pickets were out at the hospital. Patients were attended by a skeleton nursing staff, helped by a few other staff and relatives. Nursing cover fell below danger level and the health and welfare of patients were endangered.

Later that day, the Consultant was suspended from duty and the nurses returned shortly after 3.30 pm .... This industrial action was unprecedented in the history of the National Health Service.

The report of the Independent Committee of Inquiry highlighted the failure of all levels of management to deal effectively with problems about which they were well aware. The Area Health Authority sought to improve the situation by non-intervention and persuasion. This policy was soon shown to be ineffectual but it was nevertheless persisted in for too long. "At Regional level an attitude of 'wait and see' was adopted regardless of the knowledge that the 'price of waiting was being paid by patients'."

The only NHS body to be commended in the report was the CHC. "The Kingston, Richmond and Esher Community Health Council is to be congratulated on its tenacity in exposing and reporting on the situation it found at the hospital."

Stanley Royd Hospital

In August 1984 there was an outbreak of food poisoning at Stanley Royd Hospital, a psychiatric hospital with 830 patients. 19 people died and 460 patients and staff were taken ill. The subsequent public inquiry into the incident found an appalling situation. The kitchens contained open drainage channels infested with oriental cockroaches. Drains in the pan washing area gave off such an offensive smell that staff could not work there. Kitchen tables and food preparing surfaces were washed down with the same mops and buckets that were used for the floor.

The part played by Wakefield CHC was noted by the Committee of Inquiry and their 'considerable assistance' put on record.

Another example of a CHC highlighting bad practices comes from Oxfordshire.

Cervical cytology

2,000 women die a year from cervical cancer, which if diagnosed early enough can be treated, and death rates drastically reduced. In 1984 one woman died and two others were seriously ill in Oxford because they had not been recalled for treatment after their smear tests had proved positive. Oxfordshire CHC publicised this and in a survey following the situation it was found that only seven out of 201 health authorities had a proper call and recall system, 77 had no scheme at all, and the position was unclear in a further 10.

In a DHSS Circular the Minister of Health asked all RHAs to set up regional computer systems where this had not been done, to introduce a system for telling all women how to get the results of their tests, to improve the effectiveness of the laboratories which process smears and to develop more ways of offering tests to older women. He refused to make any further funds available.

Oxfordshire CHC highlighted a serious problem, which many CHCs had already taken up locally. The ensuing debate resulted in a nationwide review of recall procedure.

While CHCs have right of access to NHS premises, there is no equivalent protection of the interests of private patients. However, some CHCs have done work in this area, as the following example shows.

Consumer guide to private nursing homes

In 1983 Oxfordshire CHC published a Guide to Nursing and Old Peoples Homes in Oxfordshire. The Guide, which was updated in 1985, gives information on the amenities and facilities as well as the charges. The purpose of the Guide is to help elderly people and their families and friends to assess the homes before making a choice.

The survey was undertaken by CHC members and staff visiting every private, voluntary and charitable Nursing and Old Peoples Home in Oxfordshire.

4 IDENTIFYING UNMET NEED

CHCs have piloted new ideas and approaches to health care and developed a wider role than that envisaged in 1974. Some CHCs have worked, often with local voluntary groups, to identify unmet need and to promote the development of self help groups and community health projects. There is controversy among CHCs whether this exceeds their remit. Some feel that CHCs should restrict their activities to statutory duties, because of their limited resources.

For CHCs adopting this broad approach, there have been benefits:

- the CHC establishes its independent identity with the public and the NHS. Separate funding has been obtained for some projects and this gives the CHC more independence in the NHS;
- going out to the community to identify new areas is creative and more rewarding for CHC staff and members than commenting on DHSS, RHA, DHA and FPC plans. The CHC sets its own objectives rather than reacting to NHS management;
- the CHC acts as a catalyst for innovatory ideas and new services and encourages good practices. The CHC is in a unique position to do this because it has links with the NHS, local authority and community staff and voluntary organisations;

- the CHC can promote change by bringing to the attention of NHS staff what can be done with few resources.

Health advocacy for non-English speaking women

In 1979 City and Hackney CHC were concerned about the way ante-natal care was being delivered, in particular to non-English speaking women. Their inability to present their problems and their lack of knowledge of the system made them particularly vulnerable to bad care.

The CHC obtained funding from the Inner City Partnership to employ health workers to work as patients' advocates. The project aimed to:

- improve access to health services;
- help women understand the choices open to them so that they can make informed decisions;
- advise the health authority on policy and practice with regard to the needs of non-English speaking women;
- help and encourage NHS staff to provide a service to this high risk group.

The project employs six workers, who between them are native speakers of Turkish, Gujerati, Bengali and Punjabi. They not only translate, but also speak on behalf of the patient to make sure her needs and problems are presented to staff. Many of the staff wanted someone to interpret hospital policy for the patient. Instead the workers queried the services on behalf of the patients. From these individual requests came suggestions for policy changes. Issues tackled have included: food in hospital, access to women doctors, racist behaviour, conveying bad news, keeping ethnic records.

A study compared a random sample of non-English speaking women who attended the hospital before the project commenced in 1979 and a group attending in 1984. There are improvements in take up of ante-natal care, nutritional status of the mothers and birth weights, which can be attributed to the project. No trends were found in the control group of English speaking women, except an increase in incidents of default in ante-natal attendance.

This model has been followed in other areas. A further scheme is being developed by the project for black English speaking women at Queen Elizabeth Children's Hospital and the model can be extended to anyone who is particularly vulnerable.It is a logical extension of a CHC's role as a 'patients' friend'. Advocacy schemes such as this need to be based outside the health service, either in a CHC or a voluntary group, so that the worker is not a part of the hierarchy being questioned and can be given support in pursuing issues on behalf of the patients.

Central Manchester: Aidsline

In February 1985 Central Manchester CHC sponsored a meeting with the gay community on AIDS. Following this meeting, a telephone counselling service began operation for three evenings a week in October 1985. Aidsline gives information about AIDS, HTLVIII testing and advice on ways of reducing risk.

The Steering Group, which is serviced by the CHC, is seeking funding from the RHA for further developments, which include support and training for district testing, advisory services on multi-district basis, the establishment of local non-medical counselling services and a co-ordinated health education programme.

The Well Women of Weston

Following inquiries from women after an article in a Sunday paper, the CHC held a public meeting where women attending asked why there was no well woman service in Weston.

The District Management Team informed the CHC that such a service would be uneconomic, there was no money and they would not give it priority. The CHC held a public meeting and were astonished by the response. Speaker after speaker complained of hurried or unsympathetic doctors who had told them to 'buck up' or take tranquillisers. What they wanted was the opportunity of having unhurried consultations with a woman doctor in Weston.

When Weston Health District was merged with Bristol, it was agreed to change an existing clinic to cytology, breast screening, blood, urine and weight tests. Meanwhile the CHC organised a series of educational meetings, with professionals answering questions on topics such as pre-menstrual tension, depression and self examination of the breast. Developing from this basis, the screening clinic became the Weston Well Woman Clinic, with the Family Planning Association running a counselling clinic and the Marriage Guidance Council offered skilled leaders for therapy groups.

Coalition for Community Care: Kensington, Chelsea and Westminster

The Kensington, Chelsea and Westminster AHA planned to merge two large Victorian psychiatric hospitals — Banstead and Horton in Surrey - and use the money released from the early closure of Banstead to develop locally based services. Following the 1982 reorganisation, the AHA was divided into three District Health Authorities, two Regional Health Authorities and two local authorities. The CHCs considered that this would increase fragmentation and make joint planning an even more remote possibility, unless a fresh approach to collaboration could be achieved.

The Coalition for Community Care was set up in 1982 by the three CHCs, Paddington and North Kensington, Victoria and Bloomsbury, and two local mental health associations covering Kensington and Chelsea and Westminster. The Coalition's primary aim is to promote the development of community care for people with local mental health problems. In 1984 it obtained independent funding for two staff to further develop the programme of seminars, information dissemination and the promotion of innovative approaches to the development of community care.

5 INFORMATION AND ADVICE TO THE PUBLIC

Some CHCs have shop front premises accessible to members of the public to call in for information and advice. This involves additional work and many 'High Street' CHCs close their offices to the public for parts of the week in order to get other work done. In Manchester the three CHCs share office premises and employ an information officer. Most CHCs are less fortunate, though some share accommodation with advice agencies, which helps in making referrals for non-NHS enquiries. Most CHCs help individuals to sort out problems with the NHS, such as those concerning discharge from hospital.

Providing an information and advice service is a practical way of giving the CHC a public identity. Leaflets and handbooks about services and how to use them is a part of the process of encouraging informed consumers who are more able to be partners with the professionals in their health care. Many CHCs have produced guides to local services, covering local authority and voluntary organisations as well as NHS services. They have produced leaflets and handbooks on patients' rights, including in a variety of languages for ethnic minorities. Some CHCs have also undertaken seminars and training programmes for both members of the public and health service staff.

Information for patients about GPs

Exeter CHC in 1985 worked with the Local Medical Committee to produce a 'model' leaflet for GPs to give information to their patients about the services they provide and how best to use them.

The 'model' has been circulated to all GPs in the hope of encouraging them to produce (or perhaps in some cases modify) their own leaflets.

Good Practices in Mental Health

The Good Practices in Mental Health project was set up by the International Hospital Federation in 1977 to discover and publicise details of noteworthy small scale schemes for aiding mentally ill people and their families.

Each local study gathers information on a number of projects for people at risk due to stress or mental ill health. The identification of good local services raised the morale of staff involved and publicises little known resources. The studies also have an

educational role and have been used as the basis for local conferences and training programmes for staff in hospitals and the community.

About 65 projects have been undertaken or are at present in progress. Over half of these have been co-ordinated wholly or in part by CHCs. CHCs have found that the 'non-threatening' approach of the project can help to break down the barriers between the organisations involved and clear the way for the closer co-operation and planning of future services.

Manchester: difficult patients or difficult problems?

In 1983 the three Manchester CHCs were approached by the FPC about patients who found it difficult to establish and maintain a good relationship with their GP, and consequently kept changing GPs. A six month pilot scheme was set up, and renewed subsequently. Under the scheme the FPC refers to the CHCs 'problem' patients who can then be counselled on their attitude, approach and expectations of their GP.

6 COMPLAINTS AND ACTING AS A PATIENTS' FRIEND

CHCs have taken different approaches and given different priority to helping complainants. In a 1982 survey, 10% of respondents saw assisting patients with complaints as the most important CHC activity, while 16% saw it as the second most important activity. Dealing with complaints is time consuming and can be emotionally distressing. Complaints create conflict with professional staff, who often do not understand the CHC's role. The role of 'Patients' Friend' is open to different interpretations and has been seen by FPC and health staff as an advocacy role, which, they consider, may destroy the possibility of understanding between the complainant and those about whom the complaint is made.

Family Practitioner Committees have a more standardised and formal complaints procedure than District Health Authorities. FPCs do not investigate complaints, but let both sides state their views before Service Committees, which have a lay chairman and are made up half of lay people and half of professionals (generally working in the same locality as the practitioner against whom the complaint has been made). By 1980 62% of CHCs had assisted a complainant at a Service Committee hearing. CHC members can present the case for the complainant at a formal hearing, but CHC Secretaries are sometimes deemed paid advocates by the chairman of the Service Committee. The legality of this has yet to be tested.

In the case of hospital treatment, complaints about clinical judgement are referred to the Regional Medical Officer. In Wales they are referred to an independent Medical Officer for Complaints. The Medical Officer for Complaints considers that the presence of a CHC Secretary is helpful in the reviews. If the complainant is subsequently dissatisfied, he or she may claim that the review was not conducted properly or impartially.

If a CHC secretary is present, he or she may be able to testify that the review was satisfactory, even though it may not have supported the complainant.

The following case illustrates some of the difficulties involved in CHCs assisting patients in making complaints about hospital treatment:

What is a patients' friend?

In 1984 a young man in his early twenties died from a heart attack. The need for surgery had been diagnosed at his local hospital a few months earlier, but he was not referred for surgery at another hospital until it was too late and he died after the operation.

His parents made a complaint under the clinical complaints' procedure. Eventually 13 months after his death a date for the complaints' hearing was set. However, one of the medical consultant assessors refused to hear the case unless the CHC Secretary, who had been assisting the patient, did not attend as Patients' Friend. While there is an established precedent for the attendance at hearings by CHC Secretaries, the procedures specify a 'close friend' or relative. The RHA informed the complainants that they had a choice of going ahead with the hearing without the CHC Secretary present or dropping the complaint altogether.

7 HEALTH EDUCATION AND HEALTH PROMOTION

A CHC can be involved in health education and health promotion in five ways:

- by undertaking health education activities;
- by giving information on health issues to the public
- by carrying out surveys and studies
- by monitoring health education activities
- by acting as a pressure group both inside and outside the NHS for health education.

Some examples of what CHCs have done are:

Dewsbury: children's multi-coloured health week

For five days in July and August, Dewsbury CHC ran a 'children's multi-coloured health week' to promote health education and to associate health information and activities with having fun.

The event was held in the town hall with two sessions daily. Children were kept busy all the time, working around the activities at their own pace. These included: a Hospital Corner, to help familiarise children with hospitals, basic First Aid Training, run by St. John's Ambulance Brigade, cookery, painting and games, with a health message. There was also a Teeth Corner, a Food Table and a Home Safety Quiz, run by the area Health Education

Department. About 500 children from three to 13 years attended the sessions.

Children' Health Club

Two boys living near St. Thomas' CHC began calling in after school asking if they could do anything in the CHC shop. This made the CHC think about how they might make contact with local children and so a weekly Health Club developed. The aims of the project were to increase awareness of the factors affecting health; identify the health care issues that most concerned children and their parents living near the office and encourage a positive attitude to health.

During the Easter holiday in 1977, the CHC ran a health event for children aged between 5 and 13 years. It was planned around the subject of nutrition and health with particular emphasis on the importance of fibre in the diet. Over four days, 30 children considered nutrition and digestion,including a visit to the local baker to see him make his weekly batch of brown bread. As the project developed it adopted a non directive peer group teaching approach.

In 1979 a grant was obtained to employ a full time worker to run and evaluate the club. The report concluded that the project was an innovative approach to child health education.

WHAT IS AN EFFECTIVE CHC?

It is difficult to evaluate the work of CHCs because there are no agreed criteria for assessing their effectiveness,nor is there agreement about what are or are not appropriate activities for CHCs. The public, NHS management and the Government have different expectations about what a CHC should do and these are not necessarily compatible.

The lack of guidelines has given CHCs scope to develop in different and innovative ways. It has also given rise to misunderstandings and conflicts with NHS management and variable standards.

1. Service promotion v service provision?

The line between promoting good practice and service provision is thin. Some CHCs have become involved in providing a patient advocacy service, information, training and health promotion. Others consider that CHCs should press for the NHS to provide such services, if they are needed, rather than directly facilitate provision themselves. Certainly an independent body such as the CHC is in a better position to provide independent advice and advocacy services - the NHS cannot provide advocacy against itself.

2. NHS v the wider community

Some CHCs have restricted their comments to services provided by the health authority, only now becoming concerned with family practitioner services. Others have taken a broad view of their remit to include public health and care for vulnerable groups, such as those in private residential care.

3. Choosing priorities for the NHS?

Some CHCs put forward the views of the community, without choosing priorities, which they consider the task of management. Other CHCs

feel that, by assisting management in choosing priorities (which may include agreeing closures and changes in use), they are actively helping to put more resources into services for priority groups, such as mentally ill, handicapped and elderly people.

4. Central activities of the CHC

CHCs have concentrated on different activities. Some, generally those with High Street premises, give priority to dealing with individual problems. Others affected by cuts give priority to responding to consultation documents on closures and changes of use. While the priorities of a CHC may change over time, if a CHC does not explicitly set priorities it is easy for it to become swamped by paper.

5. Reactive v setting their own agenda

Some CHCs have tried to set their own agenda rather than react to tasks given by NHS managers. These CHCs have often been involved in identifying unmet need and promoting good practices.

Each CHC has defined success in its own terms. An effective CHC is one which conscientiously represents its community and health service users. While CHCs may do this in different ways, reflecting the district they represent, there are basic principles for all CHCs.

1. The NHS is a service to local people. Users and the public have the right to be involved in all aspects of their health care.

CHCs look at health services as users, not staff or management. The CHC has a distinct consumer view of all health authority proposals. If a CHC is doing this, conflict may be inevitable, however reasonable the CHC or the NHS management may wish to be.

2. In dealing with large organisations, the individual is at a disadvantage. Patients need a 'Friend'.

The individual is at a serious disadvantage in dealing with any large organisation, such as the NHS. On one level, she may not know how to get the best out of the NHS (such as services available, why it is important to register with a GP, etc). On another level, if things go wrong or an individual is dissatisified, the isolation and vulnerability of the patient's position is severe. Patients are dependent for information about their health and for the most appropriate treatment from health staff. If this trust breaks down, the individual may need advice and support from a 'Friend' who understands the system. No other part of the NHS can give independent and informed advice to individuals. All CHCs must be willing to act as patients' friend, without making judgements about the rights or wrongs of the case.

3. The NHS should be open to the community.

With the best of intentions, it is not easy to attract interest and involvement in the CHC's activities. It is, however, up to the CHC to make its activities of interest and relevance to local people. CHC members are appointed or elected from a narrow base. In order to represent the community in all its different facets, the CHC must be open to participation and views from the wider community and involve non-CHC members in their activities.

4. Particular groups have not been adequately represented in the past in the NHS, and it is for the CHC to ensure their voice is heard.

The balance of power in the NHS has always favoured acute hospital services. In spite of Government policy to develop the Cinderella

services, the shift in resources has been slow. Services also need to be sensitive and relevant to the needs of women and ethnic minorities. CHCs have an important role in representing the interests of vulnerable groups.

It is worth summarising the overall achievements of CHCs.

1. CHCs have started a process of opening up the NHS to the public and voluntary organisations and raising public awareness of health issues. Some CHCs have undertaken original and innovative work, demonstrating good practices to the NHS by example.
2. CHCs have had a considerable impact on health service managers in keeping them more in touch with the local community.
3. CHCs have had a unique impact on the professions. They have helped to give lay people the confidence to challenge and question the people providing the services.
4. CHCs have kept the needs of women, ethnic minorities, mentally ill, handicapped and elderly people in the attention of NHS. They have helped to shift the traditional power balance in the NHS from acute specialities to community care and priority services.
5. CHCs have been a training ground about the NHS from the user perspective for members who then move on to serve on DHAs and FPCs. CHC members have a distinct consumer viewpoint.

4 POLICY GUIDE

This paper provides a brief introduction to a number of currently important issues in health policy. It is only an introduction and you are strongly advised to take up some of the suggestions included for further reading. Also, in an appendix are the names and addresses of some organisations that will provide you with more general information and will also answer your specific questions.

The following pages cover:

1. Health Service priorities and planning
2. Primary care
3. Community Health Services and prevention
4. Hospital services
5. Mentally ill people
6. Mentally handicapped people
7. Elderly people
8. Maternity and child care
9. Inequality and health
10. Private health care

Appendix: Further information

In broad terms the policies described in this paper apply in Wales as well as England but for detailed guidance in each field members should refer to the relevant Welsh policy documents, particularly in relation to health service priorities and planning.

1 HEALTH SERVICE PRIORITIES AND PLANNING

The Royal Commission on the NHS noted that "the demand for health care is always likely to outstrip supply and .... the capacity of health services to absorb resources is almost unlimited. Choices have therefore to be made about the use of available funds and priorities have to be set".

Priority setting means giving resources to one service rather than another: to preventive services like health education instead of general acute services like heart transplants, for example. Choices like this are difficult but inescapable, given the limited funds available to the NHS.

National priorities are published by DHSS. The relevant documents are:

1. **PRIORITIES FOR HEALTH AND PERSONAL SOCIAL SERVICES IN ENGLAND (1976)**
2. **THE WAY FORWARD (1977)**
3. **CARE IN ACTION (1981)**
4. **HC(84)2 RESOURCE DISTRTBUTION FOR 1984-5, SERVICE PRIORITIES, MANPOWER AND PLANNING (1984)**

Since 1976 it has been the intention that general hospital services should be held back while priority groups such as elderly people and mentally handicapped people and priority services such as primary care receive a larger share of available resources. The most recent statement of service priorities, HC(84)2, stated that Ministers wish to see authorities place an early emphasis on the development generally of community based services but especially those for people with mental handicap or mental illness. Within the acute sector the Government has argued that there is a special need to develop services for renal failure, coronary artery surgery, joint replacement and bone marrow transplantation. These priorities were reiterated in HC(85)5 which also stated that Ministers wish health authorities to give priority to improving services for drug misusers.

The NHS Planning System is the main means by which national priorities are intended to be implemented by health authorities. In producing their plans for local service development, health authorities have been asked to take account of national priorities as set out by DHSS. The plans prepared by health authorities indicate the extent to which authorities intend to follow national guidelines, and they help in revising future guidelines.

In line with the aim of delegating decision making to the local level, DHAs play a key role in the planning system. They prepare Strategic Plans covering developments over a ten year period or more, and these are reviewed every five years. DHAs also have responsibility for preparing Annual Programmes (also known as short-term programmes). The annual programme is in two parts: firm proposals for implementation in the following financial year, known as the Operational Programme; and provisional proposals for the financial year after that, known as the Forward Programme. FPCs plan their services on a similar basis to DHAs.

DHSS has emphasised that planning is a continuous process rather than an intermittent exercise. Planning is also a collaborative process involving managers and professionals at all levels. Consultation is a key aspect of the planning process, enabling community groups like CHCs as well as staff and professional interests to contribute their views on how services should develop. Consultation occurs formally and informally. Informal consultation takes place during the preparation of plans and programmes through mechanisms like district planning teams. These teams are usually organised on a service or client group basis. CHCs have often found it useful to be included on planning

teams, sometimes as observers rather than full members. An alternative arrangement is for the CHC's own working groups to 'shadow' planning teams and perhaps hold joint meetings. Formal consultation takes place on Strategic Plans and the Forward Programme.

Alongside the NHS Planning System has developed the Accountability Review Process. This involves annual meetings in each region to examine the long-term plans, objectives and effectiveness of the region. Regional Reviews are attended by a Minister, the regional chairman, civil servants and regional officers, and discussion focuses on an agenda of issues agreed in advance by officials. At the end of the review meeting an action plan for the region is agreed and is subsequently confirmed in a letter from the Minister to the chairman. District Reviews parallel regional reviews and are attended by the regional chairman, district chairman, and officers of the two authorities.

In some regions a number of authority members are also present. An action plan for the district is agreed at the meeting and is followed up at the subsequent meeting. The Review Process was strongly endorsed by the Griffiths Inquiry, and in 1984 it was extended to units of management.

FURTHER READING

THE NHS PLANNING SYSTEM
Health Circular HC(82)6, DHSS, 1982.

2 PRIMARY CARE

Primary care is the first point of contact with the NHS for most patients. In the last 30 years GPs have increasingly combined to work together in group practices and health centres. At the same time they have come to work more closely with other health personnel, including health visitors, nurses and social workers, in 'primary health care teams'. Generally, primary health care services are more fully developed in the United Kingdom and are provided to a higher standard than in most other countries. However, a number of shortcomings exist, including over- prescribing of drugs, unsatisfactory deputising services and poor standards in some inner city areas. Steps have been taken to overcome these shortcomings: unnecessary spending on expensive drugs has been reduced by the introduction of a limited list of medicines available for prescription; standards have been set for the use of deputising services; and a special programme has been launched to improve primary health care in inner cities.

In 1986 the Government published a discussion document on the future of primary care. The document emphasised the need to raise standards, provide more information to the public, increase the choice available to patients and improve value for money.

Specific proposals included the introduction of a good practice allowance for GPs, compulsory retirement for GPs, and simplifying complaints' procedures. The document also put forward suggestions for improving the services provided by dentists, opticians and pharmacists. The Government promised to introduce changes to primary care services after consultation was completed on the document at the end of 1986.

FURTHER READING

GENERAL PRACTITIONER DEPUTISING SERVICES
Health Circular HC(FP)(84)2, DHSS, 1984.
REPORT OF THE JOINT WORKING GROUP ON COLLABORATION BETWEEN FPCs AND DHAs
DHSS, 1984.
PRIMARY HEALTH CARE
HMSO, 1986, Cmnd 9771.

3 COMMUNITY HEALTH SERVICES AND PREVENTION

Included under this heading are various services outside hospital. Priorities here include the employment of more health visitors and district nurses, the strengthening of child health services, the further development of family planning services, a renewed emphasis on vaccination and immunisation programmes, and a reorientation of services in favour of preventive health measures of all kinds.

Government policy has tended to focus on changes in individuals' lifestyles as the means of shifting the balance towards prevention. People have been encouraged to give up smoking, drink less alcohol, eat the right foods, take more exercise, and generally 'look after themselves'. There has also been an interest in health education, fluoridation, the wearing of seat belts, screening programmes, reducing the amount of lead in petrol, and encouraging early and regular attendance for ante-natal care. A series of DHSS publications has given advice on various aspects of preventive health, including diet, safety during pregnancy and avoiding heart attacks. Drug and solvent abuse are also receiving increasing attention. At the local level, a number of health authorities have given priority to health promotion and positive health initiatives, and many DHAs see one of their most important tasks as being health education and the promotion of good health.

In 1986 a review of community nursing services was published (the Cumberlege Report). The review proposed that nursing services should be organised on the basis of neighbourhoods of between 10,000 and 25,000 people. Each neighbourhood would be served by a team consisting of district nurses, health visitors and school nurses under a nurse manager. The review also proposed the appointment of nurse practitioners to work alongside GPs and available to see patients in surgeries, clinics and health centres. The Government welcomed the report and invited comments on the proposals.

FURTHER READING

PREVENTION AND HEALTH: EVERYBODY'S BUSINESS
(1976), The Red Book.
PREVENTION AND HEALTH
(1977), The White Paper, Cmnd 7047.
NEIGHBOURHOOD NURSING — A FOCUS FOR CARE
(1986), The Cumberlege Report, DHSS.

4 HOSPITAL SERVICES

Policy on general hospital services is to establish a network of District General Hospitals (DGHs), catering for all but the most specialised needs. This policy stems from the Hospital Plan of 1962. A DGH may be provided on a single site or by linked hospitals on separate sites. Where new building is needed 'Nucleus Hospitals' are being developed, initially to provide 300 beds but capable of expansion to 600 and 900 beds. These are a quicker and cheaper way of building new hospitals than the methods used in the past. Recently, government policy has moved against the provision of very large general hospitals. A consultative paper issued by DHSS in 1980 suggested that 600 beds should be the normal maximum for a main DGH serving a population of 200,000. The paper indicated that alongside these hospitals there might be developed small local hospitals providing casualty services, some acute services, out-patient clinics, day hospital facilities, geriatric services and some mental illness provision. This is an extension of the policy set out in 1974 of providing Community Hospitals complementary to DGHs.

Over half of hospital expenditure occurs in general acute hospitals and the use of resources in such hospitals is therefore of considerable significance. With growth money limited, hospital doctors have been exhorted to examine their practices more closely to see if savings can be made and applied elsewhere. A number of attempts have been made to make hospital doctors more aware of the costs of their decisions, including experiments in specialty costing and clinical budgeting. Arising out of these experiments, work is in hand to develop a system of management budgeting as recommended in the Griffiths Report. One of the reasons why acute services are under pressure is that the development of new medical techniques is estimated to add 0.5% to the NHS budget each year. Advances such as diagnostic ultrasound, bone marrow transplants and new methods of treating haemophilia patients place increasing demands on health authority budgets, particularly in respect of drugs and equipment. As a consequence, many health authorities have sought to achieve higher levels of efficiency in acute services in order to fund new developments and as a way of shifting resources to the priority services.

FURTHER READING

STATEMENT OF POLICY ON PROVISION OF HOSPITAL SERVICES
DHSS Circular DS85/75, 1976.
COMMUNITY HOSPITALS
Health Circular HSC(IS)75, DHSS, 1974.
THE FUTURE PATTERN OF HOSPITAL PROVISION IN ENGLAND
A Consultative Paper, DHSS, 1980.

5 MENTALLY ILL PEOPLE

Policies in this area stem from the 1962 Hospital Plan and the White paper, Better Services for the Mentally Ill, published in 1975. A recent summary prepared by the DHSS reiterated the need to provide comprehensive district-based services for the mentally ill, to phase out

the large, old psychiatric hospitals and to build up services in the community. The summary identified the essential elements of district services as community care in the form of day hospitals, community psychiatric nursing and support services available in the patient's home; and hospital care in the form of in-patient services for long-stay patients, local accommodation for some elderly patients, DGH facilities for assessment and short-term treatment, and a psychiatric department providing in-patient, out-patient and day-patient services. DHSS stressed that these services needed to be complemented by provision organised by local authorities, voluntary bodies and the private sector. Despite these objectives, and the initiative taken by a number of health authorities in moving services away from psychiatric hospitals,much treatment and care is still provided in an institutional setting.

Within mental illness hospitals, the aim has been to improve staffing ratios and standards of patient care. The work of the Health Advisory Service (HAS) is relevant here, for by visiting and reporting on conditions at mental illness hospitals, HAS provides a stimulus to change. The problem of organising and managing mental illness hospitals was examined in the Nodder Report, published in 1980, which recommended a clearer management structure for psychiatric services. The Report suggested the establishment of district psychiatric services management teams and hospital management teams to provide leadership in the development of local services and facilities.

The law relating to mental illness changed in 1983 with the passage of the Mental Health Act. The provisions of the Act affect in particular those patients who are compulsorily detained, about 10% of all patients admitted to mental illness hospitals. The Act resulted in the establishment of the Mental Health Act Commission which has a general responsibility to protect the rights of detained patients and to keep under review the exercise of the compulsory powers and duties conferred by the Act. The Secretary of State for Social Services has the power to extend the jurisdiction of the Commission to informal patients.

A minor but nevertheless important category of patients are those needing treatment under secure conditions, including mentally abnormal offenders. These patients are currently accommodated in either the prisons or the special hospitals. DHSS policy is to provide a secure unit within each region, and by the end of 1984 nine permanent regional secure units were in operation.

FURTHER READING

BETTER SERVICES FOR THE MENTALLY ILL
DHSS, 1975.
REPORT OF THE WORKING GROUP ON ORGANISATIONAL AND MANAGEMENT PROBLEMS OF MENTAL ILLNESS HOSPITALS
(Nodder Report), DHSS, 1980.
A PRACTICAL GUIDE TO MENTAL HEALTH LAW
MIND, L. Gostin,1983.
COMMUNITY CARE
Government Response to the Second Report from the Social Services Committee, 1984-85 Session, Cmnd 9674, 1985, Annex 1.

6 MENTALLY HANDICAPPED PEOPLE

Current policy for mentally handicapped people is based on the White Paper, Better Services for the Mentally Handicapped, published in 1971. The main aims are to reduce the role played by hospitals in the care of the mentally handicapped and to increase services provided in the community.It is envisaged that specialised care will be needed by only the severely handicapped and that this care will be provided in small units near to patients' homes. Within the community it is intended that local authorities should build up residential and training services.

A review of progress made in meeting these objectives, carried out in 1980, suggested a further reduction in the targets for hospital provision. The review stated that fewer beds were needed than envisaged in the White Paper, and that these should be provided in smaller units. The Jay Committee on Mental Handicap Nursing and Care in a report published in 1979 went further and recommended a model of care based outside hospitals. The report emphasised the importance of enabling mentally handicapped people to live a normal life within the community. This principle has also been stressed by the National Development Group for the mentally handicapped.In a series of pamphlets and reports the Group provided guidance on various aspects of mental handicap policy. At the time of its dissolution in 1980, the Group published a checklist of standards aimed at improving the quality of services for mentally handicapped people, and it emphasised the need to move towards locally-based services.

A summary of current policies on mental handicap services published in 1985 indicates that the recommendations of the Jay Committee and the National Development Group have been broadly accepted by the Government. The DHSS has emphasised that the aim is to accommodate eventually in small homely units based in local communities all mentally handicapped people requiring care in a health setting, except possibly some with specialist needs. The latter may need the services of a core unit but large hospitals are not required.

The most recent policy initiatives on mental handicap have centred on moving people out of hospital. In September 1983 the DHSS asked health authorities and local authorities to put particular effort into getting mentally handicapped children out of hospital and announced special funding to enable this to happen. At the same time, policy on care in the community and Joint Finance (see How the NHS Works) has continued to stress the importance of moving patients and resources from hospitals to the community. In 1985 the DHSS estimated that a minimum of 9,000 people living in hospitals could be discharged immediately if services were available. It is likely to take some time before this aim is achieved, although the centrally funded pilot project programme developed as part of the care in the community policy has enabled some progress to be made.

The National Development Team for Mentally Handicapped People assists authorities on service development in their own areas by carrying out visits and writing reports.

FURTHER READING

BETTER SERVICES FOR THE MENTALLY HANDICAPPED
DHSS, 1971.
REPORT OF THE COMMITTEE OF ENQUIRY INTO MENTAL HANDICAP NURSING AND CARE
(Jay Report), HMSO, 1979.
MENTAL HANDICAP: PROGRESS, PROBLEMS AND PRIORITIES
DHSS, 1980.
COMMUNITY CARE
Government Response to the Second Report from the Social Services Committee, 1984-85 Session, Cmnd 9674, 1985, Annex 2.

7 ELDERLY PEOPLE

Priority has been given to the elderly because the over 65s comprise a growing proportion of the population. Elderly people are major users of health services, and this is particularly true of the very old, those aged 75 and over, whose numbers are also increasing. Currently the main aim of policy is to help elderly people remain in the community as long as possible. Hence the concern to increase the availability of services used by the elderly living at home: home helps, home nurses, meals on wheels and so on. As far as hospital services are concerned, the intention is to provide one-third of each district's geriatric beds in general hospitals, the balance being provided in community and other hospitals.

A consultative document, A Happier Old Age was published in 1978, setting out ideas on the way in which services might develop. Subsequently, a White Paper, Growing Older, was published in 1981. This stressed the need for statutory services to be complemented by support from families, friends and neighbours.

In 1982, the Health Advisory Service published a report on mental illness in old age, The Rising Tide, drawing attention in particular to the increasing incidence of dementia in the elderly population. The Rising Tide offered a checklist of questions for use by health authorities and local authorities in deciding how to develop specialised services in this field. Partly in response to the report, the Government launched a £6 million programme in 1983 to stimulate the development of comprehensive local services for the elderly mentally ill. 27 schemes were funded in the first phase of the programme.

An important recent development which affects statutory services for elderly people has been the growth of private old people's homes. Changes in supplementary benefit regulations have stimulated the development of these homes which provide an increasing number of places for elderly people. There has been concern that standards in some parts of the private sector may be inadequate and doubts about whether health authorities and local authorities have sufficient powers and resources to inspect homes and monitor performance.

FURTHER READING

A HAPPIER OLD AGE
DHSS, 1978.

GROWING OLDER
DHSS, 1981.
THE RISING TIDE
HAS, 1982.

8 MATERNITY AND CHILD CARE

These services have been given priority because of the growing concern with the high rate of perinatal, infant and childhood* mortality in this country. The Court Report, Fit for the Future, published in 1976, drew attention to the unacceptably high levels of death, illness and handicap occurring at the time of birth and in the pre-school years. The report made recommendations for an integrated child health service, and this has been accepted in principle by Government. The report of the House of Commons Social Services Committee on Perinatal and Neonatal Mortality published in 1980 reaffirmed the importance of tackling ill health and handicap among babies and children, a view reinforced in the Committee's follow-up report of 1984. Government policies include the need to develop special care for babies in hospitals and to reach particularly at-risk groups such as the children of working class families and ethnic minorities. Community health staff such as health visitors have an important role to play here, as have voluntary initiatives of various kinds. The need to prevent illness has been stressed by Government, and the importance of ensuring that services are used by the most vulnerable groups has been emphasised.

Of particular relevance in this respect is appropriate and timely ante-natal care. The Maternity Services Advisory Committee, set up after the Social Services Committee's report, published a guide to good practice in ante-natal care in 1982, and followed this with reports on care during childbirth, and post-natal and neonatal care. These reports have been commended to health authorities by the DHSS.

Perinatal mortality =	stillbirths and deaths in the first week of life
Infant mortality =	deaths in the first year of life
Childhood mortality =	deaths between 1 and 14 years

FURTHER READING

FIT FOR THE FUTURE
Report of the Committee on the Child Health Service, 1976, The Court Report.
PREVENTION IN THE CHILD HEALTH SERVICES
DHSS, 1980.
PERINATAL AND NEONATAL MORTALITY
Second Report from the Social Services Committee, Session 1979/80, HMSO, 1980, and Third Report, Session 1983/84, HMSO, 1984.
ANTE-NATAL CARE, CARE DURING CHILDBIRTH, CARE OF THE MOTHER AND BABY
Reports from the Maternity Services Advisory Committee, DHSS, 1982, 1984 and 1985.

9 INEQUALITY AND HEALTH

In 1980 a major report on Inequality and Health was published by DHSS. The report was prepared by the working group under the chairmanship of Sir Douglas Black. It noted the existence of inequalities in mortality and morbidity rates between social classes, with professional and managerial groups having a better health record at all stages during the life cycle than manual and unskilled groups. The report also drew attention to differences in the use of health services between social classes. Recommendations were made for reducing these differences including proposals to tackle poverty and poor housing, as well as suggestions for developing preventive, primary care and community health services.

FURTHER READING

INEQUALITIES IN HEALTH
Report of the Working Group (Black Report), DHSS, 1980.
INEQUALITIES IN HEALTH
P. Townsend and N. Davidson, A, (Penguin, 1982).

10 PRIVATE HEALTH CARE

The role of the private health care sector has become more important in recent years, and has received particular encouragement since the election of a Conservative Government in 1979. Four issues in particular have been the subject of investigation and debate. First, there has been some discussion of Alternative Methods of Financing the NHS. A working party comprising representatives of the DHSS, the Treasury and the Health Departments of Wales, Scotland and Northern Ireland has examined this issue and has studied health insurance schemes in a number of Western European countries. Although the working party's report was not published, the Secretary of State for Social Services announced in July 1982 that the Government had no plans to change the system of financing the NHS largely from taxation. This seems to imply that a health insurance scheme will not be introduced.

Second, apart from the debate about funding the NHS through insurance, there has been a considerable growth in subscriptions to the Provident Associations such as BUPA and Private Patients' Plan, and also a growth in Private Hospital provision. 4.2 million people or about 8% of the population are covered by the main provident associations. The biggest increase has been in group subscriptions, particularly those provided by companies as a fringe benefit. The rate of growth in subscriptions has, however, declined in recent years, and premiums have been increased because of the growing number and size of claims. Also, in some parts of the country it is feared that there may be a surplus of beds in the private sector, even though the overall number of private hospital beds comprises less than 10% of the total NHS bed stock. The unplanned growth of private hospitals has led the general manager of one of the largest private hospital groups to call on the Government to create a board to regulate and supervise a partnership between private medicine and the NHS.

Third, following a change in supplementary benefit regulations, there has been a growth in the private sector of Residential and Nursing Care. To date this has mainly affected elderly people but it also has implications for mentally ill people and mentally handicapped people. What has happened is that supplementary benefit offices have been helping to support people in private and voluntary residential and nursing homes. It has been estimated that this involves payments of around £100 million a year. The change in regulations means that the payments available to people being cared for in the private sector are much higher than before and it is this financial incentive which has led to the growth in provision. The DHSS has recently taken action to reduce these payments and this is likely to result in much slower growth in the private sector.

Fourth, a rather different issue concerns the attempt to privatise catering, domestic and laundry services currently provided directly by health authorities. In a circular published in 1983 health authorities were asked to test the cost effectiveness of these services by inviting tenders from their own staff and from outside contractors. DHAs were requested to submit a timetable for Competitive Tendering to enable all services to be tendered for by September 1986. This policy has caused some controversy and not all health authorities have shared the Government's enthusiasm for competitive tendering.

FURTHER READING

THE PUBLIC/PRIVATE MIX FOR HEALTH
G. McLachlan and A. Maynard (eds), (Nuffield Provincial Hospital Trust, 1982).

COMPETITIVE TENDERING IN THE PROVISION OF DOMESTIC, CATERING AND LAUNDRY SERVICES
Health Circular HC(83)18, DHSS.

FURTHER INFORMATION

Apart from the suggestions on earlier pages for further reading, more details and help on the policy areas summarised can be obtained from the following sources:

YOUR OWN CHC

Your own CHC will possess a wealth of information on both local and national policies and services. This will include government policy documents and circulars, local plans and papers, and information gathered during the course of surveys or campaigns. The files held by your CHC will therefore be a good starting point if you need more details of a particular policy.

KING'S FUND CENTRE LIBRARY

The core material of the library's collection is made up largely of government and other official reports dealing with planning and management aspects of health care provision related to the National Health Service (telephone: 01-267-6111) — 126 Albert Street, London NW1.

DHSS LIBRARY

This library has produced over 100 detailed bibliographies on health related topics, eg hospital staffing, day care of the mentally ill, and battered women. Each bibliography contains a comprehensive list of suggestions for further reading. Individual bibliographies or a complete list of topics covered can be obtained from: DHSS Library, Alexander Fleming House, Elephant and Castle, London SE1 6BY.

VOLUNTARY ORGANISATIONS

MIND (National Association for Mental Health)
22 Harley Street
LONDON W1N 2ED

Campaign for People with Mental Handicap
16 Fitzroy Square
LONDON W1

Age Concern (England)
Bernard Sunley House
60 Pitcairn Road
MITCHAM
Surrey CR4 3LL

National Association for the Welfare of Children in Hospital
Argyle House
29-31 Euston Road
LONDON NW1 2SD

Association for the Improvement of Maternity Services
40 Kingswood Avenue
LONDON NW6

The Patients' Association
18 Charing Cross Road
LONDON WC2H OHR

Royal Society for Mentally Handicapped Children and Adults (MENCAP)
117-123 Golden Lane
LONDON ECIY ORT

The Spastics Society
12 Park Crescent
LONDON W1N 4EQ

National Childbirth Trust
9 Queensborough Terrace
LONDON W2 3TB

FURTHER READING

Here is a list of books, reports and official publications which will enable you to find out more about the work of CHCs and the operation of the NHS:

1 THE ORGANISATION AND FINANCING OF THE NHS

HEALTH POLICY IN BRITAIN
Chris Ham, Macmillan 1985. Second Edition.
COMPENDIUM OF HEALTH STATISTICS
Office of Health Economics, 5th Edition, 1984.
HEALTH CARE AND ITS COSTS
DHSS, HMSO, 1983.
PATIENTS FIRST
DHSS, HMSO, 1979.
NHS MANAGEMENT INQUIRY REPORT
DHSS, 1983.
IMPLEMENTATION OF THE NHS MANAGEMENT INQUIRY REPORT
DHSS, Health Circular HC(84)13.
SHARING RESOURCES FOR HEALTH IN ENGLAND
Report of the Resource Allocation Working Party, HMSO, 1976.
THE HEALTH SERVICE IN ENGLAND ANNUAL REPORT 1984 AND 1985
DHSS, HMSO.

2 OFFICIAL INFORMATION ABOUT CHCs

These circulars and regulations will be useful if you want to check on the 'rules' about the work and position of CHCs.

THE COMMUNITY HEALTH COUNCILS REGULATIONS, 1985.
Statutory Instrument SI 1985 No.304. National Health Service, England and Wales.

COMMUNITY HEALTH COUNCILS
DHSS Health Circular HC(81)15
COMMUNITY HEALTH COUNCILS
DHSS Health Circular HC(85)11

3 OBSERVATIONS ON CHCs

These books and articles have been written by various researchers who have studied some CHCs.

THE PEOPLE'S VOICE IN THE NHS — CHCs AFTER FIVE YEARS
R. Levitt, King's Fund, 1980.
CHCs IN ACTION
Nuffield Provincial Hospitals Trust 1976, J. Hallas.
THE POLITICS OF CONSUMER REPRESENTATION
Centre for Studies in Social Policy 1976, R. Klein and J. Lewis.
ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE
Report — especially Chapter 11, HMSO, 1979.
COMMUNITY HEALTH COUNCILS: A REVIEW OF THEIR ROLE AND STRUCTURE
A. C. Hogg, ACHCEW, 1986.

4 EXAMPLES OF GOOD PRACTICE BY CHCs

These articles, all from CHC News, show some of the different ideas and activities CHCs are pursuing around the country.

A CASE STUDY IN CONSULTATION
March 1977, page 9.
CHC TAKES TO THE ROAD
September 1977, page 3.
PATIENTS' COMMITTEES ARE HERE TO STAY
July 1978, page 5.
CHECKLIST OF CHC's SURVEYS
April 1978, pages 9-10: May 1981, pages 10-11.
CHC BAKES A HEALTH CAKE
August 1977, page 1.
CHC AND REALISM
May 1979, page 5.
WHERE THE CLOUT REALLY IS
May 1979, page 5.
CONSULTATION OR .....
July 1979, page 5.
COMMUNITY HEALTH WORKERS IN HACKNEY
March 1980, page 13.
COMING AND GOING — A CHC SURVEY
November 1980, page 5.
WHEN A SURVEY BRINGS RESULTS
January 1981, page 12.
THE BIRTH OF A COMMUNITY PLAN
August/September 1981, page 5.

TESTING THE WATER
March 1982, page 6.
PLANNING WITH THE PEOPLE — OR DESPITE THEM?
April 1983, page 5.

CHC News ceased publication in 1984 but back issues should be available in the CHC office.

The following journals have current relevant items of news and information:

The Health Service Journal
Hospital and Health Services Review
NAHA News
Community Health News (published by ACHCEW)