GOOD PRACTICES

IN CHCS

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PREFACE

Community Health Councils (CHCs) were set up in 1974 "to represent the interest in the health service of the public" in each District. They keep under review the local operation of the NHS and make recommendations for the improvement of services.

There are 216 CHCs in England and Wales. Each one has its own interpretation of this very broad remit. This diversity reflects the variety of local circumstances, but it also reflects the fact that CHCs have tended to develop in isolation without necessarily learning from each other's experiences.

One of the tasks of the Association of Community Health Councils for England and Wales (ACHCEW) is to promote good practice amongst CHCs within this diversity. The purpose of this handbook is to draw attention to some of the initiatives taken by CHCs in the course of their work, so as to encourage CHCs to review their own practices in the light of innovations and ideas elsewhere.

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INTRODUCTION

The great strength of Community Health Councils is the diversity of the issues they have tackled and approaches they have adopted in pursuit of the central aim: to acheve better health services for their community.

Good practices are found in many different approaches by CHCs. They have in common a contribution towards public participation in the NHS and towards making the NHS more responsive to users. *'The Public and the NHS'* reviewed the work of CHCs since 1974. This report follows on by bringing together some of CHC experiences and examples of 'good practice'. It aims to stimulate new good practices and encourage CHCs to share ideas in order to learn more from each other. This is a first attempt and there are many further examples which have not yet been publicised. This document will need frequent review and updating.

This report is not meant to be read from cover to cover, but to be dipped into and used for refererence. The first four sections look at the ways some of the targets of CHCs are being tackled. The last section is devoted to the internal issues which can help or hinder the effectiveness of a CHC.

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PART 1: MONITORING AND ASSURING QUALITY

"It is the duty of each CHC to keep under review the operation of the health service in its district and make recommendations for the improvement of that service".

Statutory Instruments,1973,No 2217, para 19.

There are many sources of information by which CHCs can monitor and assess the effectiveness of services: ranging from complaints to public meetings. In this section information gathering activities are discussed.

1.1 CHC VISITING

NHS PREMISES

The CHC has a right to enter and inspect any premises, except staff residential accommodation, controlled by the District Health Authority (DHA). The CHC and DHA have to agree between them the arrangements for these visits. (If they are not able to agree, the Regional Health Authority will determine the arrangement for access). Guidance introduced in 1981 suggested that such arrangement should not interfere with the efficient running of the service and that the appropriate consultant and nursing officer should be informed beforehand of any proposed visit.

In general health service staff welcome the interest of the CHC, when they feel members are genuinely concerned about the welfare of patients and the good of the service.

The formality and amount of notice that a DHA requires from the CHC varies according to local arrangement. CHC members, who are free to visit informally and talk to patients without senior staff in attendance, find this valuable. However, such flexibility depends on the agreement of NHS managers and the CHC may have to allay the two main fears of the NHS staff: that members will upset the ward routine and so affect patient care; and that, if senior staff are not present to deal with questions and explain the situation, the CHC may make inaccurate reports public.

Some CHCs set up schedules of visits for members well in advance. This has the advantage of ensuring continuity and consistency. There may, however, be concern that everything is 'tidied up' for the visits. If senior staff are present, it may also be harder to talk informally with patients and more junior staff.

DHA members also make visits and it can be valuable to liaise with DHA member groups.

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INPROMPTU VISITS

In Nottingham there are no guided tours and members select a time and venue and notify the hospital. Members visit singly or in pairs and only meet senior management if there is a specific reason. CHC members are 'attached' to some units, for example, to wards in the mental illness unit or to a health centre.

In Central Manchester they have recently developed a drop-in visiting rota. The senior DHA officer contacted is noted on the report form and a copy of the report is sent to him/her and factual information is checked out before any action is taken on the report.

In Waltham Forest, the visiting team split up and visit different areas and meet up to discuss their findings with each other at the end of the visit.

VISITING IN SHIFTS

Nottingham and West Essex has worked a shift basis with members visiting throughout an 8 - 12 hours period. Initially this was met with suspicion, but later welcomed by staff,

REPORTING BACK TO THE DHA

North Tees has introduced a system of DHA liaison officers, who discuss the CHC observations soon after the visits. This has led to better visit reports.

VISITING OVER TIME

Hastings CHC have defined a detailed data base for each mental illness and mental handicap ward they visit. This enables them to check any changes and to keep abreast of discharges and to challenge whether policy and procedures have been properly followed.

Plymouth CHC has collated together all the reports from visits to a particular unit. This gives a perspective of changes and developments over time.

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FAMILY PRACTITIONERS' PREMISES

The premises of GPs, dentists, opthalmic practitioners and pharmacists can only be visited with the consent of the practitioner concerned. CHCs can ask to visit a practice, if they so wish. Such visits give the opportunity to talk to patients, receptionists and other staff as well as the GPs.

LOCAL AUTHORITIES

CHCs do not have a statutory right of access to local authority social services, though this has been arranged locally in many areas. Hastings CHC has an arrangement whereby they can visit certain social services establishments where there is a "health interest". This has given them the opportunity to follow up hospital patients in the community after discharge.

PRIVATE FACILITIES

With the move towards community care, the use of private homes by the NHS and local authorities for their ex-patients/clients is increasing.

CHCs do not have a statutory right of access to private hospitals or registered nursing homes. *"However,"* according to the DHSS *"..where NHS patients receive services under contractual arrangements, representatives of the private health sector have agreed that CHCs should have access to appropriate parts of the premises concerned."*

The right of CHCs to visit patients in private care funded by the NHS is now established. Many CHCs have negotiated informal visiting arrangements with private proprietors. In 1987, however, the North Western Region informed CHCs that such visits were outside their remit. No other RHA has issued this guidance to CHCs and the legal position of CHCs who disregard the guidance is not clear.

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OXFORDSHIRE: GUIDE TO NURSING HOMES

Oxfordshire and the Berkshire CHCs have published a 'Guide to Nursing and Old People's Homes' to help elderly people, their families and friends to assess the Home before making a choice.

Weston CHC have established an arrangement with the local association of propriaters to cover visiting in all homes in the area.

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MAKING THE MOST OF VISITING

Some hints on visiting are given below.

1. General visits are useful as an introduction for new members and to monitor policy and its implementation. The visit must have specific objectives and members be well briefed before they go. Visits need to be 'targetted' to particular areas - such as following a patient's route or looking at services where developments or changes are likely in the future.

2. Visits for monitoring should be frequent and regular in order to to maintain contacts and follow up issues. It is important where a closure is proposed to plan visits to ensure that an accurate picture is obtained.

3. Visits should reflect the whole day in the life of the ward. Rotas are needed to cover different times.

4. Visits need preparation in advance. Look up previous reports to follow up issues which arose earlier.

5. Checklists can be valuable. Remember that patients are people. A good test is: would you accept what is being done, if it were being done to you?

6. Large group visits are more disruptive to ward routine and make it more difficult to talk to staff and patients informally. It may be better for members to split up and visit different areas.

7. A clear record of the visit must be made and the findings discussed among the visiting team afterwards and specific recommendations made.

8. If you want to publicise the results of visits to the press, make sure that the unit manager has had a chance to comment. The CHC can only make informal impromptu visits, where there is trust from management. If this is broken, the CHC may be restricted to formal planned tours.

9. Be aware that staff may lobby the CHC for their particular interests.

Some CHCs have produced checklists for members to use when making visits. Two examples are given.

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VISITING: WHAT ARE WE LOOKING FOR?

EXAMPLE 1 (Adapted from South Birmingham)

"People as Patients: Would I like it, if it were being done to me?"

1. Immediate impact: physical appearance and conditions; atmosphere. Modify or confirm this immediate impression as you go around. Try to pinpoint what gives you this general impression? Shiny floors? Smiling faces?

2. Patient dignity and respect: What systems, environment guarantee that patients are treated as individuals with a need for respect and dignity? e.g. What information do they have about their condition? Who gives it to them ? What choice do they have in daily routine? What privacy do they get?

What facilities are there for disabled people- toilets, bathing, hoists, ramps etc?

3. Assessing the quality of staff: Experience, training, in-service training, communication (with patient) skills. Actual staffing levels - any difficulties providing adequate cover at night? holidays? sickness?

Case conference - when are they held? who attends them? How is it ensured that any special instructions for a patient are carried out?(i.e. diet and medicines).

4. Para-medical services: In general what services are available? How much time do para-medical staff spend on the ward? What is the frequency of service to any individual patient?

5. Approach to, and facilities for patients and visitors: What information is available ? How is it available? Do you get the impression that visitors are seen as important, and part of the 'whole patient' approach? Can visitors find their way round easily? Catering facililties for visitors and well as patients.

Other services - trolley shop, hairdresser, library services, newspapers etc. Access to disabled people as visitors and as patients?

6. Hospital/ community links: What links are there, and for what reasons, between hospital, GP, other community services, home transport arrangements for patients.

7. Waiting times and notice of appointments: How do patients find out about appointments? What notice is given? What are waiting facilities like? What kinds of booking systems are in operation? Do they have as much regard for the value of time of the patients as the doctor? Find out about patients' experiences by asking them.

8. Food: Choice, cleanliness, nutrition presentation, temperature, edibility and service, cultural and ethnic acceptability.

9. Problems: What do patients/ staff see as problems? Why? Explore possible solutions.

10 Safety and cleanliness for patients: 'Hospitals are dangerous places'. Physical cleanliness, temperature on wards, safety in bathrooms, cross infection, Smoking control policy.

EXAMPLE 2: LONG STAY UNITS
(adapted from Blackburn, Hyndburn & Ribble Valley CHC)

Admission Procedures
1. How are patients made to feel welcome?
2. Is there reasonable privacy for the admission procedure?
3. Is the new patient introduced to other patients?
4. Is the new patient shown around the ward and routine explained?

Daily Routine
1. May patients go to bed at a time of their choice?
2. May patients go and lie down when they fancy a nap?
3. At what time are patients woken in the morning and do they consider this time reasonable?
4. Subject to treatment considerations, may patients wash and dress when they like?
5. Is all clothing personal to the patient?

Food and Dining Arrangements
1. Is the menu for residents variable?
2. Do patients have genuine opportunity to choose from the menu?
3. May patients indicate how much food they want?
4. Are patients permitted to provide food to suit their own taste?
5. Is there a dining room or recognised dining area in the ward?
6. Are table settings homelike?
7. Is there food suitable to meet cultural requirements of people from different cultures and religions?

Noise
1. Are patients with transister radios asked to use an earpiece?
2. Is the volume of the ward radio or TV set kept down to a level acceptable to the patients?
3. Are staff mindful, when they are in the ward, that they are in a place which is, in effect, the patients home?

Washing, Bathing and Toileting
1. May patients decide for themselves when and whether to wash?
2. Are patients afforded due privacy for bodily functions, even when the ward is closed to visitors?

Religious Beliefs
1. What arrangements are made to cater for different denominatons and religions?
2. Are patients who wish able to attend church services?
3. If patients cannot go out, is there an attempt to bring church members in to them?

Relationships with Other Patients
1. Are patients encouraged or allowed to help other patients in however small a way?

Problems which require medical and nursing intervention
1. When specialist medical or nursing procedures become necessary, are these explained in advance to the patient, in understandable terms?
2. When patients are more frail or incontinent, are they helped to discuss with understanding staff their anxiety, insecurity and feeling of demoralisation?
3. Even when patients are quite helpless, do staff still respect their dignity and personality and avoid treating them as babies?

Some CHCs use a standard form for recording visits.

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VISIT REPORT
(Adapted from South Birmingham CHC)

Name of the Unit.....
Date of visit.....

Members on visit.....
.....
.....

Staff met (Names and positions)
.....
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.....
.....

Description of visit (e.g. parts of the unit visited, what patients and staff were doing, physical appearance of places visited)

What did you find out?
About the facilities available
About quality of treatment
About patients
About level of activities
About staff

COMMENTS AND FOLLOW UP

(NB the draft of this section needs to be discussed by members/ appropriate working party before being sent to the Unit.

What are members observations/ comments?
e.g. What impressed you? surprised you? alarmed you? Would like to know more about?

Are there any specific recommendations members would like to make?

Are there any matters which you would like to draw to the attention of the CHC?

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1.2 INFORMATION FROM HEALTH AUTHORITIES/FPCS

It is the duty of the health authority and Family Practitioner Committee (FPC) to provide the CHC with information which it may reasonably require. If the CHC is refused information, it can appeal to the Regional Health Authority or the Welsh Office in Wales.

CHCs can ask for information on a wide range of issues - from the Equal Opportunities Policy of the DHA to clinical practices. Districts vary in what they consider a CHC may 'reasonably require' so it is always worth asking. Even where the information is refused, asking the question may provoke information from other sources.

NHS staff can be an important source of information about what is happening and alert the CHC to areas of concern. It is also important that the CHC protects its sources where information has been given in confidence.

The Korner Committee has recommended ways that health authorities should collect and use information. In principle it might be possible to establish a modem link with District Health Authorities' information systems. There are many problems of security, cost and computing expertise to be resolved. However, performance indicators are available from the health authority and can provide interesting comparative information about district services.The Annual Statistics (based on SH3 returns) and the Summary of Annual costs produced by the Regional Health Authority can also provide useful comparative information.

1.3 CONSUMER SURVEYS

Recognition of the importance of consumer feedback in the NHS has been growing. Consumer satisfaction with services is a criterion on which the effectiveness of general managers is judged.

DHAs are undertaking more consumer surveys and this is welcome. However, CHCs have a distinct role which cannot be replaced by DHA surveys. CHCs may be in a better position to look at unmet needs and issues as they relate to users - which may not be of great priority for NHS managers, who have to take account of possible resource implications. The CHC is also in a position to put pressure on the health authority to take action on any results. If a DHA does not wish to act on the results of a survey it has commissioned, it may play it down.

There are obvious advantages of collaboration between CHCs and DHAs in consumer surveys. The CHC has the independence and an awareness of the issues. The DHA has the resources and the ability to act on the results.

The quality of CHC research will need to be of increasingly high standard, if CHCs are to retain a role in undertaking consumer surveys. The following points need to be considered before embarking on a major survey.

1. Ask why the survey is being done

Is a survey the best way of getting the information required? Consumer surveys are expensive in staff time and resources. Are there other ways to get this information which would be equally effective?

2. Define the problem and the information required

The more specific the brief, the more useful will be the information in practical terms. General questions which attempt to assess patient satisfaction or dissatisfaction are not useful as a basis for planning change.

3. Involve the service providers

The more commitment or involvement from people providing the services - NHS, local authority or voluntary organizations- the higher the chance that they will accept the recommendations and change will result.

Without co-operation from the relevant consultants, it may not be possible to gain access to the names of patients and ex-patients.

If administrators and professional staff are consulted in advance on the questionnaire and the methodology, there is less chance of their disputing the results on those grounds later.

4. Plan the survey

It is important in planning the survey to involve someone with experience of consumer surveys in working out the best methodology, including sampling and statistical analysis. Universities or Colleges of Further Education may be able to help. It is also useful to find out how other CHCs and health authorities have approached the topic. ACHCEW keeps information on surveys undertaken by CHCs.

In planning, the following points need considering:

* Is follow up planned to see if any changes occur, for example, six months after the first survey? This can be useful in surveys on clinic organization and in-patient routine to see if improvements are working and to put further pressure on the NHS administration to improve arrangements, if necessary.

* Are the results to be compared either between units in the district or nationally? If comparisons with other districts are wanted, it will be necessary to replicate a survey carried out elsehere. The Kings Fund (on outpatients) and the University of Manchester Institute of Technology (UMIST on in-patient care) have produced standard questionnaires. ACHCEW may be able to advise on this.

* How will the results be analysed? Depending on the complexity of the data, a computer may be helpful in analysing the results. Some CHCs have used local colleges or the DHA information office to undertake this. This requires expert advice.

* Self-completion is easier than interviews, but the results may be biased. Are there ways to compensate for this? Self-completion may give a biased result if you are looking at access and the use made of services. It may matter less if you are looking at the needs of a particular client group, such as people who are hard of hearing or families of mentally handicapped children, or people from ethnic minorities.

5. Define the resources required

Work out the amount of staff time and resources required at each stage of the survey. It is easy to underestimate the support interviewers may need and the time that analysis and report writing takes. Publication and print costs also need to be considered. Can the DHA or FPC provide any resources in cash or kind?

6. Prepare and test the questionnaire

After the information needed has been clearly identified, only then convert these points into questions. Each question should relate to a particular piece of information required.

Pilot the questionnaire among many different people. This will show which questions may:

* be misunderstood and ambiguous. It is important that questions are as specific and factual as possible.

* not produce useful information or give so much diverse information, that it cannot be used.

* suggest an answer which would bias the results.

It will show how long each form takes to complete and analyse. The more questions and more open-ended ones, the more time is required for each interview and to analyse the results If possible, make it shorter.

Once you have revised the questionnaire, try it out again.

7. Recruiting and training interviewers

Where will the interviewers come from? Wherever they come from, they will need training, support and supervision. At an early stage plans for training and support need to be made. Interviewing is a skill and requires discipline. Interviewers will also be seen as representatives of the CHC and it is important that they present the right image.

8. Analysis and report writing

The target audience may determine how you write up the report. Conclusions must be clearly based on the information in the survey and accessible to the reader. Include the technical details for those interested, but do not let them dominate so other readers are lost.Using direct quotations or case studies, backed up with statistics, can make the case for change very effectively.

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MANCHESTER: ACCIDENT AND EMERGENCY SURVEY

CHCs in the North West Region worked in collaboration with UMIST to study Accident and Emergency Services. The CHCs pooled their funding to employ a researcher.

SUNDERLAND AND NORTHUMBERLAND: NON-EMERGENCY AMBULANCE TRANSPORT

In 1985 Sunderland CHC undertook a survey of ambulance services for outpatients. later that year Northumberland CHC undertook a similar survey. This meant that any of the results could be compared not only with the national standard performance levels (known as ORCON standards), but also with a neighbouring area.

Northumberland CHC looked at the ambulance service for outpatients to Hexham Hospital. They were particularly concerned about punctuality for appointments, waiting times after the appointment, time spent in the ambulance as well as the use of escorts, cars and taxis and booking arrangements.

Following the pilot, a briefing meeting was held for interviewers, hospital and ambulance staff. All patients attending outpatients were surveyed over a two week period. The questionnaire was in two parts: Part 1 was completed by the interviewer with the patient and Part II patients were asked to complete at home and return.

OUTPATIENT SURVEY:

West Surrey and North East Hampshire CHC undertook a survey of opthalmology outpatient clinics at two hospitals in 1986. The survey was based on the King's Fund model questionnaire.

Questionnaires were given out to all patients attending the clinics in one week with a stamped addressed envelope. It was noted that people who took the form home to complete were far more critical than those who completed the form at the clinic and returned it to the researcher.

As a result of the recommendations, the DHA reviewed the way appointments are booked in order to decrease waiting times. An informal follow up is planned.

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1.4 TESTING PUBLIC OPINION

Not all surveys need to be elaborate. The 'dipstick' survey can give evidence of problems. Such surveys need careful preparation to ensure that the sample is representative and will provide a fair picture.

If the CHC holds a large mailing list of key groups and individuals on a computer, it can be easy to carry out a quick test of local opinion. It keeps the CHC in touch with a wide range of people and widens the number of people involved in the CHC. Such surveys can provide indications of areas needing further work.

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WEST BIRMINGHAM: PANEL OF THE PUBLIC

West Birmingham CHC have established a Panel to assess informed (but disinterested) public opinion. It set out to recruit a group of people, orginally 200 in number but subsequently increased to 250, which reflects the population of the district in terms of geographical area, age, sex and membership of minority groups. The Panel is updated every two years.

The CHC sends panel members policy papers to be considered at each CHC meeting and also sends out questionnaires on topics on which the CHC wishes to assess public opinion. Members of the public become more aware of health service issues and the CHC can assess public response. If it is accepted that the panel can only indicate areas for further and more scientific work, it can be a very cheap way of assessing public opinion and of increasing public awareness of helath issues within the district.

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1.5 ASSESSING QUALITY

Performance Indicators are providing increasingly sophisticated means of measuring and defining various aspects of health and social care. However, they are mainly quantitative and other means must be found to obtain information about the quality of the services provided.

CHCs have developed various ways of doing this. The objective is to identify and reflect experiences and insights of users rather than establishing statistical significance. For example, small user group discussions can also give useful feedback. In general a different viewpoint emerges when users discuss their experiences rather than giving their views as individuals.

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WORKERS AND USERS WORKSHOPS: BRENT

Brent Community Health Council undertook a series of workshops in 1985, bringing together workers and users to focus on what each thought and felt about the services. Four workshops were held on Pensioners' Health, Child Health, Womens' Health and Environmental and Occupational Health. Reports of these enquiries were produced.

WHAT IT IS LIKE TO BE A PSYCHIATRIC PATIENT

Central Manchester CHC used a team of four people to carry out open ended interviews with psychiatric patients, allowing them to speak for themselves about the services they were receiving. These were then incorporated into a small book: 'Coming from Me'.

SURVEY OF CARERS

In 1986 Waltham Forest CHC undertook a survey of carers. They wanted to find out the services carers wanted to help them in their task.

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1.6 GENERAL SURVEYS

CHCs can also undertake or commission reports to look at national issues as they affect the health of their community, which can provide a basis for further action and development.

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UNEMPLOYMENT AND HEALTH IN TYNESIDE

In 1981 North Tyneside CHC commissioned a report on the health implications of unemployment - *Unemployment and Health*. The CHC was aware of the lack of information, both nationally and locally on what effect unemployment was having on people.

The report pointed to a complex pattern of factors. The principal result of unemployment is identified as stress, and this triggers-off a sequence of events which is ultimately seen in increased levels of ill-health and death rates. Certain areas of North Tyneside were highlighted as particularly disadvantaged. The report recommended that the Inner Areas Partnership Programme should develop particular programmes to tackle the problems of inequality and health in North Tyneside.

INEQUALITIES IN HEALTH: SPITALFIELDS AND GREENWICH

The Black Report in 1980 showed the inequalities in health between people from different social classes and the impact of social, economic and environmental factors on health. Two neighbourhood health surveys have recently been done in London: one in Greenwich and one in Spitalfields. Though the two surveys looked at the issue of inequalities in health from different angles, the conclusions of both are similar.

Both surveys showed that local residents saw their health as related to the social and environmental conditions in which they live. They both also revealed inequalities in access to health services for residents from ethnic minorities, who had particular language and cultural barriers which needed to be overcome. Both suggested the need to help people to develop the necessary skills to use the services more effectively and to exercise their rights to them.

The Spitalfields Health Survey aimed to discover what people living in Spitalfields thought about health related issues. It was hoped to use this information in planning and determining health education policy. The survey was undertaken by the Tower Hamlets Department of Community Medicine, with funds from the Spitalfields Local Committee and the Tower Hamlets CHC in 1983.

Greenwich CHC looked at the health of local people in Glyndon ward, which is in a particularly poor and deprived area. The aim of the project was to examine the health of people living there and to help them to improve their own health. It was funded by the local authority and carried out in 1984.

BLACK PEOPLE AND THE HEALTH SERVICE: BRENT

Low incomes, bad housing and hazardous working conditions all mean bad health. Black people face some of the worst housing and working conditions in Britain, as well as the constant stress of racism.

Black People and the Health Service was published by Brent CHC in 1981. It looked at black people's experiences of the NHS. The report challenged the view that black culture is to blame for black people's ill-health. It showed how dominant ideas about black pain thresholds, 'neurosis', family structure and child rearing practices are incorporated into the everyday practice of the health service, re-inforcing and perpetuating racism.

Although the report came out of black people's experiences in Brent, it is also about policies and practices throughout Britain.

BEREAVEMENT SERVICES

In 1986 South Birmingham CHC received funds from the King's Fund to carry out research into how hospitals deal with bereavement. The survey looks at current procedures in health authorities and follows up any good or innovative practices.

Out of this survey, it is intended to produce a Code of Practice which can be used as a basis for campaigning for improvements locally.

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1.6 PROMOTING CHANGE

When the CHC has established what it wants to achieve, how does it influence the NHS decision makers?
First of all the normal channels - the Planning Teams, the DHA, RHA and the FPC- must be used. If these achieve nothing, the CHC may wish to launch a campaign.
There are many ways of campaigning. However, the following points, derived from the experiences of CHCs, may be helpful.

* Campaign with an identifiable and achievable aim, which has a recognised time-scale from the start. Otherwise it is difficult to maintain the momentum and public interest.
* Use a good strong slogan, along with well produced and widely distributed publicity materials
* Identify a target person for letters and petitions - This could be the Chair of the DHA, RHA or whoever is most appropriate. All letters and petitions from the public should be directed to the target person.
* Encourage members of the public to write to the target person, directly or via the CHC office. You can then establish a mailing list which can be used to ginger-up the campaign.
* Identify service providers who support your campaign and see what co-operation is possible.
* Gain the support of local MPs, as well as DHA and FPC members.
* Gain the support of the local authority and of local professional committees

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LIVERPOOL : HEALTH CARE FOR WOMEN

In December 1983 Duchess Ward in the Women's Hospital in Liverpool, which had 21 gynaecology beds, was 'temporarily' closed. Liverpool Health Authority granted a 6 month consultation period. In conjunction with the CHC, the Women's Hospital Support Group began to campaign, using mass letters, petitions and some spectacular demonstrations. In one, 400 women dressed in white, representing the women on the waiting list, marched through the town. The 'temporary' closure was extended for a further 6 months in July and January 1984. In April 1985 the DHA Chair and General Manager made it clear that they did not feel that there was sufficient 'evidence' that Duchess Ward needed to be re-opened.
Up until then the Support Group had fought the issue on the terms of the Health Authority - arguing about waiting lists, turnover intervals and throughput. They decided to change their tactics and give DHA members examples of the realities of women's lives behind the statistics. For example, a woman with a positive result from a cervical smear was waiting three months before diagnostic treatment began; a woman requiring tubal surgery for infertility was waiting for over 18 months. The effect was dramatic. In July 1985, the DHA agreed to open the Duchess Ward as a ten bed day ward.
The Campaign did not achieve its full objectives but did manage to save a vitally needed service. It also mobilised women and raised people's awareness of the state of the health services in Liverpool.

NORWICH WELL WOMAN CLINIC

Norwich CHC first put forward proposals for a well woman clinic in April 1982 in the city centre. There was tremendous public support for the proposal. Between 1981 and and 1985, the CHC received well over 1400 letters and numerous phone calls in support of their proposal. A survey was undertaken through the Norfolk Association of Womens Institutes. 78% were in favour of the establishment of a separate service, stating embarrassment and the desire not to waste their doctor's time as the main reasons for supporting the proposals. A further survey was also undertaken by the Well Woman Clinic Campaign Group.
However, there was a division of opinion between some professional groups and the users about how appropriate a such a service was. So the CHC undertook a nation-wide survey of all health authorities in England, Scotland and Wales to find out how services elsewhere were run.
As a result of this information, the CHC modified their original proposals, sacrificing the proposal for the appointment of a development worker. A one year pilot scheme was set up in 1985 and plans for well woman clinics for each part of the District have been made.

PART 2: ASSISTING THE PUBLIC

> *"It is part of a CHC's role not only to tell people how to complain about services but to contribute ideas for the development of services. To do this they need to inform the public about the availability of local services and propose changes and developments in them",*
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> Royal Commission on the National Health Service, para 11.8, 1979.

Access to information gives the basis for choice for people to participate in their own health care, as well as the basis for public participation in both planning and monitoring health services.

The CHC has an important role in providing people with information and also in raising expectations of users, in order to improve standards iin the health service.

2.1 INFORMATION ON SERVICES

Leaflets and guides can demonstrate the relevance of the CHC to local people and health staff. They can also mean that CHC staff need to spend less time with enquirers as information most commonly requested is available in leaflets.

However, it is the responsibility of the NHS to provide information to enable better use of local services and many DHAs are now producing their own guides and leaflets. Where health authorities and FPCs are doing this, the CHC can concentrate on more specialist and innovative information and advice.

A number of CHCs have joined with health authorities, FPCs, local authorities and voluntary organizations to produce information leaflets and handbooks. The production and updating are sometimes funded in whole or in part by the health authority or the FPC, often through joint financing or funding.

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SELF HELP HEALTH DIRECTORY: SOUTH BIRMINGHAM

In 1984 South Birmingham CHC put together a directory of local self help health groups. Information was collected through a questionnaire and the results compared to national listings of self help groups and through national organizations making contacts with local groups or contacts.

LEAFLETS IN DIFFERENT LANGUAGES

Many CHCs have produced leaflets in different languages. The Manchester CHCs have produced leaflets in Mandarin Chinese and Urdu.

In 1986 North Tees CHC produced an Ethnic Minority Project Handbook. This is a multilingual booklet, *Your Health Service*, which puts translations in Chinese and Urdu alongside the information in English. It was undertaken by MSC workers.

HEALTH LEAFLETS: LIVERPOOL

Liverpool CHC collaborated with a local GP to produce a set of 30 health information leaflets, covering many different common conditions and problems from acne, colds, catarrh and runny noses to the menopause. The leaflets won first prize in Pulse Magazine competition in 1985.

CERVICAL CYTOLOGY PUBLICITY: SUFFOLK

In April 1985 East Suffolk CHC asked the Family Pracititioner Committee to publicise the cervical cytology call and recall system more widely. Following this, a working group was set up between the FPC, DHA and CHC who produced, funded and distributed 100,000 copies of a leaflet locally.

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' leaflet has been circulated to all GPs to encourage them to produce (or perhaps in some cases modify) their own leaflets.

TAKE-UP OF EXEMPTION OF PRESCRIPTION CHARGES

In 1987 North Tyneside CHC co-operated with the FPC to run a campaign to increase the uptake of exemption from prescription charges. Two main areas identified for action were: providing information on where people can get advice on how to apply under the low income provisions; and providing sixteen year olds with information on their entitlement to exemption from prescription charges, cost of dental care etc.

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2.2 ENQUIRIES FROM THE PUBLIC

Two issues need to be considered in planning how the CHC should deal with enquiries from members of the public: staff security and the volume of enquiries. Where a CHC is located in a high street, both may need particular attention.

* **Staff security:**

In most CHC offices, there is often only one or two staff in the office and this can introduce security and safety problems. In Camberwell CHC a sophisticated burglar alarm system has been fitted by the RHA. This has a panic button for an emergency. This alerts a central monitoring station, which contacts the police. The panic button is behind a counter and only people known to the CHC are allowed past.

The DHA or RHA may run sessions for staff in dealing with violent behaviour, which is an increasing problem in Accident and Emergency Departments. CHC staff may wish to undertake training where violence is a problem.

*** Workload**

Dealing with public enquiries is time consuming and many of the enquiries are not directly related to the NHS or health. CHCs who have moved from less accessible offices to a central location, estimate that the number of callers increases by three times. It will certainly distract from other work the CHC can do.

Many of the enquiries received by the CHC are about problems which are causing distress. This might be the length of time for an outpatient appointment - in that case the CHC might be able to suggest a neighbouring hospital where the waiting time is shorter. It might be about lost medical records or services which can be arranged in the community for someone leaving hospital.

It is important that staff are given training and support in information and advice work, which involves specialist skills. Problems should be solved with the enquirers not for them. The aim is to help people to make the most of the services for themselves and not to come to depend on an outside body, like the CHC. In Manchester CHC staff have attended counselling courses to enable them to help enquirers more effectively.

Many CHCs with High Street premises have restricted opening hours to the public, as do Citizens Advice Bureaux.

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LIMITED OPENING HOURS

Central and Southern Liverpool CHC give callers who have a complaint or enquiry that needs time to resolve a form to fill in. The form asks for details of the problem and the caller is asked to fill it in in the office or return it by mail. The office then follow it up. They find this enables staff to control their time, instead of having to deal, without notice, with problems which may take 1 - 2 hours. The CHC also closes the office to the public every afternoon and uses the telephone answering machine from 12.30 to 4.30pm. This reduced access for the public by 50%, but the number of contacts made with the CHC by the public reduced by only 11%.

CHC SURGERIES IN THE COMMUNITY

There are many ways that CHCs can reach a wider community - whether or not they are centrally situated. They can, for example, run mobile 'surgeries' in different parts of the district or run sessions at a desk in the foyer of a hospital. Barnet CHC members have held sessions in a large mental illness hospital, Napsbury in Hertfordshire.

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RECORDING ENQUIRIES

CHCs vary in the way they record enquiries and the purposes to which these records are kept. They may be kept primarily to illustrate the main concerns of the public or to show how busy the CHC office is.

It is worth considering how the information is now being used and how it might be used if additional or different information was collected.

2.3 THE ROLE OF THE CHC IN COMPLAINTS

"Since no procedure is likely to be known or immediately understandable to all who might have cause to use it, there is a good case for making the CHCs' role in complaints procedures a more active one".

Royal Commission on the NHS, 1979, 11.25

"Other sources of help are available to people who wish to pursue a complaint - personal friends, the complainant's Member of Parliament or local Councillor, Citizens' Advice Bureaux. Ministers do not therefore propose that CHCs should extend their role formally to providing an individual service to complainants, for instance, by writing to health authorities on their behalf or acting as 'Patient's friend' at an inquiry".

Community Health Councils in England: Consultative Paper on their Role and Membership, DHSS, 1981

The role of the CHC in receiving complaints is:

* to assist and support the complainant. Given the complexity and size of the NHS it is important that complainants are helped to resolve the difficulties and obtain redress, if appropriate.

* to endeavour to secure changes in procedures as a result of certain complaints.

Complaints can provide the CHC with useful indicators of areas needing investigation. However, their main importance is as an individual service to complainants. CHCs vary in the amount of help they give complainants.

Based on the experience of CHCs, the following points need to be considered in dealing with complaints.

1. Find out what the complaint is, and what the complainant hopes to get out of it.

Some complainants want information to find out what happened to them or their relative. Others may want compensation. Most are also concerned to improve services so that other people do not have the same problems. In a few cases, complainants may just want their complaint on record and to make sure someone knows about it and will follow it up. The formal complaints procedures, with the apparently inevitable defence and counter-attack, may be an unnecessary ordeal for someone already in distress.

Some complainants welcome a meeting with the staff members concerned to discuss the complaint. Where a meeting is useful, the presence of CHC representative can give support and ensure that complainants ask the questions that concern them and that they understand, though not necessarily accept, the replies.

2. Assess the amount and type of help each complainant needs.

Each complainant needs a different type and level of help. Some CHCs explain the procedures and assist in writing letters and ask that copies of all correspondence between the health service and the complainant are sent to the CHC while the replies are sent directly to the complainant.

Other CHCs write letters on behalf of complainants to the health service. Where this is the practice, it is important that the CHC is not left in the role of complainant, when the CHC cannot verify the complaint for

accuracy or truth. It is also important that NHS staff do not respond to the CHC staff rather than the individual complainant. They may make personal remarks in writing about the behaviour or mental stability of the complainant which can be seen as an attempt to make the CHC 'side' with the NHS.

3. Advice must be informed.

Many complaints involve clinical judgements. While most CHC staff may be experts in understanding the system, they do not necessarily have the expertise to question the validity or otherwise of the clinical comments - except for interpretation, obvious omission or refusal to answer.

While CHC staff cannot normally assess clinical aspects of a complaint, they should have access to basic medical reference information. For example, the Merck Manual, provides guidance to GPs on possible complications of apparently minor symptoms and can provide useful background information.

Where legal action may be possible, the CHC can help in advising complainants on the procedures, assist them to get more information in order to know if there is any chance of compensation and refer to specialist legal advice. It is important that complainants obtain legal advice from a lawyer experienced in medical negligence cases. Action for the Victims of Medical Accidents (AVMA) maintains a register ofsolicitors and will advise. AVMA also monitor on a regular basis the cases they refer to solicitors in order to ensure that the case is properly handled.

4. Complaints are confidential.

CHC staff are usually the main point of contact with the complainant and confidentiality must be rigorously respected. Information about complaints should not be circulated to members, without the specific permission of the complainant, unless the names and all identifying facts have been erased.

2.4 COMPLAINTS AGAINST DISTRICT HEALTH AUTHORITIES

The major problems for complainants against health authorities is the lack of independence in the investigation of complaints and the length of time that investigation takes.

Under the Hospital Complaints Procedures Act 1985, all health authorities must have an agreed complaints procedure and ensure that patients are informed about it. DHAs must identify senior officers who will be responsible for processing complaints within the DHA.

Though CHCs are not mentioned in the Act, it provides an opportunity for CHCs to establish their role as patients friend with the DHA. CHCs and DHAs should agree a procedure about complaints.

The following points might be included in an agreed complaints procedure.

1. Details of the procedure for making a complaint should be widely available and include reference to the CHC. People need this information at the point of contact with the health service. Such information should be included in all hospital information booklets and on noticeboards.

2. All written complaints should receive an acknowledgement immediately which explains the procedures and likely timetable for the response. Complainants should be informed about the service of the CHC, with address, phone number and contact name.

3. Where the CHC is in touch with the complainant, copies of all correspondence from the health authority to the complainant should be copied to the CHC Secretary.

4. All complainants should be offered an informal meeting with the appropriate staff and be accompanied by a friend and/or CHC staff, if they so wish. This should be without prejudice to any further action the complainant may wish to take.

5. All complainants should receive a final reply within 6 weeks of the complaint being registered. This reply should include:

- Results of the investigation
- Any proposed changes resulting from the complaint
- Further recourse available to the complainant (e.g. Health Service Commissioner, Clinical Review).

6. The DHA should circulate a quarterly schedule of all formal complaints received and a review of the stage in the procedure each complaint under investigation has reached, including those awaiting legal proceedings.

2.5 COMPLAINTS AGAINST FAMILY PRACTITIONERS

FPCs can only investigate complaints on the grounds that the practitioner has failed to comply with his/her terms of service. In making complaints against family practitioners, it is important to check the terms and conditions of service to see which items may have been breached. This not only means the FPC may take the complaint more seriously, but in the event of future legal action, means that the issues have been clarified.

Some FPCs have an informal system for investigating complaints, which may be preferred by some complainants. The formal procedures are complex and at formal hearings it often seems that complainants are on 'trial' themselves. They may be treated as the defendent not a witness.

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COVENTRY: INFORMAL PROCEDURES

Coventry FPC has introduced a informal procedure for medical complaints. The complainant, assisted by the CHC Secretary meets informally with the practitioner against whom the complaint is made to ask the questions and make the points that have caused concern. The meetings are without prejudice to the right of the complainant to go through the formal procedures.

NORTH TYNESIDE: CHC OBSERVER AT SERVICE COMMITTEES

North Tyneside FPC gives the CHC the opportunity to send an observer to a Service Committee hearing. Complainants are also entitled to bring along a friend or colleague, who may be the CHC Secretary, to assist them in the presentation of their case.

MANCHESTER: DOCTOR/ PATIENT LIAISON

The FPC refers patients to the CHC office when they have particular problems in securing or keeping a GP. The CHC role is a mixture of advice, advocacy and counselling.

However, it is felt that more emphasis needs to be placed on informing doctors of the existence of the scheme and encouraging them to co-operate through the FPC, if it is to be a true partnership. Efforts are also being made to persuade the FPC to refer patients before they are struck off the GPs list.

2.6 ADVOCACY

> *"If CHCs are to develop their role as patients' friends, we suggest experiments with 'patient advocates', on the lines of those in the USA. The advocate's function would be to take up problems as they arose with the person or department responsible quickly and informally. He or she would be based at a hospital or health centre, and would be a paid employee, part-time or full-time, of the CHC".*
>
> Royal Commission on the NHS, 1979, 11.26

Advocacy is a logical extension of providing information, advice and acting as the 'Patient's Friend'. Advocates represent the interests of someone else as if it were their own. They represent people who find it difficult to express their own needs and to obtain access to the services they need. This may be because they are mentally handicapped, have language difficulties or are socially or culturally disadvantaged.

Advocates must be independent from the service provider. Schemes need to be based outside the health service, either in a CHC or a voluntary group. This means the advocate is not a part of the hierarchy being questioned and can be given independent support in pursuing issues on behalf of the patients.

There are three main types of advocacy scheme:

* **Self- advocacy**: whereby someone is helped to speak for themselves and given training in assertiveness - mainly people with learning difficulties or inexperienced in speaking for themselves.

* **Citizen Advocacy:** whereby the advocate works in partnership with the person, to help to ensure s/he receives necessary services and to give practical help. Advocates in schemes for people with a mental handicap or mental illness, are generally volunteers.

* **Legal advice and advocacy,** whereby legal advice and representation are given.

EXAMPLES OF ADVOCACY SCHEMES

Most advocacy schemes work with people from ethnic minorities or people with mental illness or handicap. Some schemes are described below.

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Ethnic Minorities

HEALTH ADVOCACY FOR NON ENGLISH SPEAKING WOMEN

In 1979 City and Hackney CHC were concerned about the way antenatal care was being delivered, in particular to non-English speaking women. Many had difficulty in communicating their problems and finding their way through the system.

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

* to improve access to health services,

* to help women understand the choices open to them so that they can make informed decisions

* To advise the Health Authority on policy and practice with regard to the needs of non-English speaking women

* to help and encourage NHS staff to provide a service to them.

The project employs 6 workers, who between them are native speakers of Turkish, Gujerati, Bengali and Punjabi. They do not only translate but 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; and 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 antenatal 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 non attendance at antenatal clinics.

HEALTH LINK WORKERS: HARINGEY

Health link workers project in Haringey was set up by the CHC in 1984 to help women from ethnic minorities who were having babies in Haringey. Languages covered by the Link workers include: Greek Turkish, Bengali, Gujerati, Hindi, Urdu and Cantonese. A West Indian Link worker has also helped West Indian women who may feel that the maternity services do not relate well to them.

Link workers meet pregnant women at their first ante-natal appointment, offer their help during pregnancy and childbirth and attend interviews with doctors and midwives when women wish it. Link workers have helped clients of community midwives, health visitors, and have also been involved with problems which arise during pregnancy and childbirth with benefits, housing and immigration.

The project expanded in 1985 to provide a 9 - 5 service for the whole of Haringey, including community clinics, families with mentally handicapped children and adults and elderly people admitted to hospital. There are also frequent requests from the Accident and Emergency Department.

The project is funded through the MSC Community Programme. There are 20 establishment posts for part time Link Workers and a full time Co-ordinator and Supervisor. There have been difficulties in recruitment and turnover. MSC regulations about the length of period of unemployment and the need to be in receipt of benefit has meant that there have been difficulties for the project in recruitment and the annual turnover of staff.

People with mental illness or handicap

CITIZEN ADVOCACY IN HEREFORD AND WORCESTER

In 1986 a citizen advocacy scheme was set up in Worcester and Hereford with funding for three years from the DHSS Opportunities for Volunteering Scheme. The Kidderminster and District CHC worked jointly with Project DIS-CO (a resettlement project for patients from two mental handicap hospitals in the district). The initial idea was to provide this service for people leaving hospital through Project DIS-CO, but they intend to extend the service to include people already living in the community and those still in hospital.

Volunteer advocates are recruited and given training and support. Volunteers are matched with each mentally handicapped person. They develop longterm relationships, both befriending them and representing their interests, for example, in helping them claim appropriate benefits. Mental handicap services are undergoing dramatic changes and resettlement exposes people to new situations and stresses. The advocacy service will assist in the actual process of resettlement.

SELF ADVOCACY FOR PEOPLE WITH LEARNING DIFFICULTIES

West Lambeth CHC has been involved in setting up a small scale scheme for self-advocacy for people with learning disabilities.

This involves a 2 hour assertiveness training session on a weekly basis. It is funded by the National Bureau for Handicapped Students.

SPRINGFIELD: ADVICE AND LEGAL REPRESENTATION PROJECT

This project was initiated by three law centres in Wandsworth and the Wandsworth CHC. It opened in 1982 with three staff: a solicitor and two advice workers.

It provides independent, confidential and free advice to patients in Springfield Hospital, a large psychiatric hospital with 900 patients. The advice given is wide ranging and generally reflects the areas of work undertaken in a high street law centre - with the additional complications and difficulties which arise because of the clients status as a psychiatric patient. Advice and casework include, rent arrears and housing problems, divorce and custody and adoption problems.

Under the Code of Practice agreed with the Health Authority, Project staff are not allowed to become involved in complaints or litigation against the hospital. All such inquiries are referred to the CHC or MIND. A Health Authority representative attends the management committee as a co-opted member. The Health Authority is not involved in hiring or firing staff. The project also gives training in mental health law and welfare rights to staff.

CITIZENS ADVICE BUREAUX IN MENTAL HOSPITALS

Middlewood Hospital in Sheffield was the first psychiatric hospital to have its own CAB in 1976. Since then CABx have been set up in Tooting Bec, and Prestwich, Manchester.

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SETTING UP ADVOCACY SCHEMES

1. Define the terms of reference and the purpose of the scheme.

There are different approaches and philosophies among advocacy schemes.

The Advocacy Project set up by City and Hackney CHC has taken the most radical approach. The principles of the scheme in Hackney are based on the experiences of community health projects in developing countries.

These are:

1. the project is accountable to the community.

2. work is carried out on the basis of shared knowledge, rather than professional mystique.

3. workers are selected for their commitment and concern for social justice and not for their formal qualifications.

4. workers share as many of the same characteristics as possible with the people with whom they work.

5. workers' training is flexible, informal and designed to meet specific needs of the community and the situation in which they are working.

6. workers offer a practical service.

2. Negotiate with service providers

It may be difficult to persuade service providers of the need for a scheme or that such a scheme must be separate from the NHS hierarchy. The value of interpreters or community workers may be acknowledged, but not necessarily the need for advocates.

The results of the negotiation with the service providers will determine the *options open for detailed planning.*

3. Undertake detailed planning

* method of referral/identifying 'beneficiaries'. For example, mental illness or mental handicap schemes may be particularly for people who have been or are about to be discharged into the community or for people who are remaining in hospital.

* type of scheme: Will it be run by volunteers, by MSC workers or other paid workers?

* management structure : Who will be represented on the management committee? What status will the users have? Are the NHS representatives full participating members or observers.

* operating principles: where will the workers be based? Who will supervise/employ them?

* funding: how will the scheme be funded? A detailed costing is needed. If the CHC office has a large part in the co-ordination and administration, should this be costed into the budget?

* recruitment and selection: how will workers/ volunteers be recruited and selected? Unreliable or unwise workers can be very damaging to people they work with. Advocacy works on a basis of trust and this must be preserved at all times.

* Training and support for workers/ volunteers. Who will provide this and how will it be organized? Volunteers need to be clear about the difference between hospital visiting and advocacy and the possibilities of confrontations with staff.

* Evaluation: How will the impact of the scheme be monitored and evaluated. Clear targets and mechanisms must be set at the outset.

PART 3: ENCOURAGING PARTICIPATION

"There has always been a strong tradition of involving the public in the NHS, but specific and separate consumer representation was introduced for the first time at re-organization in 1974 when community health councils were set up.....The White paper on NHS re-organization in England defined CHCs as 'bodies to represent the views of the consumer'. The need for health authorities to know and take account of the views of local communities was emphasised and 'lively and continuing interaction between management and users of the services' identified as being of 'benefit to both parties."

Royal Commission on the NHS, 1979, para 11.1

There are many ways the public can be involved in the NHS. CHCs are the 'official' channel and it is important that they enable users to interact with management, rather than act as 'gate-keeper' for NHS management.

3.1 REGULAR CHC MEETINGS

All CHCs must hold a meeting in public at least every three months and, by law, it must be publicised. CHC meetings are covered by the Public Bodies (Admission to Meetings) Act 1960. Some CHCs exclude the public from part of their meetings. This can only be done where the business is such that publicity 'may be prejudicial to the public's interest by reason of the confidential nature of the business to be transacted'. There are some issues, especially staff issues, that must be taken in confidence. As a general rule CHCs stand for open and public debate on all issues concerning the NHS and should avoid private discussion and decision making, which seem common in NHS decisionmaking.

Most CHC meetings do not attract public interest. Though many allow members of the public to speak either at a point in the agenda or join in throughout the meeting.

CHC agendas should not become so long that good discussion and debate does not develop. Worcester CHC has a liaison working group of members who meet in between full public meetings to save agenda time in the full Council. In Islington, all monthly CHC meetings are run like public meetings with speakers and a particular topic for each meeting. CHC 'business' is kept to a minimum and much of the work is left to working groups.

If the main work is done in working groups rather than the CHC, the powers delegated to them must be clear and decisions and papers on which they are based available to the public.

CHC meetings can provide an important platform for local groups to be heard. For example, in Dewsbury a group of people were affected by fumes from a neighbouring factory. The CHC meeting provided a platform which enabled their problems to be heard in public with the press present. Subsequently the factory rectified the problem.

The meetings which have a speaker or concentrate on a particular topic are generally more interesting and relevant for members of the public than 'business' meetings and will generally be better attended. This can assist recruitment of new members and co-opted members. It also means that the CHC is not shadowing the health authority in its agendas and approach to documents.

3.2 CONSULTING THE PUBLIC ON CLOSURES

In formal consultation on closures most CHCs hold public meetings. People do not generally travel far to public meetings and so it may be necessary to hold meetings in a number in different localities.

Public meetings can be dominated by pressure groups who may not be representative of the wider community. While CHCs must take into account staff views and the implications of closures for staff when making decisions, user not staff views are central to the CHCs role. It is important to structure meetings so that there is a variety of key speakers representing different viewpoints, not just that of the health authority.

Some CHCs have tried other approaches to involve a wider number of people.

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PUBLIC PARTICIPATION IN BOLTON

In 1978, Bolton CHC were faced with a plan to redevelop and extend an existing district general hospital over a period of 10 years on the site of a hospital on the edge of town. This development might have involved the closure of the centrally situated and popular Royal Infirmary. The threatened closure of the Royal Infirmary was vigorously opposed. The Metropolitan Borough Council seemed destined to vote against the plan. Opponents of it dominated the public meetings held by the CHC and the CHC deliberately took no votes. The main grounds for opposition were transport difficulties and sentimental attachment to the Infirmary.

However, the CHC was not so sure. Acute services were split between two hospitals and this involved frequent transfers of patients from one hospital to another. The central site of the Royal Infirmary was too small for any extension. Maybe this redevelopment was the only chance in the foreseeable future of improved services for Bolton.

So the CHC decided to seek the views of the uncommitted public. The CHC printed invitation cards, booked a room in a well appointed medical institute for two evenings in one week and arranged a meal for 100 people on both evenings.

CHC members and volunteers travelled a random route in every ward, inviting people to the meeting. They left a personal invitation only where there was a commitment to accept it and then knocking on the 10th door up the street or around the corner. The novelty of the random approach attracted much publicity, all of which contributed to public awareness.

At the first evening more than 100 people turned up and were given fact sheets, programmes and badges. Following the buffet, they split into groups and were asked what they expected of their ideal local hospital service. Each group had a Recorder who reported back the views of the group to the main meeting. The panel of 'experts' were then asked to explain how the proposed plan would solve or fail to solve the problems presented. Once the 'experts' were persuaded that, in this forum, they were not the 'experts' any more and to listen to the people, the discussion got going.

The plan went through the AHA, the CHC and the Metropolitan Borough Council without rancour and with the tacit agreement that the same community would now want to be involved in more detailed planning in the future.

WEST BERKS: MOBILE SURGERY BUS

West Berkshire CHC hires the bus used by Councillors to hold their surgeries from Reading Borough Council. It has been used for consultation about closures.

VICTORIA: SITING OF HOSPITALS

Victoria District had three hospitals- two general hospitals, the Westminster and St Stephens in Chelsea, and a large site with a geriatric and mental illness units at St Mary Abbots in Kensington. The DHA recognised that one of these hospitals would have to be closed by 1994 to meet the financial targets.

The CHC felt that planning should be based on what the local community wanted, not on the behind the scenes power struggles. In 1985 they undertook a survey based on a sample of the electoral register. People were asked what hospital they currently saw as their local hospital and where they would go if it were closed. The survey showed that the two general hospitals served very particular communities and that if one closed people would not necessarily transfer to the other hospital, because of transport difficulties. They would cross the District boundaries to the most conveniently located services. More than anything the survey showed the support for alternative community facilities such as health centres and community care centres and outpatient clinics.

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3. 3 COMMUNITY DEBATE

If public meetings or conferences are well planned, with a target audience, they can set in motion a constructive dialogue between users and service providers. They can often be the start of a campaign or lead to the setting up of a steering group to get new developments started.

Conferences can stimulate discussion between voluntary and patient groups and health and social service staff. They can concentrate on local issues or on the impact of national issues locally. They can question professionals about the type of services they provide, including clinical practice. Clinical judgement is an area where professionals are reluctant to share information. However, there are many views on clinical practices and user views are valid. The CHC can provide a forum for such discussions.

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CERVICAL CANCER- IS THERE MORE TO IT THAN SCREENING?

City and Hackney CHC and the Hackney Borough Women's Unit held a lunchtime meeting to "inform women employed by the Town Hall and in the community that there is more to cervical cancer than screening - something which women could be forgiven for believing, given the exclusive emphasis on screening by press, politicians and some campaigning groups. The success of the occasion was evident in the rapt attention of everyone present and their eagerness to discuss why researchers have pointed the finger at women's sexual habits rather than men's, why the protective value of barrier contraceptives has been ignored, and also the evidence that carcinogenic substances to which some men are exposed at work may be the cause of their women partners' cancer".

300 women attended. Crucial to the success was that it was advertised through the paypacket of every local authority employee, and time off was negotiated for every woman who wished to attend.

WAKEFIELD: FORUMS FOR THE ELDERLY

In Wakefield, 'Open Forums' for the elderly are regularly held. The meetings have a panel of speakers and the dual aim of disseminating information on health, social and voluntary services available to the elderly and also alerting the CHC to areas of concern among the elderly population.

WORCESTER: SEMINARS

Worcester organizes special "Open Forums" within some of its regular meetings at which members of the public are invited to put their point of view. Additionally, adhoc public seminars upon specific topical issues have been used with considerable success. The use of workshops within these seminars, with group leaders reporting back at the end of the evening has been a helpful way of airing opinions whilst avoiding confrontation between opposing pressure groups.

CENTRAL MANCHESTER: PARTICIPATION GROUPS

Central Manchester CHC uses groups for consumer consultation. This involves a day workshop which gets together a sample of people who would be affected by a potential decision, together with professionals from within the service. Discussion is stimulated by the use of group techniques, using group leaders and flip charts.

The participants are invited in a variety of ways, through voluntary organizations or, in the case of health centre meetings, by leafleting the local area.

The first exercise was on services for mentally handicapped people and subsequently they have been held on services for the elderly, health centres, alternative/third world health care (jointly with War on Want) and physical handicap.

Central to the process is the availability of trained group leaders and the CHC has run training session for them. The process focusses discussion on what people have come along to say, rather than what the speakers or professionals have to say, and so encourages involvement.

CAMBERWELL: HEALTH CARE FOR ETHNIC MINORITIES

In 1985 Camberwell CHC held a conference to discover from representatives of ethnic minorities what were their needs and the solutions. It enabled representatives of the black and Asian community organizations to speak directly to members and officers of the Camberwell Helth Authority. The conference made 17 recommendations, which the CHC supported and promoted.

Six months later a re-call conference was held in October 1985. Health Authority Members and officers reported back on the issues raised. Unfortuntely the conference was held in the wake of the Brixton riots and attendance from black and Asian community groups was low.

3. 4 ESTABLISHING NEW PROJECTS

CHCs often work with voluntary groups to promote the development of self-help groups and community health projects. This has been an area where individual CHCs have had an enormous impact on their communities, though the role can vary:

* Acting as a facilitator. This will not always involve a long term commitment, but the CHC assists in helping groups and projects get started or sets up a pilot project. A number of CHCs have been instrumental in setting up Crossroads schemes.

* Acting as a community resource. Bexley and Southend make CHC resources available free of cost to new groups to enable them to get started.

* Acting as a link between voluntary groups and the NHS. Some CHCs provide a forum for agencies, users and statutory bodies to meet and work together. For examples, many CHCs have been been involved in Good Practices in Mental Health projects.

The CHC needs to be clear from the outset about the nature and purpose of their involvement in a scheme. It is not the role of the CHC to provide care services. Where the CHC is instrumental in setting up a project, it is important that arrangements are made to hand over management to another existing body or set up a separate charity.

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MANCHESTER AIDS FORUM

In February 1985 Central Manchester CHC sponsored a meeting with the gay community on AIDS. Following this meeting, a telephone counselling service, Aidsline, began operation in October 1985.

The CHC got together a steering group, including consultants, medical officers, health education officers, representatives of the local authorites, social services, equal opportunities advisers and environmental health. The Steering Group was serviced by the CHC at the beginning who pursued possible sources of funding. In 1986 it became the Manchester Aids Forum, which is independent of the CHC and has been allocated a three year grant of £25,000 per year from the Regional Health Authority.

KENSINGTON & CHELSEA: FAMILIES WITH SPECIAL NEEDS

In 1978 there were no services - in patient or outpatients - in the district for the families with handicapped children. The only services were outside London in Surrey.

The CHC contacted the families on the AHA register for handicapped children and held a meeting to ask their views. Relationships developed among isolated parents who were able to share their problems and experiences with each other. The following year a new branch of Mencap was formed for Kensington and Chelsea.

The CHC also approached KIDS, the national charity, who set up a family support unit in North Kensington, which opened in 1982.

SUFFOLK COMMUNITY ALCOHOL SERVICES

In October 1982 East Suffolk CHC, in conjunction with West Suffolk CHC, the Probation and After-care service, and the Health Education Department convened a meeting to discuss the drink problem in Suffolk.

Fifty people attended including representatives from the NHS, Suffolk County Council, Education Department, District Councils Probation Service, police, magistrates, private employers and voluntary organizations. As a result of the meeting, a working party was set up to look at the needs of problem drinkers in Suffolk, existing resources and how they might be used and co-ordinated, as well as whether there was a need for new services and if so what they should be.

Joint finance and a grant from Alcohol Concern was received. In June 1986, a development officer was appointed and the Suffolk Community Alcohol Service was officially launched in October 1986.

HARINGEY ACTION GROUP ON ALCOHOL

The Group was started by the CHC in 1981 and now runs 13 hours of counselling about drinking problems, gives advice and information about alcohol abuse and acts as a focus for discussion of alcohol services in Haringey.

The GLC funded a part-time co-ordinator and the counsellors are seconded from the health authority and social services.

SCREENING FOR CERVICAL CANCER: THE NEWCASTLE CAMPAIGN

In 1985 Newcastle CHC held an open meeting to promote discussion about take up of cervical screening. Following this, the CHC obtained a grant from the County Council to co-ordinate a campaign using the Women's National Cancer Control Campaign Mobile Unit for 10 days in November 1985.

Sites were identified in conjunction with local groups and leaflets circulated to houses in those areas. Women attending were asked a few questions about themselves and their response to the campaign. The review of the campaign highlighted requirements for future campaigns.

BOLTON: ST GEORGES DAY CENTRE

Bolton CHC set up the St Georges Day Centre in church premises in 1977 with a grant of £3,000 from charitable trusts. It is now a registered charity and has 90 ex-psychiatric patients on the books with an average daily attendance of over 60 people. It is run by volunteers, co-ordinated by an organizing assistant and helped by tutors from the Department of Community Education, by community psychiatric nurses and a home economist.

Pressure to expand the Centre came from the Health Advisory Service who urged the DHA to provide the funding to allow the centre to expand.The DHA provide about £10,000 a year for rent and overheads and second a clerical officer to the CHC to assist in organizing the Centre and deal with referrals.

COMMUNITY CARE: BOLTON

In 1983 the CHC put forward a scheme to bring mentally handicapped people out of Brockhall Hospital. It was an attempt to test the theory that ordinary facilities can be used by a full range of mentally handicapped people and to explore ways of making these facilities available.

The application of funds from the RHA for the pilot scheme was made jointly from the DHA and a group of parents, co-ordinated by the CHC.

The scheme was in two parts: housing and employment. Housing was essential in order to bring people out of hospital and set them up with full tenant's rights. Housing association accommodation was made available and furniture and fittings paid for by the DHSS.

Those leaving hospital have an individual programme drawn up for them for employment and education. They can attend Sefton Fold which gives training in farming. Educational courses are also available from education support tutors who run 'Home of your own' and 'Do it Yourself' courses.

The Neighbourhood Network Scheme, jointly co-ordinated by the Borough Council, the Health Authority and the CHC, recruits families to provide support and offer a home to discharged patients.

SOUTHEND: PET THERAPY

Pet therapy has been used in a few health districts to 'de-institutionalise' longstay hospital wards. This can involve relatives bringing in the patient's pets or voluntary visitors attending with their own dogs. They have been successful in arresting boredom and apathy.

Following discussion about the scheme initiated by the CHC, the District Health Authority adopted the Scheme for Southend.

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3.5 NETWORKING

CHCs can encourage participation by establishing links with other bodies working in the community. Many CHCs are sensitive to the fact that CHC members may not be representative of many groups in the community. As well as representing the interests of local residents, they need to represent the interests of drug users, homeless people and those with aids.

CHCs may be concerned about the difficulty, for example, in involving local ethnic minority communities. To this end, it is important to ensure that the CHC has consulted to find out what issues are of concern to minority communities and has sought their involvement in activities relevant to their concerns.

VOLUNTARY GROUPS

CHCs can often act as a focus and clearing house for information between the groups about local health issues. Some CHCs have set up forums for discussion of health issues and publish a newsletter targetted in particular to voluntary groups. Tenants associations, churches and community groups can provide a link with specific localities.

CHCs can use local networks of voluntary groups to gather information and to promote ideas. CHCs can help voluntary organizations to be more in touch with the NHS, including getting funding or other assistance from the NHS. The can also give information support to voluntary organization representatives on Joint Consultative Committees and planning teams.

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MANCHESTER ALLIANCE FOR COMMUNITY CARE

The Manchester Alliance for Community Care was established in 1981 as a campaigning body by the major voluntary organizations in City and the CHC. It has developed as the premier organization in Manchester concerned with joint consultation between DHAs and local authorities and care in the community.

The Alliance operates through monthly meetings of full time representatives of some of the larger organizations, but it also has affiliates around Manchester and produces a regular newsletter. Recently funding of two posts has been granted from joint finance to develop new projects.

HEALTH CARE FOR ETHNIC MINORITIES

Central Manchester CHC has set up a network of CHCs and interested community groups, together with the Greater Manchester Council for Voluntary Service around the issue of Health Care for ethnic minorities.

HARINGEY FORUM

In 1985 the Haringey Forum was started by the CHC as a major co-ordinating group for people interested in the development of services for people with a mental handicap. Several working parties have been meeting and are producing ideas and policies and the Forum provides a strong voice for mentally handicapped people.

LOCAL AUTHORITIES

Many areas with which the CHC is most concerned- primary care, community services, rehabilitation of mentally ill and handicapped people - depend on the collaboration between local authority and health services, hospital staff and NHS community staff and general practitioners. The health of the community cannot be considered in isolation from the environmental causes of ill health and NHS services cannot be assessed, without taking account of local authority services available.

CHCs, with half of their membership appointed directly by local authorities, should have good links with them. Some local authorities have set up special Health Committees. The way these are structured and their terms of reference vary. However, where they exist they can provide a useful forum and an important focus for encouraging increased co-ordination of health services whoever provides them.

Some local authorities may be prepared to support CHCs in particular activities - for example in providing legal advice. A number of local authorities have taken legal action on behalf of CHCs, where the DHA has not followed the procedures for consulting about closures.

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LIVERPOOL: CITY COUNCIL'S HEALTH CARE STRATEGY SUB-COMMITTEE

The Two Liverpool CHCs have membership with voting rights of Liverpool City Council's Health Care Strategy Sub-Committee. They have found this useful and have put items on the agenda such as anti-smoking policy for City Council premises and time-off work for female employees to attend for cervical cytology tests.

WALTHAM FOREST: HEALTH ADVISORY LIAISON GROUP

The CHC pressed the local authority to form a Health Advisory Liaison Group and a Health Liaison worker was appointed in 1986.

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COMMUNITY RELATIONS COUNCILS

Some CHCs have established close links with their local Community Relations Councils (CRC). Bexley CHC has done this. In 1980 the CRC established a Health and Social Services Sub-Committee which includes officers of the health authority, local authority, the voluntary sector and the CHC. The existence of the sub-committee and a specialist worker in health provides a useful link and resource for the CHC and ensures that the needs of people from ethnic minorities are not overlooked.

PROFESSIONAL AND STAFF REPRESENTATIVES

Establishing links with trade unions and professional groups can provide useful information and also give the CHC the opportunity to pass on user views to staff. The local Faculty of the Royal College of General Practitioners may be a useful channel to link up with GPs, for example.

3.6 USER GROUPS AND LOCALITY PLANNING

There is increasing interest in the health service in planning for localities rather than for the district as a whole. On planning teams local views seem parochial and 'unprofessional', because of the need to look at the whole district.

In districts which are hospital-centred in the provision of health services, locality planning may be particularly useful in turning attention to the needs of other parts of the district and of users. Concentrating on a locality may also make it easier to involve local people. The Cumberlege Review of Community Nursing in 1986 put forward the idea of 'Health Care Associations', which would be made of local people and be involved in monitoring and planning the services.

Other user and participation groups are being established. A number of GPs have set up Patient Participation Groups with the encouragement of the Royal College of General Practitioners. The activities include assessing the quality of services, sometimes also fund raising and health education. One difficulty is that they are generally initiated by the doctors themselves and are unlikely to develop where they are most needed. They also generally only cover one GP practice.

There are ways of setting up independent user groups to monitor services. For example, health centres can have management committees with users represented on them.

There is an important role for CHCs in promoting and co-ordinating these initiatives.

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LOCALITY PLANNING IN EXETER

In Exeter planning is based on localities rather than client groups. There are 15 Locality Planning Teams in the District, covering populations ranging from 10,000 - 40,000. Health service users are involved through CHC members, local parish councillors and voluntary organizations.

Health Forums have been set up by the CHC in four localities and the DHA provided additional funding for them. The Forums have been successful in involving a wide number of lay people, in particular in scattered rural areas.

LOCAL ADVISORY GROUPS IN WEST LAMBETH

West Lambeth CHC was involved with the Health Authority in establishing Local Advisory Groups for small scale health service facilities in Lambeth. The aim of the Groups is to give local people and users a say in the way the centres are run and an opportunity to suggest improvements and discuss wider health related issues. The CHC is able to take up and campaign on issues they raise.

The first Group was set up in 1986 at a centre for the elderly. Half of the members are local health and social services staff. These include a social services representative, a district nurse and a local GP and four members are elected by the staff at the centre. Half of the group are representatives of the local community. One representative is nominated by Age Concern and six people were elected at a public meeting. The CHC co-ordinated and arranged the elections for community representatives.

3.7 PUBLICITY AND PROMOTIONS

CHCs need a high profile in order to encourage participation. The purpose of general publicity is:

* to attract more involvement of local people, to add credibility to CHC representations and develop more informed user participation in the planning and running of the NHS;

* to help inform health service users;

* to publicise CHCs and their work.

The aims of publicity must be clearly defined. The best publicity for the CHC is tied to particular objectives with a specific audience in mind.

USING THE MEDIA

The media is an important way for CHCs to communicate with the public on all health related issues. It is also an effective way of moulding public opinion and bringing pressure to bear, if necessary, on health authorities.

Regular contact and co-operation with local press and radio is important to ensure good coverge and accurate reporting. The issuing of press statements, rather than verbal reports, can assist in ensuring the publicity is accurate. Relationships between DHA and CHC have to be either very robust or very bad, for a CHC to take the line that all publicity is good publicity. On controversial issues the CHC needs to be cautious to avoid unnecessary souring of relationships.

Before circulating a press statement, there may be advantages in discussing it in advance with NHS managers. This will help to check out the accuracy of the 'story. It is also courteous to let them know in advance, if they are likely to be contacted by the press to comment. Where there is agreement between the DHA and the CHC, the 'story' will have more impact if it is issued jointly from the CHC and the DHA.

Northumberland and Exeter CHCs have their own columns in local newspapers.

In Manchester, the office which the 3 CHCs share has made it the focal point for out of London press enquiries and this has helped to enhance the CHCs profile. The CHCs have taken part in one day long phone-ins with local radio stations as well as regular phone in/ discussion programmes.

POSTERS AND LEAFLETS

Posters need a specific target - to encourage participation on a particular issue, or to inform potential complainants about the CHC.

Posters are most useful if they can be seen in a place where people come who might be interested in the CHC or in need of information and advice - i.e. GP surgeries, hospital outpatients and wards, pharmacies, social services, clinics etc. Waltham Forest CHC has its own noticeboard at the District General Hospital.

Worcester CHC experimented with distributing leaflets via the milkfloats of the local dairy.

NEWSLETTERS

Many CHCs have a mailing list of people interested in the health services and circulate a monthly newsletter. The newsletter can include news of what happens in Health Authority meetings, news about the CHC and its meetings and sometimes advertisements for 'vacancies' on CHC working groups for co-opted members.

A newsletter can be a way of keeping people informed and involved regularly without much additional work. Islington, Hackney, Wakefield and many others produce a monthly newsheet. Dewsbury produces a newsletter in collaboration with the local Council of Voluntary Service and the Community Relations Council.

On a more irregular basis, other CHCs produce a newspaper which is then distributed to all households in the District, either commercially or with another free distribution (i.e. a free commercial newspaper or Council paper). Calderdale, West Birmingham and Barnet have done this.

A number of Health Authorities are producing their own newspapers to be distributed. Where this happens, the CHC can use this medium.

SPEAKING TO GROUPS

This is useful in giving the CHC user views on local services. On the basis of these contacts the CHC can establish a network for providing information feedback. Norwich CHC has a set of slides for members to use when they talk to local groups. West Midlands RHA produced a slide tape show for the CHCs in Birmingham.

HEALTH PROMOTIONAL EVENTS

Many CHCs have been involved in promotional events or organize exhibitions, which have a dual purpose: to promote information about healthy living and to publicise the CHC.

Where CHCs are involved in health promotion, it is important to look critically at the health messages which are being given out. The CHC is not a branch of the health education department, though joint activities may be an effective way of getting messages across.

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WESTON:AIDS TO LIVING

Weston CHC organised an Exhibition: Aids to Living, which was held in the Winter Gardens Pavilion.The Exhibition was entirely self financing and voluntary bodies were given space free of charge. HRH Princess Anne opened the Exhibition in May 1984.

BRENT HEALTH FESTIVAL

In July 1983 Brent CHC, facing drastic cuts in services, defiantly celebrated a Health Festival. The League of Friends provided refreshments and a steel band provided music. Entertainment was provided by a theatre group, a puppet show, a clown, badgemaking, balloons, inflatables, videos, keep-fit and yoga demonstrations, acupuncture and free Shiatsu massage.

The CHC wanted to draw in more people from all sections of the community. The Festival was seen as a way of doing this.

WEST ESSEX : HEALTH PROMOTION DAY

Each year West Essex CHC hold a conference for local people and service providers on an aspect of healthy living. Each day takes a theme and aims to stimulate an awareness of the basic value of good health. For the past few years each conference has concentrated on a different part of the life cycle from birth to old age.

CHILDREN'S HEALTH DAY: WAKEFIELD 1985

The CHC with the local branches of the Pre-School Playgroups Association and the National Childbirth Trust organised a Health Day for children under-five and their parents. The aim of the day was educate parents in various aspects of children's health, through information and discussion workshops including 'child safety', first aid, common childhood ailments and infant feeding. There were also opportunities for parents to learn about play with their children from the PPA leaders who provided education and play activities for the children. A free health tuck shop provided a chance to sample healthy foods such as carrot sticks, additive free yoghurts, wholemeal fingers with tasty dips.

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Some CHCs have also run competitions to encourage and support individual NHS staff who are particularly helpful to patients.

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SOUTHEND: GP RECEPTIONIST OF THE YEAR

In 1986 the CHC launched a 'GP Receptionist of the Year' competition with all local GPs, chemists and the media co-operating in the event.

ANNUAL THANK-U TIME

Manchester CHCs run Annual Thank U Awards. People are invited to nominate people who work in the health service who have helped them or their family in friends in the year. A special form is provided and the 'Thank U' can be expressed in words or pictures.

Everyone nominated receives a certificate and there are also special gold and silver awards for "Patients Friend".

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PART 4: RELATING TO NHS MANAGEMENT

"In the re-organized National Health Service management and representation of local opinion will be distinct but complementry functions, entrusted to separate bodies but working in close relationship. Successful administration of the service will depend on a continuing and constructive exchange of ideas between Area Health Authorities and CHCs".

NHS Re-organisation Circular, HRC(74)4

4.1 DISTRICT HEALTH AUTHORITIES AND FAMILY PRACTITIONER COMMITTEES

CHCs, health authorities and family practitioner committees must interact in certain ways:

1. CHCs must publish an annual reports
2. DHAs and FPCs must each hold annual meetings with their CHCs
3. DHAs and FPCs must supply information to CHCs
4. CHCs must be able to visit health service premises
5. CHCs must be consulted on closures and changes of use
6. CHCs have observer status on their FPC and DHA.

Around these, relationships between health service managers and CHCs are left to local arrangement. Some conflict may be inevitable, given the different objectives of a manager and a community representative. It is a delicate balance for the CHC to maintain its independence and also a constructive dialogue with the NHS. If there are disagreements about procedures as well as issues, the CHC and NHS may be distracted from looking at what is best for the community and become involved with internal power struggles.

CHCs need to work out procedures and expectations with DHAs and FPCs and state these explicitly. This is important to ensure proper working relations are developed and also continuity when there are changes in staff and membership in both the CHC and the health authority.

Many CHCs have regular informal meetings between the District Officers and the CHC Chair and Secretary and sometimes CHC and DHA Members. This can be a useful way for both 'sides' to sound out ideas and views informally. Many CHCs have also established regular links with the Local Medical and Dental Committees.

Some CHCs have reciprocal observer status with DHAs and FPCs. Other CHCs invite DHA or FPC representatives for particular agenda items. The presence of a DHA/FPC representative can provide the CHC with additional information. However, the presence of the 'professional' NHS representative may at times inhibit open discussion on some subjects.

In some Districts, the minutes of CHC meetings are always included as an item on the DHA agenda.

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JOINT DHA/CHC WORKING GROUP ON SERVICES FOR THE ELDERLY

In West Suffolk an adhoc working group was established in June 1986 by the health authority in response to the Health Advisory Service (HAS) report on services for the elderly in West Suffolk. The group consisted of both CHC and DHA members. A CHC and DHA member visited each unit in order to follow up issues raised in the HAS report and monitor the progress of the action plan drawn up as a result of the HAS visit.

DHA AGENDA SETTING

In Manchester North, the CHC Secretary, at the DHA Chairman's invitation, attends the agenda setting meeting of the DHA. The meeting is attended by the DHA Chairman, District General Manager, Committee Clerk and CHC Secretary. The invitation from the DHA Chairman arose from a breakdown in communication on a major issue on which the CHC should have been consulted and is proving an effective way of ensuring such breakdown does not occur again. It also gives the opportunity for more informal exchange of information which has led to increased confidence between the DHA and CHC.

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CONSULTATION PROCEDURES

The DHA and FPC must consult the CHC on any substantial variation in the health service. If a CHC opposes a closure or change of use, it is required to make a detailed and constructive alternative proposal within the same financial constraints. However, the DHSS indicated in 1980 that 'the emphasis should be on a reasoned, rather than a necessarily detailed, counter argument based on the consultative document'. After the DHA has considered the CHCs views and rejected them, the matter can be then referred to the Secretary of State for a decision.

CHCs have not had much success in preventing closures - once a proposal is out for formal consultation. It is difficult to enforce the right even to consultation, let alone to a constructive debate about improving services. A unit may be saved one year, but in the the next year new regulations or new financial constraints mean the closure goes ahead. Since 1985 health authorities have been able to close units without consultation on the grounds that it is in the 'interests of the health service' to do so. Once a unit is closed, it will be very hard to get it re-opened.

The CHC, with its temporary power of veto, can substantially delay the implementation of plans. In all cases of consultation, the CHC is in a position to influence and negotiate on behalf of the local community. Formal consultations are an important opportunity to influence developments, even if the CHC does not believe that it can reverse the ultimate decision to close the unit.

There may be occasions where CHCs covering neighbouring districts have conflicting interests in a proposed closure or development.It is important that all the CHCs involved discuss the issue in detail to establish any common ground and to make sure that each understands the arguments of the others.

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LAMBETH COMMUNITY CARE CENTRE

The Centre is a part of the site of the former Lambeth Hospital which was closed in 1977, when the North Wing of St Thomas' Hospital opened. The area around the hospital had a long established and stable population who were anxious to see a local service continue. GPs living round there also wanted to see the development of primary care services. There was a 10 year campaign co-ordinated by West Lambeth Community Health Council, which resulted in support from the health authority. Capital and revenue funding for the centre was provided by the Inner City Partnership for the first eighteen months and will be funded thereafter by the NHS.

The Centre opened in 1985 and provides a new type of care and rehabilitation for local patients at a level intermediate between home and hospital. It combines a 20 bed ward, a 35 place day unit and educational facilities in a single purpose designed building. GPs, nurses and therapists, social workers and local volunteers and health groups work together to provide a comprehensive primary health care service.

WEST BERKSHIRE: CLINIC CHANGE OF USE

The Coley Clinic provided accommodation for one child health clinic per week and for community nursing staff. In 1985 the health authority proposed transferring the staff and the child health clinic in order to use the Clinic as a base for community psychiatric staff and a psychiatric outpatient clinic.

The CHC opposed the closure on the grounds that the clinic was purpose built for primary health care and that an extension of these services was needed, (and not because of the proposed use for mentally ill people).

The local community association took up the campaign and provided information to show the amount of local support for the provision of a GP branch surgery. The FPC identified 2 GPs interested in setting up a branch surgery.

The solution emerged when it was realised that two maisonettes adjoining the clinic, which were owned by the health authority, were suitable for a branch surgery. The mental illness project was given adequate premises and the local population had additional services through a GP branch surgery with opportunity for expansion if required.

REPRESENTATION ON COMMITTEES

CHCs have a right to observer status, that is speaking but not voting rights, at DHA and FPC meetings. Sometimes this also includes attendance for the confidential part of the agenda (Part II). In some districts CHC Chair and Secretary are invited to attend seminars arranged by the DHA for briefing and discussing with authority members important planning or management issues.

Representation on other committees is left to local arrangement.

Joint Consultative Committees and Joint Care Planning Teams

In 1985 voluntary organizations were given a seat on Joint Consultative Committees (JCCs). CHC do not have a seat, but can provide support and information for voluntary sector representatives.

CHCs have observer status on the JCC only. The contribution of the CHC representative, albeit as an observer only, in addition is important to represent a wider community interest that the voluntary representative can normally do.

The Joint Care Planning Team provides support to the Joint Consultative Committee. It is made of DHA and local authority officers and in practice makes decisions, rather than the JCC. In some districts the CHC Secretary is a member of the Team and this is very useful.

Planning and project development teams

Representation on planning committees gives the opportunity to influence policy in the formative stage. Some CHC representatives attend as observers, while others have full membership. Where the CHC has full membership, there may be a danger that the CHC representative becomes a part of the management process. Misunderstandings may arise if it is not clear that participation on the planning team does not prejudice the CHC's right to formally consider any proposals or developments later.

Attendance on all planning and project teams, can be very time consuming. However, some CHCs co-opt someone from the voluntary sector, to serve on relevant planning teams.

Clear terms of reference need to be given to the CHC representative.

* Is the representative representing the CHC in all s/he says or providing the input of the intelligent reasonable user view?

* How does the representative report back to the CHC?

* How does the representative or CHC gather local views to feed into the committee?

* Should the representative be 'mandated' on particular issues?

* How does the representative deal with confidential issues, if they arise?

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VOLUNTARY GROUPS AND JOINT PLANNING

In Manchester particular efforts have been made to develop links between the voluntary organization representatives on planning teams and the new voluntary sector representatives on the Joint Consultative Committee. Agreement has now been reached for Joint Finance funding of two workers to act as liaison officers between the representatives at these various levels and for them to sit on the Joint Care Planning Team. The workers are responsible to the Manchester Alliance for Community Care.(See page 34).

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ANNUAL MEETINGS

It is the duty of both DHAs and FPCs to arrange, at least once a year, a meeting between their members and CHC members. At least one third of the DHA/ FPC members must attend these meetings.

Some FPCs relate to seven CHCs and it may be difficult for them to achieve a quorum of members seven times a year. They may prefer the statutory meeting to be held with a number of CHCs at the same time. However, each CHC has the right to a separate annual meeting, if it wants.

Some CHCs hold their annual meetings in public. Waltham Forest invite the public to attend and speak at the annual meeting as they see it as the only opportunity the public has to speak directly to the DHA.

In some districts CHCs and DHAs/FPCs meet two or three times a year and find this leads to a more constructive discussion. They do not expect the full quota of DHA/FPC members to attend each meeting.

On the other hand, some CHCs have found that the statutory meetings can become a time-consuming formality. It is up to the CHC to decide what it want to get out of the meeting and structure the agenda accordingly. Some CHCs have found that it is better to focus on a particular issue, where there can be constructive discussion and leave the controversial issues to be discussed elsewhere. Examples are given below.

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CHC/DHA MEETINGS

Nottingham CHC holds quarterly meetings with DHA and CHC members. The agenda covers issues not resolved at unit level and is fixed a month in advance so that the CHC can do any visits or background research and the DHA can also be prepared. The meetings are held in private and generate a frank debate.

Central Manchester CHC has a bi-monthly joint meeting with the DHA and its Officers, which is alternately minuted by the DHA and the CHC with the minutes being placed on the agenda of both the CHC and the DHA.

West Berkshire and East Berkshire CHCs, following the change of status of FPCs arranged for their annual meetings to be tri-partite with both the DHA and FPC present. This is the only time that DHA and FPC members meet each other.

FPC/CHC MEETINGS

In East Sussex ten members of the FPC are assigned to 'look after' each of the three CHCs in the Districts.

In addition to the formal annual meeting, Bexley CHC also has a less formal meeting with FPC members who are particularly concerned with Bexley.

At the first statutory meeting between Haringey CHC and its FPC, a deputation of ethnic minority women arrived to argue for translations of the letter going to women asking them to come for a cervical smear. Following the meeting arrangements were made for a translation in seven languages to accompany the letter.

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ANNUAL REPORTS

According to the Statutory Instruments it is the duty of every CHC each year to report to the Regional Health Authority (Welsh Office in Wales) on the performance of its functions during the preceding year and to furnish copies of the report to the District Health Authority and the Family Practitioner Committee. CHCs must also ensure that the report is made known to the public in its district.

It is the duty of DHAs and FPCs to comment on the report, including a record of any steps they have taken as a result of the advice given or proposals made by CHCs. DHAs and FPCs also have the duty to ensure that their comments are made known to the public. However, few Health Authorities publicise their responses to CHCs' report and this is a matter CHCs might wish to take up.

The Annual Report of the CHC has three purposes, which may not combine easily.

* A demonstration to the RHA that they have performed their statutory functions. This may be an account of the activities undertaken by the CHC, meetings attended, visits made etc.

* A report on the operation of the health services to the District Health Authority and Family Practitioner Committee. This may be a detailed 'insider' summary of proposals and advice given over the year.

* Information to the public about the operation of local health services, written to attract interest and demonstrate the strengths of the CHC.

CHCs vary in the priority they give to the annual exercise of producing the report. Often by the time the report is produced some of the information in it is out of date.To some, it can be a marker in the year that gives the CHC the opportunity to take stock. To others, it provides a form of accountability to the public. Most important is for the CHC to consider what they want to use the report for and the priority they give it in terms of the amount of staff time and financial resources they put into it.

Some CHCs have produced annual reports as calenders, posters or with pull-out sections giving information about local health services. All such approaches may ensure the report has a longer life than the conventional report. Cardiff CHC produces a leaflet, 'Extracts from the Annual Report', which is widely distributed.

GUIDELINES FOR COMMUNICATION AND CONSULTATION BETWEEN CHCS AND DHAS

The Liaison Committee of CHCs for North West Thames Region produced guidelines on consultation and communication between DHAs and CHCs. It resulted from a survey of CHCs in the Region which showed a very wide variation in the relationships in districts. It was endorsed by the RHA in 1985.

"Recommended good practices between DHAs and CHCs:

1 a) When new developments and services are planned the view of the CHC should be sought at an early stage in order that the CHC can contribute the consumer view to the strategy and policy of those developments and services.

b) CHC representatives should have the opportunity to meet each Unit General Manager early in the Operational Planning Timetable each year.

c) any planned change of use or variation in service which will last beyond four weeks should be communicated to the CHC. Opportunity should be given to the CHC to comment and discussion take place regarding the need for any further formal or informal consultation.

2. CHCs should receive all published DHA papers in good time for effective comment.

In addition, CHCs should receive background and supporting papers by DMT officers neccessary to the full understanding of health issues and decisions affecting the NHS consumer in the district.

3 The Region's press cutting service and any similar district services should be made available to CHCs.

4 a) Where DHA members working/special interest groups exist, joint informal meetings between each of these and matching CHC groups are recommended at least once a year.

b) more frequent opportunities should be found for joint seminars between DHAs and CHCs on topics of mutual concern. Within agreed numbers, CHCs and DHAs to decide upon their own representatives at these seminars.

5 Regular meetings between CHC Chairman, Secretary and DHA Chairman and Officers are recommended quarterly.

6 a) CHCs to have membership of all district planning groups/teams/development groups.

b) CHCs to have observer status on all relevant JCCs

7. The Annual Statutory Meeting between DHAs and CHCs to include discussion on the preceeding year's Review Letter and Action Plan.

8 Direct representation by voluntary groups on JCCs and planning and development groups should not be seen to justify the exchange (substitution) of CHC representatives or observers. CHC membership includes a range of voluntary organizations as well as a wide range of the general public. It should be recognised that, as the statutory body reflecting the consumer interests in the NHS, that the contribution offered by CHC representation cannot be replaced by any other organization".

GUIDELINES FOR COMMUNICATION AND CONSULTATION BETWEEN CHCS AND FPCS

The following procedures are abridged from the agreement between Lancashire FPC and CHCs.

"Confidentiality of information

Consultaltion with CHCs about changes in service may give rise to questions of confidentiality. Paragraph 10 of the Circular (HC(85)11) does give FPCs the right to withhold information regarded as confidential, but it is difficult to be see how, in certain circumstances, consultation could be meaningful without such information. It is important, therefore, that an agreement is made between the FPC, CHCs and Local Representative Committees about a suitable way for material of this kind to be handled which would ensure that the CHC had the opportunity to comment but that either any details that were confidential should be withheld or the CHC treated any information they received, which was commercially sensitive as confidential to them.

Exchange of information

The FPC will provide CHCs with comprehensive background information on FPS by ensuring that CHCs receive, in addition to the Committee's long term planning documents, .. an agreed range of statistical and other information which may be produced on a regular basis as a part of the Committee's own attempts to update its information base.

Consultation procedure

Consultation will fall into two broad categories: basic operational issues and strategic developments

General Medical Services

There will be formal consultation on strategic developments in general medical services which will include the establishment of new practices, the closure of branch surgeries, the disposal of vacant medical practices, the redefinition of Medical Practices Committee areas, general issues on deputising services, changes in dispensing arrangements and rurality of areas. The FPC will specify the time available to the CHC for consideration of the topic, but will take account of any request from the CHC for a longer period of time. Any comments made by the CHC will be reported to the Committee and, when appropriate, will accompany any formal approach made by the Committee to the Medical Practices Committee.

There will be informal consultation on basic operational issues. It is recognised that the distinction between operational issues and strategic development is not clear cut and in cases where the CHC feels that changes should be the subject of formal rather than informal consultation the request will be considered by the FPC.

Practitioners will be informed that proposals for changes in General Medical Services will be made known to the CHC. When the changes involve sensitive issues, whether of a financial or personal nature, the views of the practitioners on the timing of consultation will be taken into account.

Some examples of basic operational issues on which informal consultation will normally be appropriate are given below, together with an indication of the point at which the CHC should be informed:-

a) the building of new surgery premises to replace existing premises: the views of the CHC will be sought at the earliest possible moment, subject to the sensitivity of the issues involved and the views of the practitioners concerned on the timing of consultation.

b) the review of surgery hours or clinics - the CHC to be informed immediately; and

c) the redrawing of individual practice bounderies - the views of the CHC will be sought at the earliest possible moment subject to the sensitivity of the issues involved and the views of the practitioners concerned on the timing of consultation.

The FPC will advise the Secretary of the CHC informally of the proposed changes of the type listed above. An indication will be given of the urgency and/or sensitivity of the matter. Normally, if this is requested by the CHC Secretary, the FPC will confirm the proposed change by letter. The Secretary may, of course, decide to take it to the full CHC for consideration but will not disclose confidential information given on a 'need to know' basis. Any comments made by the CHC will be reported to the FPC. In some instances it may be necessary for the CHC to consider the subject in closed session.

General Dental Services, Opthalmic Services and Pharmaceutical Services

The appropriate CHC(s) will be informed by the FPC when a practitioner applies to set up a new practice or ceases to provide existing services.

The CHC will be consulted when there is any substantial change in the range of services offered to patients.

The appropriate CHC will be consulted when the yearly rota for pharmaceutical services for the evening, weekend and Bank Holiday opening is drawn up.

Consultation by CHCs

The FPC welcomes the reciprocal assurance from the CHCs that suitable consultation will take place before a Council embarks on any survey or investigation of Family Practitioner Services".

4. 2 REGIONAL HEALTH AUTHORITIES

The RHA, as establishing authority, is in a position of power in relation to CHCs. It determines the way that voluntary organization members are elected, allocates budgets, and arranges staff grading and recruitment.

In terms of services, there are six areas where CHCs might wish to be consulted by RHAs:

* The Capital Programme for new buildings.

* Strategic Planning

* The development of 'philosophies of care' likely to be used as guidance for DHAs

* Regional speciality services and their location

* The pattern of consultant appointments in the Region.

* Operational services managed directly by the RHA

There are no nationally agreed procedures for Regional Health Authorities to consult the public. Nor is there a formal forum whereby RHA members and CHC members can meet. CHCs do not themselves have the resources or the regional structure to work together to look at the long-term implications for the Region as a whole.

All regions have a regional association of CHCs. The structure and ways of working vary. A few have employed part time staff and are able to undertake projects. The development of strong regional associations can strengthen the position of CHCs in relation to the RHA and also provide an information base on which to assess RHA policy and plans.

CHCs have different priorities and different approaches. There may be conflicting interests between CHCs in urban areas of the Region and in rural areas. This means that it is particularly important that CHCs develop their own information base to assist in making decisions about Regional policy.

CHCs cannot do this within their own budgets, but they can raise funds to commission a region-wide study. Many Regional Health Authority CHC budgets are underspent, negotiation with the RHA might release these funds for CHCs as a group.

Regional associations also have an important contribution to the work of ACHCEW. The Regional Representative on the Standing Committee of ACHCEW is able to gain views from CHCs and report back on what is happening at national level.

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MERSEY: PATIENT SATISFACTION SURVEYS

The Association of CHCs in the Mersey Region reviewed the patient satisfaction surveys undertaken in the Region. A synopsis of recent surveys was produced for the annual meeting between the Regional Health Authority and the Regional Association of CHCs.

WEST MIDLANDS RHA: GRANT COMMITTEE

In 1979 the West Midlands RHA set up a committee to encourage and support the development of information and library services and survey research by CHCs. A fund of £15,000 a year was allocated to assist in information projects. The Committee consisted mainly of CHC representatives, with an RHA member in the Chair.

SOUTH WEST: GOOD PRACTICES IN CHCS

In 1985 South West Regional Association of CHC Secretaries reviewed good practices in the light of the Griffith's report and put forward a proposal for a Regional Consumer Research and Special Projects Committee to allocate funds to individual CHCs for use in specific research and special projects.

NORTH WEST THAMES : REGIONAL LIAISON COMMITTEE

N W Thames employs a part time worker and the RHA raised the CHC budget to cover the cost. By working together, the Committee has had a number of successes - including the regrading the CHC Assistant in 1986.

MENTAL HANDICAP

Many mental handicap and psychiatric hospitals serve patients from many districts and are administered by one District. Most have established Joint Committees of all the CHCs involved and monitor the services provided.

The North West Thames Liaison Committee has a representative on the RHA Policy Group for Mental Handicap. They also negotiated for an additional member of staff to be attached to the CHC in the district which administers all the large mental handicap hospitals in the Region.

GREATER LONDON ASSOCIATION FOR CHCS (GLACHC)

GLACHC was set up in 1979 to look at health issues on a London wide basis. This was necessary because London is divided into four regions, with considerable cross boundary movements by patients. There was a need to look at services for London as a whole. It was funded initially by the Greater London Council and since partly by the London Borough Grants Committee.

NORTH WEST REGIONAL ASSOCIATION OF CHCS

The North West Region has a part time staff member. Projects include organizing a conference on health care for ethnic minorities. They also run autumn seminars on topical issues, bringing together new and existing members and CHC staff.

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4. 3 ENFORCING RIGHTS

In the event of a dispute, the CHC can appeal to the Regional Health Authority, though the RHA is often an interested party. The CHC can also work through the Association of CHCs for England and Wales, who may be able to take up the issue with the DHSS more effectively than an individual CHC and also campaign on the basis of this information for the strengthening of CHC rights.

CHCs, according to the DHSS, are not legal entities and it is generally considered that they cannot take legal action to enforce their rights. CHCs do not have the resources to take legal action, though some local authorities have taken legal action on behalf of CHCs where they felt it was in the public interest to do so.

Legal action is important as a last resort in enforcing CHCs' legal rights. However, like any pressure group, battles are often most effectively won through campaigning, informal lobbying and by using local politicians, the press and mobilising community support.

4. 4 CONFIDENTIALITY

There may be occasions when NHS managers give information to the CHC staff or members in confidence. However, CHCs and NHS administrators may not agree on what should be considered confidential. CHCs and DHAs need to work out a clear understanding between them about the status of discussions and information received. There should also be a procedure to cover circumstances where one side decides that it cannot consider an issue confidential.

Information which management are prepared to give only in confidence may give useful background information, but also may cause tensions by dividing the loyalty of the CHC between the public and NHS management. The CHC is a collective body and there may be difficulties if Chair and Secretary accept information which they cannot share with members.

Sometimes Chair and Secretary may feel that the information given should not be confidential and cannot be accepted in confidence. It may sour relationships unnecessarily if they publicise it. However, they can use the information to ask pertinent questions to the authority or elsewhere which may give them the same information from a non-confidential source.

The CHC itself needs to work out its policy on confidential information. Keeping a confidence is voluntary and there may be occasions when the CHC may consider it to be in the public interest to divulge the information.

The following need to be considered.

* Are there sound practical reasons for regarding the information as confidential? Why is this information being given to the CHC in confidence?

* Will the information assist the CHC in being more effective?

* What effects would the access to confidential information have on internal CHC relationships and on the CHC's relationship with the public?

PART 5: RUNNING THE CHC

5.1 PLANNING AND ORGANIZING THE WORK

AIMS AND GOALS

CHCs have not been given clear terms of reference. Each CHC sets its own priorities and goals and decides how best to achieve these. Because of the limited resources and the heavy workload, it is easy to become reactive and make policy decisions without looking at what is being achieved.

It is important for all CHCs to set itself aims and to re-assess them from time to time. On the basis of this, detailed tasks can be set and monitored.

It may be useful to go back to the aims of the NHS and relate the role of the CHC to them. The following exercise looks at the central aims and priorities for the CHC as perceived by members.

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EXAMPLE: SETTING GOALS AND METHODS

(Based on Christine Holloway and Shirley Otto, 'Getting Organized', NCVO and Bloomsbury CHC).

In this exercise CHC members, either individually or as a group, list the views on the central aims and ways these might be achieved.

Central Aim: To make the NHS more appropriate and accessible to local people.

Goal 1: To maintain an up to date record of NHS services available in the District.

Method: by collecting this information from relevant sources;

by visiting NHS units.

Goal 2: to make this information available to the public.

Method: by producing a regular newsletter;

by having an office accessible to the public;

by producing information leaflets.

Goal 3: to improve access to the NHS for people from ethnic minorities, the homeless, housebound and on low incomes

Method: - by working with groups representing the interests of these people to encourage participation in the CHC and the NHS;

-by undertaking surveys to identify needs and ways of improving care;

-by setting up innovative projects, e.g. advocacy schemes.

Goal 4: to seek actively the views of the public on the NHS.

Method: -by keeping contact with groups and interested individuals;

-by undertaking specific surveys;

-by co-opting members of the public on to the CHC.

Goal 5: to support and advise people who are dissatisfied with the services they have received.

Method -by trying to sort out immediate problem, and where a grievance exists, advising how to pursue it.

Goal 6: to promote the development of primary and priority services

Method -by campaigning for increased resouces;

-by participating in planning teams.

Goal 7: to keep informed of health authority /FPC planning and respond to consultation as appropriate.

Method: -by maintaining regular contact with health authority / FPC officers to ensure early consultation on proposals; -by representation on planning teams.

Goal 8: to evaluate the CHC's work

Method: -by incorporating a review procedure in all working groups and CHC projects.

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SETTING POLICIES AND PRIORITIES

Policies, based on defined aims, provide a basis for staff and members to pursue the goals of the CHC without constantly referring back to the CHC for guidance. Clear policy statements can also provide a coherent identity for the CHC among outside groups and the NHS. Central Manchester CHC attempts to ensure that policy statements are drawn up on areas of work. These policies, with resolutions passed at the ACHCEW AGM (and endorsed by the CHC) are published as a statement of CHC policy from time to time.

There are many areas in which the CHC may want to be involved. However, there are insufficient resources to deal with them so that the CHC needs to decide how to concentrate on areas which are most important and where it can be most effective. These priorites will need to be frequently reviewed as circumstances change.

Hastings CHC has a statement of its main priorities based on national, regional and local NHS priorities. Whenever a new important issue arises, it may be given no priority and therefore no action on it is taken. On the other hand it may be given a high priority and a decision made about what must be consequently dropped.

How does a CHC choose where to concentrate its energies? Two factors are important to consider:

* the relative importance of the current and expected issues before the CHC, listed in order; and

* The CHC's resources in time, expertise and finances.

The resources available to the CHC will determine how many of the prority issues can be tackled successfully.

ORGANIZING THE WORK

The Workplan

The workplan translates the priorities into action. It needs to:

* be based on priorities according to a general policy
* involve all members in the activities
* be flexible so that the CHC can respond quickly to issues as they arise which need immediate attention and cannot be planned
* take into account the routine work and the staff and financial resources available.
* include a time table and specific targets by which the CHC can review progress.

A variety of topics and activities - visits, surveys, public relations, campaigning, consultations- can help maintain interest and commitment of members and staff. If all the time is spent in responding to the NHS, it can be demoralising and staff and members may feel they are just shadowing the District Health Authority rather than going out into the community and finding out its views.

Working Groups

Once priorities have been determined, the work needs to be organized to reflect them. Most CHCs organize themselves in working groups. Some have just two working groups: hospitals and the community. Others may have up to eight.

Working groups can be organized in five main ways.

1. **Locality**: This is particularly useful, where there is a large geographical area to be covered or issues arising specific to a locality.

2. **User Interest Group**: The CHC can mirror the Planning Teams or DHA Care Groups, covering, for example, mental health, handicap, elderly, maternal and child health, acute services, primary health care and community care. The disadvantage is that it reflect the NHS as it is and may not highlight the needs of particular user groups whose needs are not met by the NHS, such as the needs of ethnic minorities or the single homeless.

3. **Function:** Publicity, Complaints, Campaigning, Finance and General purposes/ Executive Committee.

4. **Special issue groups**, a group is set up to investigate a particular issue or set up a particular project and report back to the CHC. The advantage of this is that members have a specific target and time limit and so may find it more rewarding and able to give more time for the duration of the project, knowing it will end.

Some CHC staff prepare agendas and papers for working groups. Others are serviced by the members themselves. If staff are expected to service the working groups, this will involve a lot of administration and evening meetings. Whatever the arrangement is, staff will need to provide access to all the necessary information and support so that the energies of the working groups are used most effectively.

There is no right or wrong approach. Most important is for each working group to have clear terms of reference and understanding of the power delegated to them. They will also need clear goals by which they can assess what they are doing and prevent them from stagnating or losing momentum. The right approach for one year may need rethinking in the next.

MONITORING THE CHC

Where the CHC has a clear workplan, it is easier to review what it has achieved and whether the outcome reflected the time and energies involved. On the basis of this, a workplan for the following year can be devised.

At the same time the CHC needs to consider how well it reflects the interests of the community and if it is attracting involvement from other groups in the community, for example, who represent ethnic minorities.

Many CHCs once a year devote a day to review the previous year and set priorities for the next year. The review meeting can also be used as a way of carrying out a staff and member appraisal and gives an opportunity for a frank exchange of views. North Manchester requires each sub group to produce yearly a detailed report which analyses the issues covered by the Group during the previous 12 months, the action taken and the outcome of that action and whether it has been effective.

A programme for a Review Day is given below.

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PROGRAMME FOR REVIEW DAY

(Based on programmes run by Northumberland CHC and North Tyneside CHC)

Session 1:

What is happening now? Sharing current concerns of CHC working parties

Members' expectations of the review

Session 2:

The context: Where is the CHC going?

Care in the community

Declining resources

Self help and the search for alternatives

Private medicine and privatisation

Session 3:

How do these apply to the CHC?

How can the CHC organize itself more effectively? (working groups)

How does the CHC relate to the Health Authority and Practitioners?

CHC Visiting

CHC Publicity

Role of members and role of staff: Mutual expectations

Members could be divided up into small groups (2 - 3 people) to discuss aspects of the CHCs work in order to:

- Review what is done, ask if it still should be done. If so discuss how well it is done and decide whether it can be improved.

- Review what is not done, ask whether it should be done, if so how to go about it.

Session 4:

Report back from workshops on their ideas and for all members to propose the future pattern of CHC work.

EXAMPLE :QUESTIONNAIRE TO MEMBERS

A questionnaire can also be sent to members asking for views, anonymously if they so wish, about their involvement in the CHC. (Adapted from North Tyneside CHC)

The purpose of this anonymous questionnaire is to provide information which will help members review the work of the CHC. The aim is to identify those aspects of CHC work and organization which members find satisfactory and those elements which are unsatisfactory or are lacking altogether.

Please tick appropriate box to signify your answers:

FULL COUNCIL MEETINGS

1. Council Meetings are generally held at (place) Do you think:

   a) They should continue there YES NO

   b) Be held in different locations in the district? YES NO

2. CHC meetings are currently held on (day) at (time). Does this time suit you? If not what days or times would suit you?

3. Council meetings are held once a month. Would you prefer them to be held:

   a) Once a month, as now ___

   b) More frequently, if so how often, ___

   c) Less frequently, if so how often ___

4. Have you any suggestions about the way CHC meetings might be structured to make them more interesting to the public?

5. The following are a list of papers routinely sent out to members. Please indicate whether you read them and find them useful

	Useful	Not useful
To be filled in as appropriate		
(i.e. newsletters, DHA papers, etc)		

6. Do you think that the information you routinely receive from the office is

   a) Too little? _____

   b) About right? _____

   b) Too much? _____

Do you have any other comments about the information supplied by the office to members?

WORKING GROUPS

The CHC has the following working groups: (.....)
Each member is expected to belong to a working group.

7. Do you belong to a working group YES NO

If not, why is this?

a) Lack of time

b) Groups do not reflect your interests

c) Other reasons

8. What topics are you particularly interested in?

_____
_____

9. Do you think a working group should look into these ?

_____
_____

10. Dates of working group meetings are decided on a month by month basis. Would you prefer them to be determined in advance on a

Quarterly basis _____

Half-yearly basis _____

Yearly basis _____

11. Do you have any suggestions about how the work of the CHC could be organized ?

12. When you joined the CHC, do you feel you had enough information about its activites and role?

YES NO

What information would have been useful to you?

Please return by (Date) to the CHC in envelope enclosed.

5.2 MAKING THE MOST OF RESOURCES

ASSESSING RESOURCES

In working out a programme for one year, first take into account the resources available to the CHC. It can be helpful if staff analyse for a short period how much time they spend on each activity:

* dealing with the public enquiries by phone or visit
* assisting complainants
* services to members
* attending meetings- NHS, local authority and voluntary organizations
* servicing committees
* administration.
* specific projects
* supervising volunteers, MSC, student placements
* reading relevant material and 'thinking'

What staff spend time doing may not reflect either their priorities or that of the CHC and this may show ways of using time better. The CHC may decide, for example, to only be open to callers to the office at certain times or to comment only on NHS consultation documents of direct relevance to the district or where they feel they might have an impact.

STAFFING

Staff establishments

Staff establishments, including gradings, are determined by the Regional Health Authority (Welsh Office in Wales). Some RHAs allow CHCs flexibility in employing part-time staff or consultants in place of a full-time post.

There are ways of increasing person power, but all involve permanent staff in considerable extra work in setting up and supervision.

Manpower Services

Community Programme

CHCs can apply for MSC placements on their own behalf. Alternatively sometimes, a local organization will act as a managing agent for a number of different projects who each have placements based with them but do not administer the salaries or employ staff.

Schemes must be of benefit to the community and involve work which would not otherwise be undertaken. They must be approved by the Manpower Services Board and local trade unions.

The employer is re-imbursed for the wages of staff and can receive some 'operating costs'. Workers must be people who have been unemployed for particular period, depending on their age and be in receipt of benefit.

Staff can be employed for up to one year. Training is encouraged and needs to be worked out as a part of the work programme for each MSC placement.

Running a Scheme using MSC workers has a number of difficulties. The fact that workers can only stay for one year means that it is most suited to short term or one-off projects rather than a continuous service, especially if lengthy induction or training is needed.The conditions of recruitment - that someone is unemployed and in receipt of benefit means that many women who might be suitable are not eligible.

Community Programme Schemes used by CHCs include: Manchester CHCs (developing an information service), North Tees (Ethnic Minority Project), Haringey (Health Link Workers). Further information is available from the Local Community Programme Link Team, whose address is available from Job Centres.

Youth Training Scheme(YTS)

YTS schemes provide training and planned work experience to up to 2 years for 16 year olds and 1 year for 17 year olds. For two year placements this should include 20 weeks off the job training at college or training centre.

CHCs who have had YTS placements include: West Essex, Central Manchester. For further information contact MSC Training Division Area Office.

Employing Project Staff

The CHC can apply for funding to undertake particular projects, such s advocacy, research or information projects, and employ staff, through the DHA or RHA.

VOLUNTEERS AND STUDENT PLACEMENTS

Volunteers

Volunteers can be used either in general office duties or on specific projects, such as information gathering or local NHS guides, which CHC would otherwise not be able to undertake.

Volunteers are not free labour. There are costs in terms of staff time and supervision. If volunteers are worth using at all, they are worth taking seriously. Most important is to find out from prospective volunteers what they hope to gain from their involvement with the CHC. If this is compatible with what the CHC wants, take them on with clear terms of reference and understanding of the arrangements for their work.

Student Placements

Many further education courses - covering health and social sciences, library and computers, involve placements for students. Many CHCs have regular placements, which vary in the length of time and in the end product required of the student. In nearly all placements, some supervision will be required for the student.

Before taking on a student, it is necessary to talk to the supervisor to ensure that expectations of the student are compatible with the needs of the CHC. If student placements are well planned and of sufficient duration, they can be useful in doing surveys or specific projects.

It may be possible to use students from local colleges, without a specific placement, to assist in graphic designs or in writing computer programmes for the CHC.

BUDGETS

The CHC needs to plan the use of the discretionary funds at the beginning of the financial year to obtain the maximum benefit. This should be taken into account in planning the year's work.

Though many CHCs do not have the resources to do what they want, there is often underspending by CHCs in the RHA as a whole. As staff costs are a major part of the budget, a period of staff vacancies can lead to underspending. In some regions a proportion of underspending can be carried over by each CHC and the remainder is 'lost'. Where the CHC knows that it is likely to underspend, it can give funds for a project by ACHCEW or the regional association.

In other regions both underspending and overspending are carried forward and the total regional CHC budget is treated as a whole, so the overspending in one CHC is used against underspending in another.

Some CHCs have negotiated a reserve pool for projects which can either be made available to projects for particular CHCs or for projects of benefit to all CHCs. The Yorkshire Region allows the underspend for all CHCs to be used on such projects. The West Midlands RHA set up a small group to encourage research and information projects in the Region. The North West Thames RHA funds a part time person to service the Regional Liaison Group. North West RHA is exploring the possibility of establishing a 'Bridging Fund', to which CHCs might apply for major items of equipment. Other RHAs will let a CHC pay for expensive equipment over 2 financial years.

It is obviously to the advantage of CHCs to persuade the RHA to provide such a fund which could be used for region-wide research projects or even for servicing the regional association.

ADDITIONAL FUNDING

There are additional sources of funding for CHCs. The CHC is in a fortunate position compared to voluntary organizations in that it may be able to cover the costs of overheads from their own budget and only need to apply for the direct costs.

Sources of funding

Sources of funding can include the RHA (Research Committee), DHA, FPC or the local authority, joint financing and Inner City Partnership money. RHAs have Research Committees which can give small grants. Joint funding has been obtained by some CHCs to produce information handbooks and leaflets.

There are also short term (3 years) grants available from time to time from the DHSS for particular services. The 'Opportunities for Volunteering' scheme, for example, gave funding to start a citizens advocacy scheme in Worcester.

Some CHCs have been concerned that accepting money directly from the DHA may lead to a loss of independence. However, if the CHC is undertaking services for the DHA - such as carrying out a survey or producing information leaflets/ handbooks, it is reasonable that this should be paid for by the health authority.

There are also local and national charities who can give grants to CHCs. The Kings Fund also has given grants to CHCs or a group of CHCs. The National Council for Voluntary Organizations produces a Directory of grant making trusts.

Writing Funding Applications

The following outline matters which need to be covered in writing a project proposal.

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SUMMARY: This should be a clear and short summary of what the project will do and achieve.

INTRODUCTION: Describe who the group is making the application, its aims and activities. Letters of support from the DHA or other agencies or clients can be used to back this up.

PROBLEM / ASSESSMENT OF NEED: Describe the problem which it is intended to tackle, using back up statistics.

PROJECT OBJECTIVES: Set out the objectives and the outcome you hope for.

METHODS: How will you set out to accomplish your objectives. You can bring in information about how other groups have successfullly used the methods you propose to adopt.

EVALUATION: How do you plan to evaluate the project to see you are meeting your objectives?

FUTURE FUNDING: If the project is to continue after the initial period of funding, say how it will be funded.

BUDGET: A checklist of items which may need to be costed is given below.

CAPITAL/ START UP COSTS

Phone installation, office equipment, Fire prevention equipment, programme equipment.

Staffing costs (advertising, interviewing)

REVENUE

Staff costs

Salaries, NI and superannuation; Travel and subsistence for staff; Contingency fund for employing temporary staff; Staff Training

Administrative

General Insurance; Rent/Rates; Heat and light; Cleaning and maintenance; Phone;Printing/ Photocopying; Publicity; Affiliations/ subscriptions; Stationary; Postage

Fees: Audit, book keeping, consultancy, specialist fees

Evaluation Costs

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COMPUTERS

Before buying a computer, the following points should be considered:

1. Work out what the computer will be used for.

The main uses for a computer for CHCs are :

* Wordprocessing: It terms of drafting, updating leaflets and reports, wordprocessing can save much time and labour. It is also possible to get reports and leaflets typeset straight from computer disks.

* Mail outs: Most CHCs keep long mailing lists. Using a data base programme it is possible to sort it out and use it flexibly. For example to target mailing to groups and people interested in particular subjects or to groups or GPs in particular areas.

Without difficulty you can also personalise letters which can improve the number of responses received from information enquiries or questionnaires sent out to key people on the mailing list.

* Information services: Database programmes can also be used to enable access to information. Manchester CHCs developed a small computerised information service of about 3,500 publications. It started with one year MSC funding and the RHA agreed to fund it for a further year. This will enable the service to be better publicised and made available to the public on a more regular basis.

* Recording complaints and enquiries

* Research: On a more advanced basis computers can be used to record and analyse research data and survey results.

* NHS information systems. There are a number of packages for performance indicators available for a BBC and a IBM compatible. Each DHA and RHA has its own systems at present. However, they will be conforming to a set of international standards (OSI) and after that machines will be required to conform to these standards.

2. Draw up a detailed specification of your requirements

This should be as specific as possible, including the likely size of mailing list, the different ways you might want to access them. (i.e. Will you want access by area, by the individual's particular interest or skills?)

3. Identify the software you require.

Software is the procedures and programmes you use on the computer for your data base, mailing list or wordprocessing.

Ask the advice of ACHCEW, Regional and District Computing Services and anyone else who has used different types computers and software.

4. Identify the computer

For databases, you need two disc drives. For wordprocessing and mailing labels only, one drive is enough in the short term. Try out the software on the machine before buying it. Not all machines which are IBM compatible are 100% compatible.

At this stage you need to work out the funds available, who will be using the machine and what sort of training and support will they need. Ensure that the dealer provides a good customer support service.

5.3 CHC MEMBERS

The CHC depends on the commitment, local knowledge and contacts of members. It is important that the CHC attracts and keeps the interest of useful and committed members. It is also important to encourage the involvement of local people who may later become members.

ATTRACTING COMMITTED MEMBERS

It may be necessary from time to time to remind appointing bodies what CHC membership entails. It is also important to look at ways of attracting people from different ages and sections of the community, including representatives with disabililties and from ethnic minorities.

Information for prospective members

In some CHCs prospective members discuss the role with the Chair or Secretary. Many CHCs produce guidance for prospective members, indicating the amount of time and the range of duties which membership of the CHC entails.

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INFORMATION FOR PROSPECTIVE MEMBERS

(Adapted from Wakefield CHC)

Membership of the CHC involves a significant commitment so that it is vital that all interested people are fully aware of what this will entail before taking up membership.

1. CHC AND OTHER MEETINGS: Frequency, time and length of duration

2. INTEREST/WORKING GROUPS: These Groups provide an opportunity to look at health of specific parts of the community and at particular services in depth, to develop special interests and become involved in particular campaigns or projects. List the current interest groups, frequency, times and duration of meetings

3. VISITS TO NHS UNITS

4. ATTENDING COURSES, CONFERENCES AND SEMINARS

5. KEEPING UP TO DATE ON HEALTH SERVICE ISSUES

6. REPRESENTING THE CHC ON COMMITTEES

7. PARTICIPATING IN LOCAL ACTIVITIES ORGANIZED BY THE CHC: to publicise the CHC and educate the public about health and health services.(e.g. assisting at CHC stalls at fairs or exhibitions, participating in open fora and public meetings).

8. REPRESENTING CHCS AT NATIONAL AND REGIONAL LEVEL.

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Voluntary organization elections

The organization of the elections is the responsibility of the Regional Health Authority. Some RHAs organize the elections themselves, others pay a Council of Voluntary Service or the Electoral Reform Society to organize them. The electorate is based on a list of voluntary organizations eligible to vote. The election can be postal ballot or at a special meeting. The detailed arrangements are normally agreed in advance between the Regional Association of CHCs and the RHA officers.

Some CHCs hold separate meetings or do their own publicity for the elections - to inform organizations about what the role of a CHC member entails and to introduce candidates. Local publicity by the CHC, in addition to that of the RHA, can produce results in attracting more interest and involvement by groups.

The most important points to consider are:

* Does the list include all the voluntary organizations with an interest in health in the District?

* How can voluntary groups be encouraged to put forward appropriate candidates;

* How can the CHC encourage the range of organizations, covering the main client groups, to put forward candidates for election.

A reserve list is maintained from which new members are drawn if an organization representative fails to take up the place.

BRIEFING NEW MEMBERS

What do members need to know in order to be most effective? How can they get this knowledge. There are many different approaches. It is worth checking what members want before giving them files of background papers or elaborate training programmes.

Training Programmes

Training and briefing is important and most arrange this to include background to the NHS, the District, including visits, and also the CHC's style of working. This is important to arrange as soon as members are appointed so that they can feel involved and take their role in the CHC. For the general introduction, some CHCs combine together to share training sessions and seminars. Many CHCs either individually or more often as a regional association have set up links with local polytechnics or university departments who run seminars and courses for members.

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GETTING NEW MEMBERS INVOLVED

Manchester CHCs have for several years organized an induction course for new members. In 1986 a different approach was tried.

In a relaxed atmosphere with food and drink, new CHC members were paired off and asked to find out about each other, their reasons for coming on the CHC and what they thought they could offer. The new members then reported back on each other to everybody in the room and this highlighted many issues which might become priorities in the next year. After that each CHC Secretary took a particular aspect of the work and outlined what was expected from members and what rights they had in carrying out their duties. Then major issues were drawn out for more detailed induction sessions.

In the past it was assumed that all new members realised that they were there to ascertain and represent the patient's viewpoint. However, there may be some difficulties when new members work or have previously worked in the NHS and therefore come on to the CHC with a different viewpoint. Throughout the session the message was deliberately geared to engender a feeling of esprit de corps between members and that they were in a unique position on the CHC to work for the patient.

Following the meeting, it was felt that new members who attended the evening had a greater sense of common aim.

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CHC BRIEFING PROGRAMME

South Birmingham developed an ambitious programme for new members in 1986.

The aims of the programme were to:

a) welcome new members and integrate them into the CHC as a group

b) inform them about the role of the CHC and their responsibilites and contribution as members

c) widen their existing knowledge about the characteristics of the District and introduce them to the health services provided

d) give some background information about the NHS in the District, e.g. financing and planning of services and discussing key issues for particular services with health service managers and officers.

The programme was built around the routine programme of meetings (CHC and working groups) with additional visits and opportunities for socialising (e.g. coffee evenings, a tour of the district and a course of evening briefing seminars).

The programme ran for 14 weeks. In this period there was one evening meeting a week (either the CHC meeting itself, a working group meeting or a training session) and one visit a week (day time or evening).

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Members Handbooks

A number of CHCs produce handbooks for members. These include not only basic local information about the health service and about the services which the office can provide, but also a code of practice indicating what is expected of members. (For example, procedures on visits and contacts with NHS staff and procedures when members talk to the press).

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TRAINING INFORMATION PACK

Walsall CHC have produced an information pack for new members. This has provided a basis on which to develop a more informed discussion in the subsequent training sessions. The information pack is divided into sections so that it can be updated easily or additions made.

The Contents (with adaptations) are given below:

A Address, telephone number, office hours and staffing of the CHC

B Membership:
Council membership, process of nomination, terms of office, absence rule
-Current Membership
-Co-opted members

C Internal Organization:
-Internal structure of the CHC
-Remit of sub groups
-CHC representatives on committees
-Regional and national organizations of CHCs
-Standing Orders for CHC meetings
-Standing financial instructions for the CHC
-Services carried out by Secretariat -complaints and administration.

D CHC Statutory relationships to the DHA and FPC
-Relevant Circulars (HC(81)15, Statutory Instruments,etc
-NHS planning system

E Information about local health services
-Profile of DHA services
-Profile of FPC services
-Brief CHC guide to NHS services
-List of abbreviations
-List of senior staff at DHA,FPC and RHA.

F Being a member
-The work involved- meetings, visits, training opportunities
-Legal liability and defamation
-Members expenses
-Comments to the media
-Data Protection Act

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Involving new members

Briefing new members is not just a question of giving out information, but also finding out what new members expect from the CHC and can contribute to the CHC.

It may be worth asking new members about what they hope to achieve as a CHC member, what skills they can bring as well as their availability for attending meetings or visits during the day.

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QUESTIONNAIRE FOR NEW CHC MEMBERS

(Based on North Tyneside CHC)

1. The CHC is invited to participate in meetings and make visits during working hours. Are you available during the day?

Never _____

Occasionally by prior arrangement _____

Often _____

2. The CHC is often invited to speak to local groups and send representatives to local meetings. Would you be:

a) Willing to give talks to local community groups about the CHC

b) Represent the CHC at meetings of local groups/ health service?

3. What would you like your main contribution to the CHC to be?

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KEEPING MEMBERS INFORMED

Information, circulars, courses, newsletters stream into a CHC office. The amount of this information passed out to members, digested or undigested, varies from CHC to CHC. Too much information can discourage member involvement as well as too little information.

There are four categories of incoming mail, and members need to consider how much information they want:

* Information which gets sent to all members
* Information which goes to specific working groups or members
* Information which goes only to the Chair
* Information which goes to the file or wastepaper basket.

Some CHCs send a weekly envelope to all members with any information thought relevant. In Liverpool all Members are asked to fill in a form stating the topics on which they are willing to be consulted or would like to receive information.

Others produce a summary of publications, notices of meetings and conferences and courses received in the office as a service to Members. Members can then ask for more information if they are interested. In addition some CHCs produce a short newsletter for members outlining the main matters about which members should be informed, both national and local.

ACHCEW produces Community Health News, which has many items of interest to members.

Seminars on particular issues, such as joint financing, the working of the family practitioner services, looking at health needs of ethnic minorities, rights of patients or information sources in the NHS may also be held from time to time to inform members. In the West Midlands, these are arranged with the Department of Extra-mural studies at Birmingham University.

CO-OPTING MEMBERS

According to the regulations CHCs can appoint non-CHC members to serve on sub-committees of the CHC. Two thirds of the members of a sub-committee must be members of the CHC. Co-options can be a good way of involving other interested people who can't easily be appointed as members or who have particular interest or skills in a particular area. It can also be a good experience and grounding for people who can then become full members. As there are statutory limits on the number of co-opted members, it may be simpler to refer to them as 'observer members'.

Many CHCs advertise for co-opted members in their newsletters or in the press. Wakefield CHC has a formal selection procedure with interviews by the member group and selections are ratified by the whole council. North Gwent runs a postal ballot of all members in appointing co-opted members. Some appoint co-opted members for a limited time period.

Others work on a principle of self-selection. Central Manchester CHC normally have between 10 - 15 'observer members' and have put particular efforts into recruiting local people, working class, black, disabled and younger people. Originally women were included in the list, but this is no longer a problem. They have been particularly successful in relation to people who live in the district and black people; less so in relation to young and disabled people. A number of observer members have gone on to become full members of Council.

STANDING ORDERS

Some CHCs have developed Standing Orders for the conduct of CHC meetings and to regulate CHC procedures. Some are based on the instructions in the Statutory Instruments. Others are very detailed and generally developed only after conflict which has arisen within the Council.

Financial Instructions have been developed by a few CHCs. The CHC is an independent budget holder and accountable to the RHA through the Secretary for the disbursement of its budget. Clear procedures should be laid down to ensure that the expenditure is properly controlled. Misunderstandings can arise between the Secretary and Members or the Chair about expenditure. Staff are also in a vulnerable position, if clear regulations are not laid down.

An example of Financial Standing Instructions is given below.

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FINANCIAL INSTRUCTIONS

(Adapted from Walsall CHC)

1. Individual items of expenditure up to £150, except courses and conferences, can be authorised by the Secretary.

2. Items of expenditure exceeding £150 but below £500, except courses and conferences, shall be authorised by the General Purposes Committee, of on the Chair's authority if the item is urgently needed.

3. Items costing over £500 should be approved by the full council, or on the Chair's authority if the item is urgently needed. If authorised by the Chair, the expenditure should be reported to the next Council meeting for ratification.

4. Regional Supplies Divison will be used whenever practicable for purchases.

5. Rent, rates, electricity and phone bills are to be authorised for payment by the Secretary.

6. The Secretary may transfer money across budget headings as necessary during the course of the finanical year in order to make the best use of the budget, and notify the DHA's financial management section.

7. The Secretary will provide an estimate of expenditure to the General Purposes Committee at the beginning of the financial year, after 6 months and as soon as possible after the end of the financial year.

8. The CHC Secretary is responsible for certifying that members and co-opted members and CHC staff expense claims are in respect of CHC duties and ensuring that they are correct as far as possible. Members should provide receipts where possible and submit claims monthly.

9. The Chair, or in his/her absence the Vice-Chair, is responsible for certifying the Secretary's expense claims are in respect of CHC duties and are correct as far as possible. The Secretary will provide receipts wherever possible.

10. All courses whether attended by staff, members or co-opted members, costing over £25.00 for the course fee, must be approved by the Council. They may be authorised by the Chair if the course needs to be booked urgently and the subsequent Council meeting should be notified of the Chair's action for ratification.

11. The CHC Secretary may authorise attendances at conference by staff or members costing less than £25.00. The Chair should be informed of all such conferences which staff wish to attend.

12. The record of expenditure is available for inspection by members at any time in the CHC office.

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5.4 THE ROLE OF MEMBERS AND STAFF

In an effective CHC the professional skills of staff are complemented by the skills, commitment and local knowledge of members. Staff bring in particular professional skills, which are defined by the selection committee on appointment - knowledge of the NHS, community development, public relations, social work, administrative or research. Members bring knowlege and contacts with the local community and, often, of particular groups of users.

Perhaps the most serious disabling factor in a CHC is the mismatch of the expectations of members and staff. CHC staff are isolated with no immediate supervisor and the nature of the job means that they do not relate closely to or identify with their official employer, the RHA. For staff a change in Chair or membership expectation, may lead in practice, to a change in the job they do.

The following is mainly based on notes developed by the North East Thames Secretaries and Staffs which were sent out to Chairs by the Regional General Manager as guidance. All text in the quotations come from this paper.

> "Care should be taken by all to ensure that roles do not become confused. A Chair should take an interest and be supportive of the Secretary's work and be satisfied that Council business is being properly attended to. Secretaries should not assume the status of a CHC member and should demonstrate understanding of their role and status as an Officer of the Council. Trust and confidence are essential in relationships between officers and staff.It is important for members to realise that they are not managers and that the success of the Council will depend as much on the work which they contribute as it will upon the staff efforts".

ROLE OF THE RHA

> "The RHA has a dual responsibility as the employer of the Secretary and staffs and as the establishing authority for CHCs.As an employer, the RHA must comply with all the relevant employment legislation, terms and conditions of service and negotiated agreement. It should also offer suppport, guidance and advice, maintaining the closest possible contact with Secretaries on an individual and collective basis so as to assist them in developing their full potential".
>
> As the establishing authority the RHA is responsible for determining the level of funds, the provision of resources, including premises, employment of staff and the appointment of the full complement of members. The RHA has responsibility to make available the resources of its own training, press and public relatiorns, legal and other specialised services when requested.

ROLE OF THE SECRETARY

Secretaries are accountable to the full Council and report to the CHC Chair. All CHC Secretaries should have a job description, with clear delegation of power. In general the job is in two parts:

1. "those duties where the Secretary work within clearly defined parameters and act as the 'servant' or agent' of the Council". These duties include the management of the CHC office, budget, keeping minutes of meetings, producing papers and information required by members in accordance with the policies and priorities which have been established by the CHC.

2. "those duties which lead the Secretary to produce ideas and take initiatives for members consideration".

All other staff are accountable to the CHC Secretary, who is responsible for monitoring staff performance and ensuring observation of the terms and conditions of employment.

One of the major differences between CHCs is how they see staff in relation to members. Three examples, elements of which feature in the work of all Secretaries, are given.

The Secretary as Committee Clerk: Staff act on instruction from Chair and members. The CHC may become dominated by a few active members who may only represent a particular aspect of community interest. It is dependent on active members, who if they leave may not be easily replaced. The CHC may find it difficult to develop independent projects, because staff may not be of the calibre to act on their own initiative.

The Secretary as Development Officer: The Secretary, as the 'professional', filters the priorities and information but encourages members to develop in particular ways according to their agreed work plan.

The Secretary as Director: CHC members determine overall policy and monitor the work of the staff. They leave most of the work to the staff. Staff may set up projects and raise funds and undertake surveys etc. There is a danger that the CHC fails to use the most important resources available to it - the membership. The CHC is a lay committee and this is its strength.

There are strengths and weaknesses in each of these three examples. In general, the more unpredictable and less routine the work is, the more independence must be given to staff. If there is a high turnover of members, the Secretary has an important role in ensuring continuity in the CHC.

The situation also changes over time. CHC staff after being in post a few years often have far better local knowledge and contacts for getting things done than members. On the other hand they may experience 'burn out' and understand too well the problems of management.

THE ROLE OF CHAIR

The North East Thames guidance advises thus.

> "There are readily identifiable lines of demarcation between the functions of the Secretary and the Chair. The Secretary is clearly responsible for the day-to-day administration of the CHC's work, its office and for the supervision, within terms and conditions of RHA employment, of any CHC staff.
>
> Chairs are not involved in day-to-day administrative matters, which are the clear responsibility of the Secretary. They have a responsibility to keep in touch on the progress of CHC business and on matters which are likely to be the subject of consideration by the Council, or upon which they may be approached independently.

In some of their activities - servicing the Council, providing information and advice, dealing with correspondence and enquiries and complaints- Secretaries will have a clear mandate stemming from a decision of the Council, from legislation or established practice. However, in others they may need to seek the support and authority of the Council and where this is necessary between meetings or in cases where the Council's formal direction is not essential, the Secretary may require the Chair's approval of a course of action.

Chairs have the duty and authority to lead and monitor the passage of CHC business. It will be necessary from time to time to take Chair's action but of course this must not run counter to any decision of the Council. Where no such direction exists, authority is limited to the extent that it is reasonable to take decisions without first referring to the CHC. These actions must be reported to the CHC for ratification.

The Chair needs to be well informed as regards the work in hand and whilst it would not be appropriate for the Chair to take on a managerial role it must be expected that they will need to be briefed on certain matters, such as office workload in order to establish priorities within the office.

A clear understanding needs to be reached from the start about arrangements for regular contact between CHC meetings and establish a good working relationship. The Chair should be able to contact the CHC Secretary whenever necessary and should be informed of annual leave intentions, and sick leave at the earliest opportunity. Similarly Secretaries should be able to get in touch with their Chairs or Vice Chairs if necessary.

Vice Chairs will also need to establish a good working relationship and be involved in discussions between Chair and Secretary in order to ensure that they are adequately informed and able to stand in for the Chair when necessary."

The Chair and Vice Chair are elected by the members. It is up to each CHC to determine the period of office. There are advantages in having more than one Vice Chair to give members experience and continuity when there is a change over of Chair.

Some CHCs have a a fixed term for the Chair to ensure a rotation of members.

5.5 STAFF DEVELOPMENT AND MANAGEMENT

STAFF RECRUITMENT

The CHC needs to work out what sort of person they want as Secretary. They are unlikely to get all the skills in one person and the background and skills of the person they appoint will determine the future direction of the CHC. It is unreasonable to require other skills, after the appointment is made.

It is normal practice in many regions to include a CHC Secretary from a neighbouring CHC on the selection panel for the post of Secretary as an assessor. A Secretary, with an understanding of what the job entails, will contribute a different viewpoint, both in shortlisting and selection. A representative from the Regional Health Authority attends the interview. it is customary for them to advise the CHC rather than to participate in the appointment decision.

The interview panel needs to discuss the sort of person they are looking for, the qualities and the experience, either necessary or desirable in staff. This can be developed as a proforma and used in shortlisting. To help ensure equal opportunities, shortlisting should be done by the interviewing group. The reasons for the acceptance and rejection of candidates should be clearly kept so that the decisions could be later justified and to avoid any accusation of discrimination.

The interview panel should meet in advance of the first interview to discuss the areas they want to cover in the interview and frame questions to extract the information they want. Fifteen minutes should be allowed between interviews. This is necessary to allow the panel to discuss each candidate's application and prepare for the next applicant so the interview can focus on any experience, qualifications or gaps which the panel want to know more about. It is also necessary to take notes and discuss each candidate after the interview and not leave it until the end when memories have become blurred.

In accordance with their job descriptions, the Assistant and other office staff are responsible to the Secretary not to members. CHCs vary in whether members are involved in the selection of the Assistant and other staff. However, as the Secretary is the supervisor and responsible for managing staff, it is important that these lines of responsibility are clear.

STAFF SUPERVISION AND DEVELOPMENT

It is important to remember that CHC employees depend on the CHC for their livelihood, they are isolated, have heavy and varying responsibilties, no promotion prospects as well as anti-social hours with no overtime pay.

The Chair supervises the Secretary and monitors the work of the office. Members do not supervise or monitor the CHC staff.

From the start it is important that:

* Secretaries understand their job description and the level of decisions which they can take without referral to the Chair.
* Chair and members understand that the Assistant and other staff are responsible to the Secretary and, in general, all instructions should go through the Secretary.
* Staff are encouraged to take time-off in lieu for any work over

the 36 hour week, for which they are paid.

The Chair, in the role of supervisor, should encourage and support staff and discuss ways in which they can develop and be more effective in the job. There should be a regular staff review once or twice a year (more often for a newly appointed Secretary). At this meeting Chair and Secretary review the internal relationships and effectiveness of the office. The staff review can be based on specific targets and related to the work of the CHC or on a more general level. This need not be particularly formal, but is important to ensure, as far as possible, misunderstandings do not arise.

A basis for reviewing staff is outlined.

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CHECK LIST FOR REVIEW

(based on Checklist in 'Getting Organized', by Christine Holloway and Shirley Otto, NCVO).

On each point, action to help the Secretary develop should be considered.

* Does she/he have the skills needed to carry out the tasks? if not, how can these be developed?
* Does she/he understand which tasks should take priority?
* How does she/he feel about the work as a whole?
* How would she/he like to develop?
* Does she/he work the right number of hours - not too long or too short?

Relation with other people in the organization

* Does he/she ask for support? And offer support?
* How does he/she delegate and relate to other staff?
* Does he/she carry out the decisions of the CHC?
* Does he/she allow the CHC to know what he/she is doing?
* Are there any specific problems relating to individual staff or relating to CHC members?

Relation with other organizations

* Is he/she developing local knowledge and meeting other relevant organizations?
* Does she/he understand the relationship between other organizations and the CHC?
* Is he/she developing links with the NHS and local groups?

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DIFFICULTIES BETWEEN MEMBERS AND STAFF

RHA grievance and disciplinary procedures apply to CHC staff. These notes are based on the North East Thames guidelines.

> "Difficulties do arise in the relationship between a CHC and its Secretary. Problems should be tackled locally in an amicable and sensible way and difficulties resolved and not left to fester".
>
> "CHC Secretaries, whose jobs are their livelihood, are in an isolated position if problems develop in the relationship with the Chairman or the CHC, or in circumstances where a Council has failed to follow properly given advice. The help of RHA Officers in these circumstances should be supportive, or point to alternative or better ways of dealing with a given situation".

Informal discussions

> "When unresolved differences are leading to difficulties the RHA should be willing to give whatever help it can either to the Chair or the Secretary. Such assistance might range from advising on further local initiatives to resolve the problems or that the approach should be disclosed to the other party with a view to moving to a stage of informal three party talks between the Chairman, Secretary and relevant RHA officers. At this stage, it may be desirable to involve the Vice-Chair as well.
>
> "If informal discussions fail the second stage should be an independent person with the necessary skills of conciliation and arbitration paid for out of the Regional budget".

Formal Discussions

If informal discussions do not resolve the problems and there is a possibility of disciplinary action against the Secretary, the RHA's formal proceedings must be invoked. The CHC should seek advice at this point. The CHC can ask the RHA to discipline or give 'advice' to the Secretary. The CHC must conduct its affairs in a way that is consistent with the RHA's Disciplinary and Appeals Procedures.

In no circumstances should any staff disciplinary matter be discussed by the CHC other than after the passing of a formal motion under the Public Bodies (Admission to Meetings) Act to exclude the public and which places members under a legal obligation to maintain confidence".

5.6 ACHCEW AND CO-OPERATION AMONG CHCS

If CHCs in neighbouring CHCs can work together, they can pool their resources and increase what they can do. In Manchester, where the three CHCs share an office they were able to employ between them an information officer. In other areas CHCs set up joint briefing or training sessions for new members.

A strong association for CHCs in England and Wales is important for safeguarding the long term future of CHCs as the public's voice in the NHS and in promoting high standards among CHCs. ACHCEW was set up by Statute in 1977 to advise and assist CHCs in the performance of their functions, and to represent for England and Wales the interests whch CHCs represent locally.

ACHCEW's strength in providing an information resource and a voice for CHCs to Government and other national bodies lies in the support that it is given from member CHCs. This will determine the sense of direction and the quality of the support services. The more individual CHCs contribute to ACHCEW, the more effective it will be as a national voice for users and in assisting member CHCs in their work.

Information Clearing house

An essential part of ACHCEW's work is to collect and disseminate information on the work of CHCs - reports, campaigns, project, and topical issues. By this means, ACHCEW can help CHCs to avoid the dangers of isolation and parochialism.

ACHCEW maintains a good collection of journals, reports and reference material on health issues and policy. This enables it to answer a wide range of questions from CHCs. Where ACHCEW is not able to answer an enquiry, it is in a good position to refer CHCs to an individual or agency able to provide an answer.

Development work

ACHCEW also undertakes research, produces occasional reports and briefing papers. This work is intended to anticipate the needs of CHCs for information, but it is vital that CHCs inform ACHCEW what they might want.

FURTHER INFORMATION

CHCS - GENERAL

Handbook for Community Health Council Members, Christopher Ham, School for Advanced Urban Studies, University of Bristol, 1986 - basic information of NHS structure and issues facing the NHS of concern to CHCs,

The Public and the NHS, Christine Hogg, ACHCEW 1986, - reviews CHCs csince 1974, including different strategies adopted by CHCs.

MONITORING AND ASSURING QUALITY

Visiting

The Social Needs of People in Long Term Care, James R Elliott, Kings Fund 1982.

CHC Visiting, Pat Gordon, Kings Fund Project Paper, 1979, includes a 100 questions for members to address, when visiting.

Better Visiting: Improving the effectiveness of visiting by health authority members, Michael Drummond, National Association of Health Authorities, Members Information Pamphlet No 3., 1986

Surveys - general

Consumer Feedback for the NHS: A Literature Review, Leah Lenenman, Lyn Jones and Una Maclean, Dept. of Community Medicine, University of Edinburgh, 1986, summarises the approaches and mehodological issues arising from consumer surveys, largely undertaken by CHCs.

Consulting Consumers, and The Opinion Poll approach, Health & Social Services Journal, 1983, Nov 3 pp 1315-1316 and Nov 10 pp 1354-1355.These articles give practical hints about setting about surveys and ensuring the follow up action.

Survey methods

Research Methods, Patrick McNeill, Tavistock Publications, 1985 - A general introduction to survey methods.

Survey Research Methods, Floyd J Fowler, Applied Social Research Methods Series Volume 1, Sage Publications, 1984.

Model Questionnaires

'Being an Out-Patient', Kings Fund Project Paper No 15, 1977. (Includes a 'model' questionnaire.

What the Patient thinks, A survey of patient opinion of life in hospital,University of Manchester Institute of Science and Technology (UMIST), 1978. (Includes model questionnaire for inpatients).

Information

Performance Indicators for the NHS, Guidance for Users. available from Tony Kirkely, DHSS, Room 1419, Eston Tower,286 Euston Road, London NW1 3DA

Inter authority comparisons: An alternative method of analysis is available from John Yates, Health Services Management Centre, 40 Edgbaston Park Road, Birmingham B15.

ASSISTING THE PUBLIC

Complaints

DHSS Circulars: CHCs and complaints, DHSS HC(81)5

Complaints relating to the exercise of clinical judgement, 1981 (GEN) 43.

The Merck Manual, Saunders.- A medical textbook which covers a braod range of medical conditions.

Terms of Service of Family Practitioners, Schedule attached to the NHS (England and Wales) General Medical and Pharmaceutical Services Regulations, 1974. (These are amended from time to time).

Action for the Victims of Medical Accidents, 24 Southwark Street, London SE1 1TY, Phone: 01 403 4744

Advocacy

An Experiment in Advocacy, The Hackney Multi Ethnic Women's Health Projects, Ed. Jocelyn Cornwell & Pat Gordon, Kings Fund Centre, December 1984.

Advice and Advocacy services for people with psychiatric disorders: Good Practices in Mental Health, Advocacy Information Pack.

Advocacy: The UK and American Experience, Bob Sang and John O'Brien, Kings Fund Project Paper, 1984,

Advocacy Alliance, 115 Golden Lane, London EC1Y OTJ - set up in 1981 by One-to One, MIND, the Leonard Cheshire Foundation, the Spastics Society and Mencap.

ENCOURAGING PARTICIPATION

Using the Media

Using the Media, How to deal with the press, television and radio, Dennis Macshane, Pluto Press, 1979

Ethnic minorities

ACHCEW mantains an up-to date record of CHC activities in this area.

Providing effective health care in a multi-racial society, Health Education Council and the National Extension College for Training in Health and Race, 1984 (includes a check list for looking at local issues).

Health care in a multi-racial society, Health Education Council and the National Extension College for Training in Health and Race, 1986

No Alibi, no excuse, Greater London Association for Racial Equality, 1987. A review on the implementation of Equal Opportunities Policy in London DHAs.

Ethnic miniorities and health care in London, King's Fund, 1982

Mental health services in a multi-racial society, IND policy Paper No 2, MIND, 1986.

Racial equality and good practice maternity care, Training in Helth and Race, 1985

RELATING TO NHS MANAGEMENT

The Hospital and Health Services Year Book, (McMillian), lists health circulars chronologically and by subject. There are also summaries of all major reports and White/Green papers from 1954 onward.

DHSS Statutory Instruments, The Community Health Council Regulations, 1985, No 304

Community Health Councils, DHSS HC(85)11 - basic arrangements for the relationship between CHCs and FPCs

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