HANDBOOK FOR COMMUNITY HEALTH COUNCIL MEMBERS

SCHOOL FOR ADVANCED URBAN STUDIES

UNIVERSITY OF BRISTOL

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School for Advanced Urban Studies

UNIVERSITY OF BRISTOL

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INTRODUCTION

In the pages that follow you will find a variety of information to help you in your work as a Community Health Council member. The material has been developed in work with other new members, and modified in the light of their comments. It is intended to be interesting and easy to use, and to provide basic factual information which all new members need to know. Suggestions for further reading and where to obtain further information are included at the end of the booklet if you wish to find out more.

While the material is intended for you to use on your own, you may find it helpful to discuss certain points with your CHC secretary and fellow members. You may also find it of value to participate in a seminar soon after you have gone through the material here. The particular advantage of combining work on this handbook with a seminar is that you can hear from other new members the sorts of issues they are tackling in their CHCs and discuss your ideas and interests with them. New members from a number of CHCs (perhaps within a region) could attend such an event arranged jointly by their CHCs.

I would like to wish you well in your new career as a member of a CHC. Membership is quite demanding but it is also very rewarding. I hope this handbook stimulates your interest and encourages you to work with enthusiasm towards improving the consumer's voice in the National Health Service.

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This handbook is an updated and revised version of a training booklet for CHC members originally prepared by Chris Ham and Ruth Levitt in 1978. The handbook draws on material from the original booklet as well as on a training programme for District Health Authority members prepared by Chris Ham, Stuart Haywood and Ruth Levitt in 1981. Any comments about the handbook should be sent to Chris Ham.

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GLOSSARY OF ABBREVIATIONS

Below is a short list of the more commonly used abbreviations in the National Health Service. The list is not intended to be complete, and space has been left at the end for you to add to it.

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

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HOW THE NHS WORKS

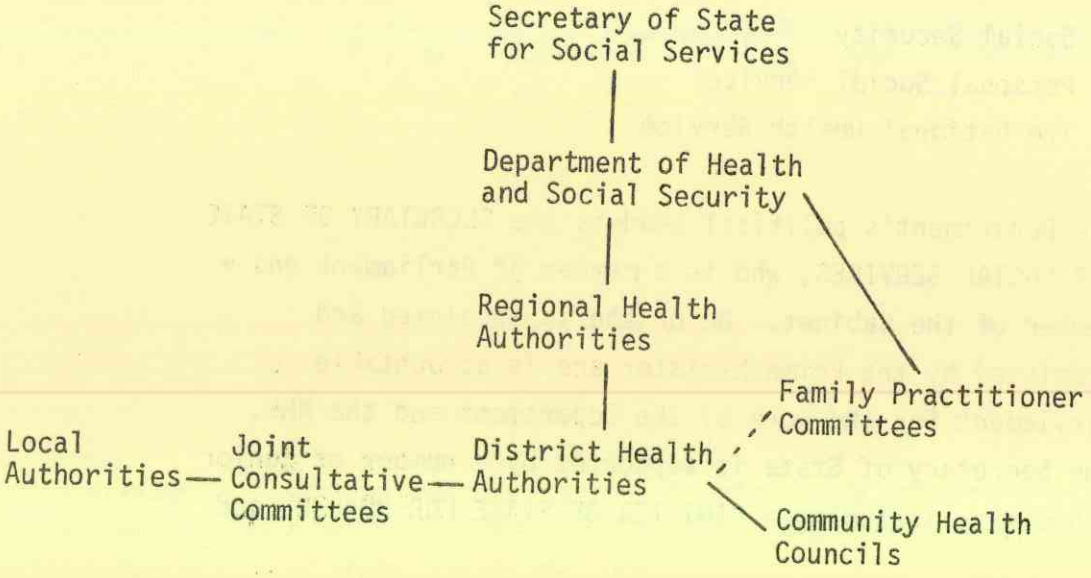
This section sets out some of the main things you need to know about the National Health Service (NHS). The paper is divided into two parts as follows:

1. The Organisation of the NHS
2. Finance

1. The Organisation of the NHS

The National Health Service (NHS) was reorganised on 1 April 1982. The new structure looks like this:

DIAGRAM 1



At the top of the structure is the SECRETARY OF STATE FOR SOCIAL SERVICES in the DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Lower down are REGIONAL HEALTH AUTHORITIES (RHAs) - there are fourteen of these in England - and they are responsible for planning and providing services for populations ranging from under two million to over five million.

Regions are divided into DISTRICT HEALTH AUTHORITIES (DHAs), of which there are 192 in England. DHAs are the basic units for management and planning in the NHS, and they each have to relate to three other bodies: COMMUNITY HEALTH COUNCILS (CHCs) who represent the views of the community to the managers of health services; FAMILY PRACTITIONER COMMITTEES (FPCs) who administer the contracts of general practitioners, dentists, opticians and pharmacists; and LOCAL AUTHORITIES who provide related services such as personal social services, housing and education. JOINT CONSULTATIVE COMMITTEES (JCCs) provide a formal link between local authorities and DHAs.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY (DHSS)

DHSS carries national responsibility for three services:

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

The Department's political head is the SECRETARY OF STATE FOR SOCIAL SERVICES, who is a member of Parliament and a member of the Cabinet. He or she is appointed and dismissed by the Prime Minister and is accountable to Parliament for the work of the Department and the NHS. The Secretary of State is supported by a number of junior ministers, including a MINISTER OF STATE FOR HEALTH, and

by around 6,000 civil servants. The most important of these civil servants are the PERMANENT SECRETARY, who is a general administrator, and the CHIEF MEDICAL OFFICER, who is a doctor.

The Secretary of State receives advice from a number of bodies, including the HEALTH ADVISORY SERVICE (HAS) and the DEVELOPMENT TEAM (DT) for the Mentally Handicapped. Between them HAS and DT visit and report on hospital and community health services for the mentally ill, the mentally handicapped, the elderly and children receiving long-term hospital care.

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

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

Each year DHSS has to share out the NHS budget between the fourteen RHAs. In doing this the Department tries to ensure that each region receives a fair share of the money available, in line with the recommendations of the RESOURCE ALLOCATION WORKING PARTY (RAWP) which reported in 1976 (see part two for more details of finance). At the same time DHSS informs health authorities of the way in which it thinks the money allocated to them should be spent, through policy documents like *CARE IN ACTION* issued in 1981. The Department also gives more specific advice through health circulars.

Individual Members of Parliament are able to raise issues through parliamentary questions and debates, and a SOCIAL SERVICES COMMITTEE of the House of Commons investigates various aspects of the work of DHSS. This select committee, which takes oral and written evidence from ministers, civil servants and others involved in health policy and the provision of health services, was

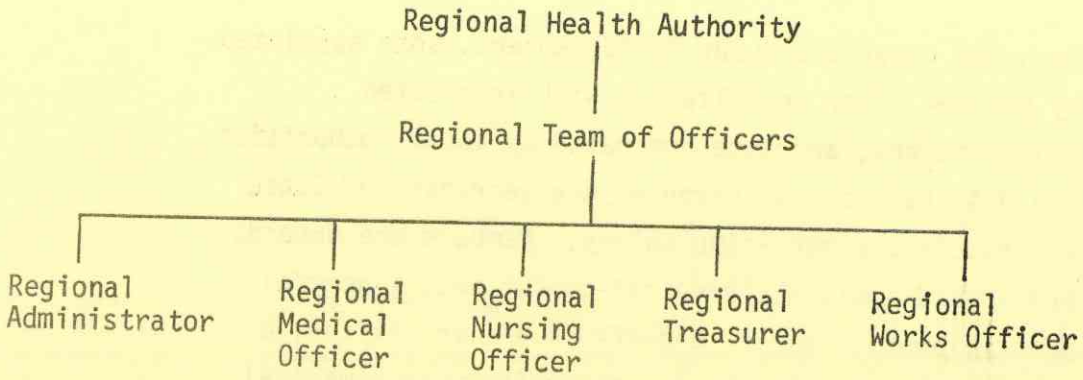
set up in 1979. The Committee has so far produced a number of important reports, including studies of perinatal and neonatal mortality and the planning and expenditure systems of DHSS. The PUBLIC ACCOUNTS COMMITTEE of the House of Commons also examines the NHS from time to time, paying particular attention to the way in which the money voted by Parliament has been spent.

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

REGIONAL HEALTH AUTHORITIES (RHAs)

Each Regional Health Authority comprises about twenty members appointed by the Secretary of State after consultation with interested organisations including professional groups, trade unions, local authorities, and voluntary bodies. All members are unpaid apart from the chairman who receives a part-time salary. RHAs normally meet monthly, and each authority is served by paid officials headed by the REGIONAL TEAM OF OFFICERS (RTO). This is made up of the regional administrator, regional medical officer, regional nursing officer, regional treasurer, and regional works officer.

DIAGRAM 2



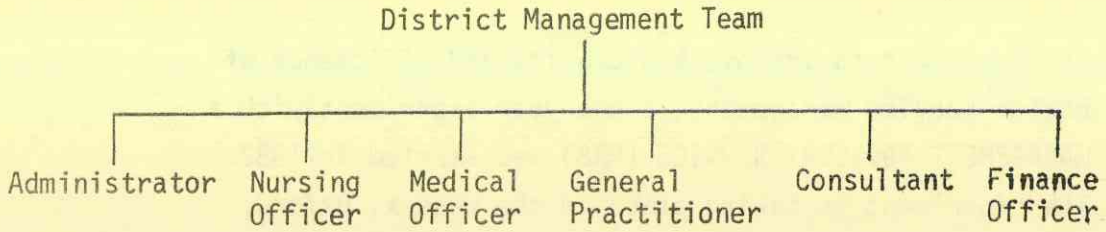
RHAs provide a few services themselves - for example, blood transfusion - but their main task is to plan the development of health services and allocate resources to districts. This they do by issuing guidance to DHAs; by co-ordinating the plans of DHAs; and by monitoring their implementation. RHAs are also responsible for designing and arranging the building of major capital projects like new hospitals, and for employing senior medical staff in non-teaching hospitals. In addition RHAs are the bodies responsible for setting up COMMUNITY HEALTH COUNCILS (CHCs) and keeping their running under review.

In an attempt to improve the quality and efficiency of health service management, a two year experiment with a MANAGEMENT ADVISORY SERVICE (MAS) was started in 1982. The experiment is taking place in the Wessex, Oxford, South Western and North Western regions, under the guidance of the respective RHAs and DHAs. Different approaches are being used in different parts of the country, and the MAS is being evaluated to see if there are lessons for the NHS as a whole.

DISTRICT HEALTH AUTHORITIES (DHAs)

Each DHA comprises about 16-19 members, some appointed by the RHA after consultation with interested organisations, and some nominated by local authorities. The DHA Chairman is chosen by the Secretary of State and receives a part-time salary. Members are unpaid, and should include a hospital consultant, a general practitioner, a nurse, midwife or health visitor, a nominee of the appropriate university with a medical school in the region, a trade unionist, and normally 4-6 members appointed by local authorities. Those DHAs which contain a university medical school and teaching hospital facilities include additional members with medical school or teaching hospital experience. DHAs usually meet monthly in public, and CHCs are allowed to send observers to the meetings with the right to speak but not to vote. Each DHA is served by a DISTRICT MANAGEMENT TEAM (DMT) made up of four appointed officers and two elected medical representatives.

DIAGRAM 3



The four appointed officers are the administrator, the medical officer, the finance officer and the nursing officer. The two medical representatives are elected by their colleagues in the district, and one is a consultant, the other a general practitioner. The team

is *jointly* responsible for the formulation of advice to the authority on district-wide policies, priorities and programmes, and for determining how decisions should be implemented. Decisions must be based on the consensus of all the team members, and differences of view between team members on significant items should be reported to the district health authority. However, consensus management need not mean complete unanimity and can vary from lukewarm acceptance to enthusiastic support.

UNITS OF MANAGEMENT

The services provided by the DHA have to be organised through units. These are some examples of units:

a) A large single hospital;

b) All the community services in the district;

c) Client care services, for example a mental illness hospital with psychiatric community services and possibly the psychiatric units of a district general hospital on the lines described in the Nodder report (see *POLICY GUIDE*). Larger client care groups may need to be divided into two or more units, provided that there is adequate co-ordination between units;

d) The maternity services of the district;

e) An individual hospital, or group of hospitals, with the community services, to form a 'geographical' unit;

f) A group of smaller hospitals.

The intention is to devolve as much responsibility and authority as possible from the DMT to the units. At unit level there is an administrator and a nursing officer with responsibility for managing their respective services. The medical contribution to units involves one or more doctors collaborating with the administrator and

nurse on behalf of the medical staff. The medical representative, unit administrator and director of nursing services at unit level together form a unit management team or group.

JOINT PLANNING

One of the most important functions of DHAs is to work with local authorities to ensure that services are provided in a co-ordinated way. To assist collaboration, DHAs and local authorities are required to set up JOINT CONSULTATIVE COMMITTEES (JCCs) of their members to review and co-ordinate plans and to advise on the operation of the two services. JCCs usually draw their members from one local authority and one or more DHAs. In London, arrangements are more complex, and sometimes involve one DHA relating to two local authorities. JCCs are supported in their work by a JOINT CARE PLANNING TEAM (JCPT) bringing together officers of the two types of authority.

DIAGRAM 4 A JOINT PLANNING FRAMEWORK

One of the main functions of the JCPT and JCC is to make recommendations for the use of joint financing money (see part two). In addition to these arrangements most

authorities appoint officers with specific responsibilities for joint planning. These are usually the health services liaison officers in the local authority personal social services department, and community physicians in DHAs. The local authority councillors who are appointed as members of DHAs provide a further potential channel of collaboration.

A consultative circular on community care issued in 1981 made suggestions for transferring some patients from the NHS to local authorities. Among the ideas put forward were an extension of joint funding and the sale of hospital property with the proceeds being used to develop community services.

FAMILY PRACTITIONER COMMITTEES (FPCs)

The contracts of general practitioners, dentists, pharmacists and opticians are administered by FAMILY PRACTITIONER COMMITTEES (FPCs). The members of FPCs number thirty and are appointed by DHAs, local authorities, and local professionals. Family practitioners are not salaried employees of the NHS but are independent contractors who contract with the FPC to provide a service to the local population. Because of this the FPC has no managerial authority over practitioners - it simply handles contracts with them and arranges for them to be paid.

The status of FPCs will soon change. Currently (June 1982) responsibility for providing FPCs with accommodation, staff and certain services, and for meeting their administrative costs, rests with DHAs.

The Government has stated that FPCs will be given the status of employing authorities in their own right as soon

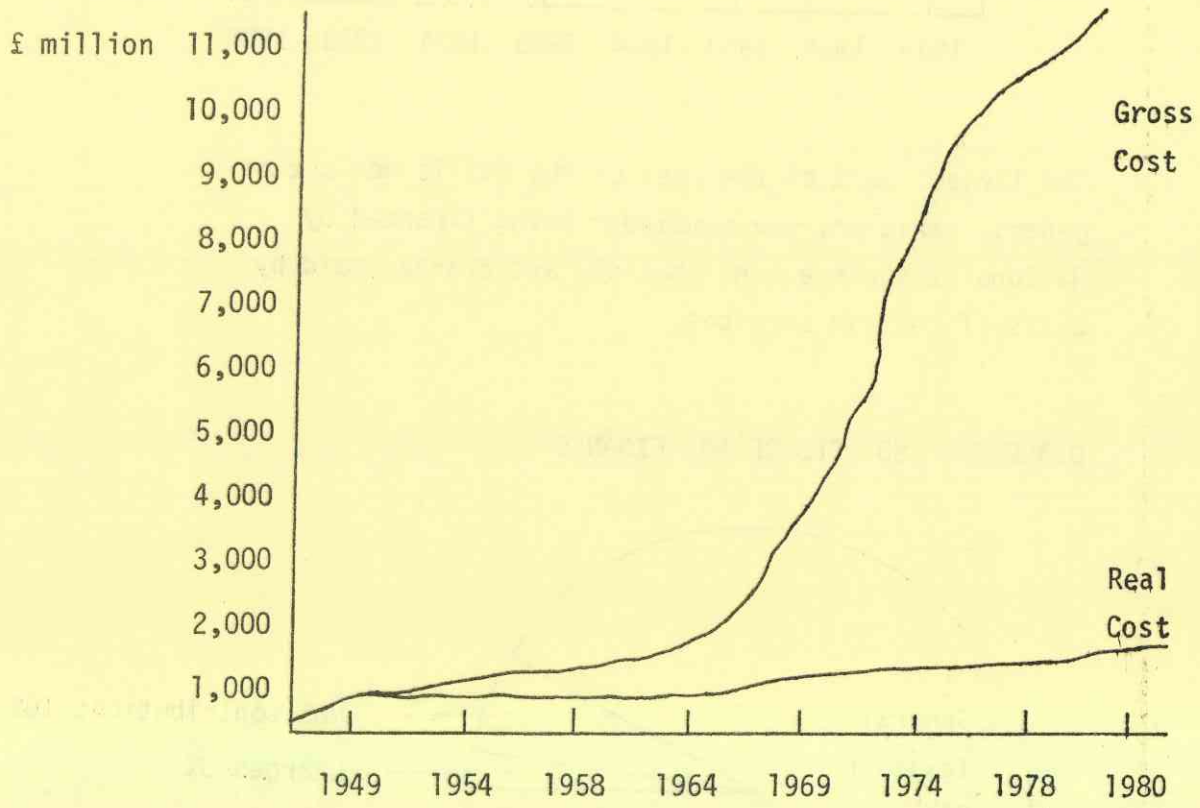
as legislation can be fitted into the parliamentary timetable. In administrative terms, this represents a further separation of family practitioner services from other health services. On the other hand, it will secure a direct line of accountability from FPCs to the Secretary of State for Social Services. It has been suggested that collaboration might be helped by the establishment of joint liaison committees between FPCs and DHAs. Complaints against family practitioners are heard by sub-committees of FPCs, known as SERVICE COMMITTEES, made up of professional and lay members.

The HEALTH SERVICE COMMISSIONER (or Ombudsman) is another channel for complaints, though services covered by FPCs are outside his jurisdiction. In the main he investigates complaints about hospital services (excluding grievances involving the use of clinical judgement by doctors) after the health authority has had an opportunity to reply to the complainant.

2. Finance

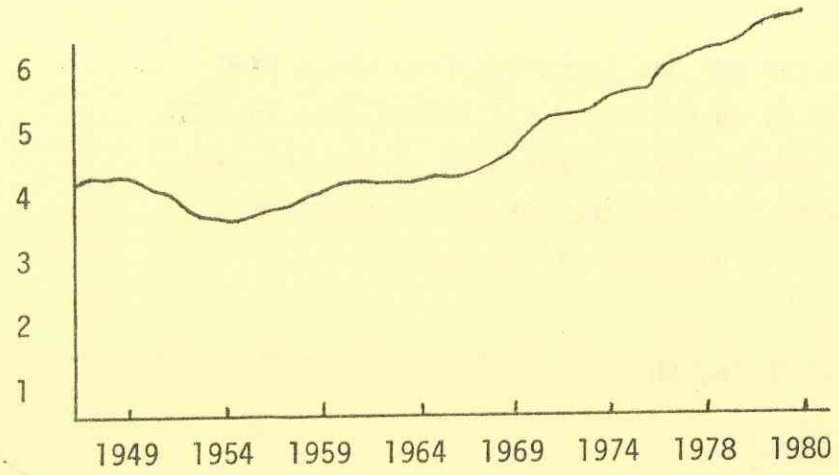
Expenditure on the NHS has increased from about £450 million in 1949 to an estimated £11,200 million in 1980. Rising prices account for a large part of the increase, but even allowing for this the NHS still costs three times as much as it did when it was set up.

DIAGRAM 5 COST OF THE NHS



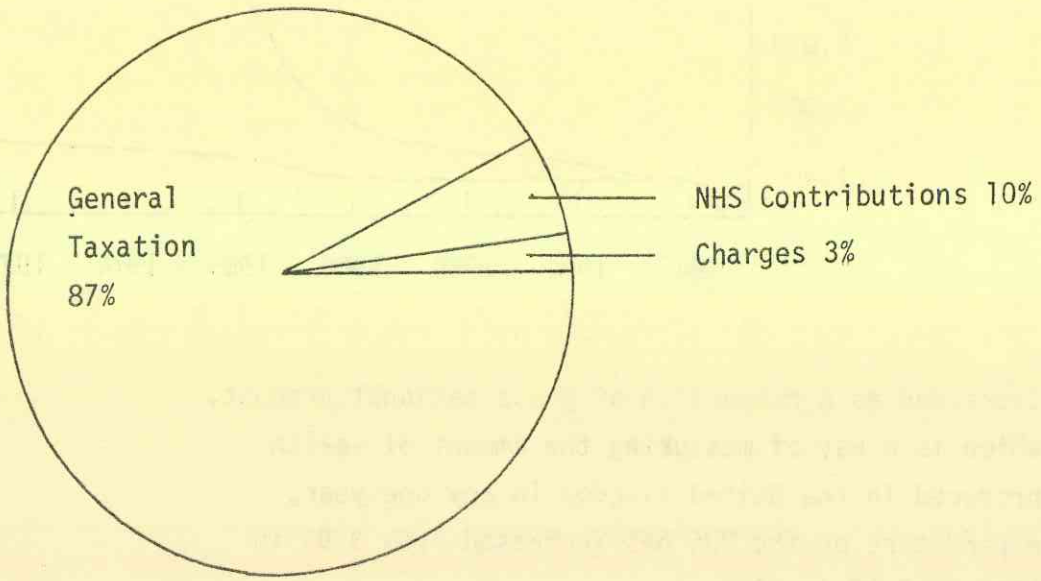
Expressed as a proportion of gross national product, which is a way of measuring the amount of wealth produced in the United Kingdom in any one year, expenditure on the NHS has increased from 3.9% in 1949 to 5.8% in 1980.

DIAGRAM 6 COST OF THE NHS AS % OF GNP



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

DIAGRAM 7 SOURCES OF NHS FINANCE



The Conservative government elected in 1979 has been examining alternative methods of financing health services. This may lead to a move away from a taxation

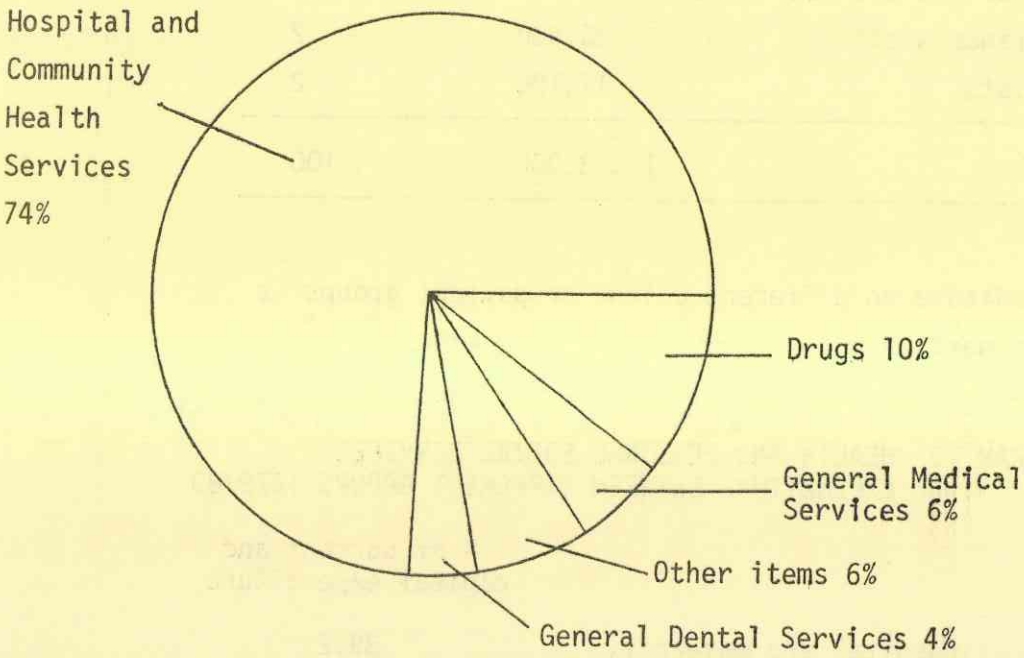
funded health service and towards private health insurance, but no firm decisions have yet been made.

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

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

In 1979-80 HOSPITAL and COMMUNITY HEALTH SERVICES accounted for 74% of expenditure; the DRUGS BILL for 10%; GENERAL MEDICAL SERVICES for 6%; GENERAL DENTAL SERVICES for 4%; and other items for 6%.

DIAGRAM 8 DISTRIBUTION BETWEEN SERVICES



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

DIAGRAM 9 NHS STAFF - UK (approximate figures)

Staff	No.	% total
Nursing and midwifery	430,000	43
Ancillary and Others	219,700	22
Administrative and Clerical	123,200	12
Doctors	67,200	7
Professional and Technical	64,700	6
Works and maintenance	31,600	3
Pharmacists and Opticians	27,800	3
Ambulance staff	20,900	2
Dentists	17,100	2
TOTAL	1,003,000	100

Expenditure on different client or patient groups is shown next:

DIAGRAM 10 HEALTH AND PERSONAL SOCIAL SERVICES EXPENDITURE BETWEEN DIFFERENT GROUPS 1979/80

	% of current and capital expenditure
General hospital and maternity	39.2
Primary care	19.0
Elderly people	14.2
The mentally ill	7.5
Children	5.5
The mentally handicapped	4.4
Other	10.2

This shows the largest share of expenditure (39.2%) going on general hospital and maternity services, and the smallest share going to services for the mentally handicapped, the mentally ill and children.

RESOURCE ALLOCATION WORKING PARTY (RAWP)

The distribution of health services expenditure between different geographical areas varies widely. The four Thames RHAs are the most favoured, and the North Western, Trent and Northern RHAs the least favoured. There are even wider variations in expenditure between DHAs. In 1976 the RESOURCE ALLOCATION WORKING PARTY (RAWP) made proposals for reducing these variations, involving the use of a formula designed to allocate resources according to the need for care. A start has been made on implementing the Working Party's proposals but progress will be slow as long as overall resource allocation to the NHS is severely constrained.

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

Using the RAWP formula, a target revenue allocation was calculated for each region, and the Secretary of State for Social Services decided the targets would be progressively worked towards over a period of years. At a time when national growth rates in NHS expenditure have been no more than 2%, this has meant increases in regional allocations ranging from around 4% in the Trent Region to 0.25% in some of the Thames regions.

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

CASH LIMITS

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

Until recently health authority budgets were calculated on the basis of the previous year's expenditure plus an element of growth and full allowance for inflation. The significance of cash limits is that they do not necessarily

provide full allowance for inflation. If the government's forecast of inflation is too low, then health authorities have to make up the difference from their own budgets. And whereas in the early years of cash limits this shortfall was made up in the following year, this is no longer automatically done. The budgets of health authorities have been squeezed further by the requirement that they should make 'efficiency savings' of 0.2% in 1982/83, and 0.5% in subsequent years. The overall effect of cash limits and efficiency savings is to limit severely the ability of health authorities to develop additional services.

JOINT FINANCING

JOINT FINANCING between health and local authorities was introduced in 1976. This is a scheme whereby the Secretary of State allocates funds to health authorities, and the money is spent mainly on local authority personal social services projects like old people's homes and home help services. One of the purposes of the scheme is to encourage and improve co-ordination between health and social services, and the use of joint financing money is decided jointly by DHAs and matching local authorities.

The amount of money made available nationally for joint financing has grown from £8 million in 1976/77 to £54 million in 1980/81. Support may be given to capital or revenue projects, and may meet all or part of the cost of these projects. However, joint financing tapers off over a period of years as the local authority assumes responsibility. The normal maximum period of support is seven years, although this may be extended with the agreement of the Secretary of State. Joint

financing may also be used for schemes concerned with primary health care, community health and prevention, and voluntary sector initiatives. The main client groups to benefit from joint financing have been the elderly and the mentally handicapped.

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HOW CHCs WORK

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

CHCs were set up in 1974. They are statutory bodies - this means their existence and functions are established by an Act of Parliament and official regulations. The operation of CHCs was reviewed as part of the reorganisation of the NHS which took place in 1982. As a result of the review the government decided to retain CHCs. However, the longer term need for CHCs is to be reconsidered in the light of the experience of district health authorities. The government has not said when this reconsideration will occur.

The following pages cover:

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

1. Who's Who in CHCs?

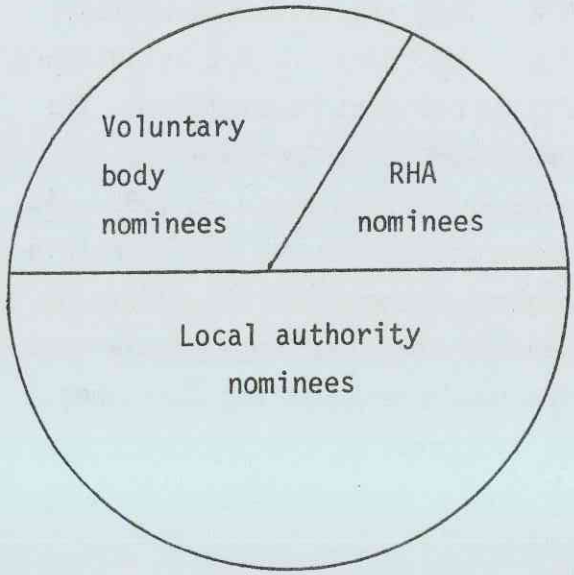
Community Health Councils (CHCs) normally have 18-24 members.

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

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

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

DIAGRAM 1



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

The SECRETARY of the CHC is a paid employee of the Regional Health Authority chosen by and accountable directly to the CHC for all the work he or she undertakes on their behalf.

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

Some CHCs have CO-OPTED MEMBERS who are appointed by the CHC to help with particular work.

2. How Long Do Members Serve?

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

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

Not all members serve the same four years. People appointed in 1976 served until 1980 when they retired or were reappointed; people starting in 1978 complete a term in 1982. This 'staggering' will continue in the new arrangements.

If a member fails to attend any CHC meeting for six months, the RHA will, after consultation with the appointing body concerned where that body is a local authority or voluntary organisation, declare the place vacant unless satisfied that absence was due to a reasonable cause.

3. How Long do Chairmen and Vice-Chairmen Serve?

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

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

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

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

4. The National Picture

As a general rule there is one community health council for every health district. The only exceptions to this rule are in three districts (Liverpool, Bristol and Weston, and Cornwall and Isles of Scilly) where there are two CHCs. This means that there are 195 CHCs in England. Wales has 22 CHCs, and, at the time of writing, Scotland has 45 similar bodies called local health councils.

Regional Health Authorities (RHAs) are, in England, the bodies responsible for setting up CHCs and enabling them to function. RHAs have the power to alter the total number of CHCs, the number of members and staff of each CHC, and to approve the administrative arrangements

(premises, staff, budget) of the councils. They may review these matters periodically.

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

Since 1977, CHCs have had their own national organisation: the Association of Community Health Councils for England and Wales, known as ACHCEW. This promotes CHCs' views nationally and undertakes work on projects to do with the public interest in the National Health Service.

Most CHCs belong to the Association and pay an annual membership fee. The work of ACHCEW is governed by a standing committee composed of representatives from CHCs in each region and Wales.

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

5. What Do CHCs Do?

Officially, it is the job of CHCs to represent the interests in the health service of the public in the district. This means that CHCs are one of the channels through which the patient's voice is heard in the NHS. In the main CHCs deal with district health authorities, although they may also relate to regional health

authorities, family practitioner committees, local authorities, the DHSS and other bodies with an interest in health and health services.

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

The rights of CHCs comprise:

- the right to information from DHAs
- the right to be consulted by DHAs on all matters of interest to CHCs
- the right to challenge closures or changes of use of health buildings, and if CHCs object to have the matter referred to the Secretary of State via the regional health authority
- the right to send observers to DHA meetings. Observers may speak but not vote
- the right to visit and inspect premises under the control of DHAs (this has been extended by agreement to include private hospitals where NHS patients receive services under contractual arrangements).

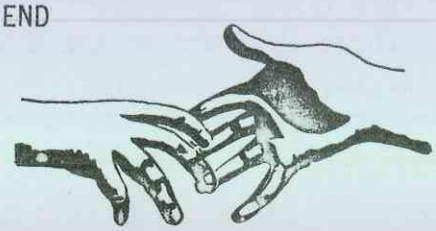
The duties of CHCs include:

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

It is worth noting that many FPCs now accept CHC observers at their meetings, although they are not required to do so.

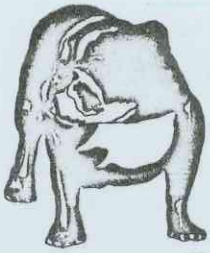
Another way of looking at the work of CHCs is that they act as

(1) THE PATIENTS' FRIEND



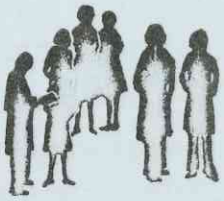
and

(2) THE COMMUNITY'S WATCHDOG



and also play a part in

(3) PARTICIPATION



THE PATIENTS' FRIEND

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

THE COMMUNITY'S WATCHDOG

This means that CHCs have to find out for themselves what local health services are trying to achieve and how they are organised, so that the CHC can comment on the range and quality of the services provided, from the community's point of view. To do this, most CHCs divide up into small working groups to study in more detail the needs of particular patients or specific problems. These

groups may examine the needs of groups such as mentally handicapped people, or they may focus on issues like finance or planning. Many CHCs find it useful to carry out surveys to discover what the community thinks about local services.

PARTICIPATION

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

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

6. Resources

There are four sorts of resources available to all CHCs:

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

MEMBERS

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

STAFF

Each CHC has people working for it (usually) full-time. The Secretary of the CHC has a demanding and varied job, acting partly as a committee secretary preparing and circulating papers, taking minutes, etc.; partly as a helper for members of the public who call in for advice or who want to make a complaint; partly as a researcher, planning and carrying out surveys and investigations; and partly as a press officer keeping the press, radio and TV well informed and interested in the CHC. The Secretary has a particularly important role as an adviser to CHC members on matters of planning and policy.

The Secretary is the key link between members, co-ordinating their activities and helping them to plan their work and achieve the CHC's objectives. It is a very responsible position, and it requires the ability to work efficiently on your own, with quite long hours and to be able to cope with all sorts of demands.

People from all walks of life have become CHC Secretaries - not only those who have worked in the NHS before but businessmen, voluntary organisation workers, servicemen

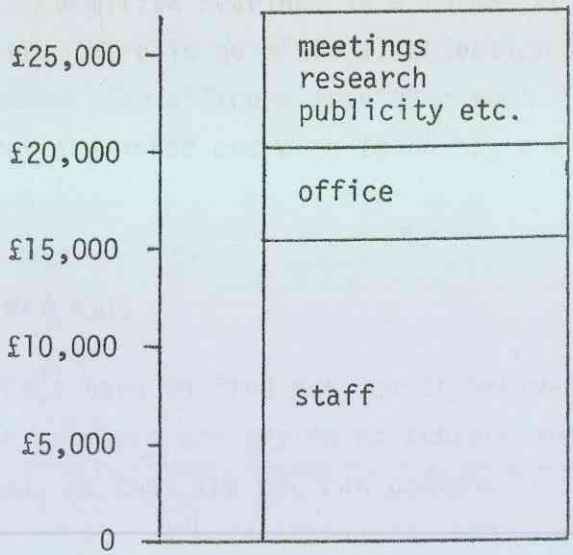
and ministers, and all kinds of others. Men and women, younger and older, have become involved. The job is graded as a middle-level administrative position with a salary of around £8,000 per annum.

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

MONEY

Even with the vital contribution from members, CHCs still need a little money to keep things functioning effectively. Annual budgets for CHCs are worked out between the regional health authority and the CHC and currently most CHCs receive about £25,000 from their RHA. (Some get less, some get more, depending on local arrangements).

DIAGRAM 2



The money is needed to:

(a) pay staff - the secretary and assistant are paid employees, and the annual salary bill is roughly £15,000.

(b) pay for the office - most CHCs have to pay rent, rates, heat, light, telephone and other bills for their offices; the amounts vary considerably, but, for example, could be £5,000 in a year.

(c) this leaves about £5,000 to do the work of the CHC, and that includes holding meetings, going on visits, publishing reports, advertising, training members, going to conferences, etc. etc.

FREE HELP

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

'free' staff, provided through the government's work experience scheme

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

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

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

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

CHC NEWS

A monthly magazine and an information service is provided by CHC News, 362 Euston Road, London NW1 3BL. Tel. 01-388-4943. Until 1982 this was provided free to

CHCs with the support of a DHSS grant. The grant was withdrawn in 1982 and it is hoped that subscriptions from CHCs will enable the magazine and information service to continue.

HANDBOOK FOR COMMUNITY HEALTH COUNCIL MEMBERS

CHCs - THE STORY SO FAR

This article was published in CHC News in September 1978 and is based on a paper* given to the British Association for the Advancement of Science by Pat Gordon, when she was secretary of City and Hackney CHC.

The article traces the development of CHCs in the four years after their establishment in 1974. It provides an early summary of the experiences of CHCs and the way in which their relationship with area health authorities evolved. Many of the points made by Pat Gordon remain relevant in 1982 even though district health authorities have replaced area health authorities. The postscript to the article contains some brief comments on developments after 1978.

HISTORY OF CHCs

"Consumers have a long history in running the National Health Service. The novelty about CHCs was that for the first time the consumer representatives were to be independent. They would have no part in managing, employing or providing services. But they were an afterthought, and the beginnings were not auspicious. The NHS Reorganisation Bill was well on its way through the legislative process before, as a result of the new structure, CHCs came into the picture. Each district was to have its own health council,

* Pat Gordon's paper has also been published in *PROVIDING FOR THE HEALTH SERVICES* (edited by Sir Douglas Black and Dr. G.P. Thomas), Croom Helm £8.50.

separate from management, whose duty it would be, in the words of the Act, "to represent the interests in the health service of the public in its district". The original proposals were that the councils would live in premises provided by their AHA and take as their secretaries, administrators from within the NHS.

However, the Government changed three weeks before reorganisation was due to take place, and the new Secretary of State introduced a paper called DEMOCRACY IN THE HEALTH SERVICE which was to strengthen CHCs in two important ways; they were to be free to appoint their own secretaries by open competition, and they were given powers over hospital closure.

When CHCs were set up in 1974 there were very few rules about what they should do, and this has allowed them to develop in very different ways.

A good summary of what CHCs do is given in Huddersfield CHC's annual report for 1977:

CHCs have been set up by Parliament as independent bodies to:

Evaluate present standards in hospitals, health centres, clinics and the community health services,

Think about future needs in the Health Service,

Consult with you about these matters,

Discuss them in public,

Tell the Health Service managers what you think,

Act as the 'patient's friend' and help to get complaints dealt with quickly by the right people.

CHCs operate in different ways according to the wishes of their members and nature of the health problems and facilities in their district. Some set up permanent working groups to cover services for certain kinds of patient - such as children or the elderly or mentally handicapped: some form ad hoc committees when problems arise: some co-opt a lot of people on to their groups in order to extend their expert knowledge: some, particularly those with large districts, have committees to cover different sections of their district. Some

councils are now reviewing the effectiveness of their way of working. And the matters in which they have become concerned are legion. But for the purposes of a general review, four areas of activity stand out as the main strands of the CHC's efforts to date.

INFORMATION TO THE PUBLIC

It is often said that people are not interested in the health services until they are ill, but when City and East London AHA proposed radically reorganising hospital services in Hackney more than 500 people went to the CHC's meeting to hear the proposals. It was the largest public meeting in the district for years. Before 1974 proposals such as these were made by hospital boards, and who ever knew what they were planning? Some time after this meeting, when the proposals had been drastically altered, it was discovered that a 'nucleus' hospital was to be built in the district. Such were the murmurs and confusion about atomic medicine and nuclear hospitals that the CHC asked the DHSS to come and explain: over 100 people came to hear them.

The NHS is not noted for its easy, open literature or its ability to publicise services and encourage people to use them well. Some CHCs believe that collecting information on local services and publishing a guide is a good way of promoting the CHC as well as helping the consumer to get the best out of health services. City and Hackney, Kettering and Northampton, St. Helens and Knowsley, and Trafford have already produced comprehensive guides. Leaflets on specific services, and on such things as how to choose your doctor, on patients' rights, on immunisation for children, as well as on the function of the CHC have been published.

But there are CHCs who believe that this is going too far, and that the real task is to press the DHSS to make official leaflets and posters more informative and easily understood, and to press health authorities to produce guides to local services.

There are other ways of telling people what's going on. In Kent and in Leeds the CHCs have regular programmes on local radio: Kettering has advertised on Anglia TV: some CHCs issue newsletters and press releases, and most have good contacts with local newspapers - East Surrey runs a regular advice column in its local paper: there are stalls at local fetes: Plymouth has a publicity bus, East Dorset a caravan. And CHCs hold meetings and show films - on all aspects of health education, and on such things as well-women clinics, asthma, care of the dying, strokes, drug abuse, childbirth. Small scale events which respond to local problems and interests are one of the CHC's great strengths.

INFORMATION TO HEALTH AUTHORITIES

One of the most useful and potentially powerful things CHCs can do is to choose some aspect of the NHS in their neighbourhood and find out whether it really works the way it is said to. In Worthing the elderly population is 27% of the total - one of the highest in the country. If you live in Worthing you know how hard it is to get an old person into hospital. The CHC decided to find out what the need for community care was and how far it was being met. They used the Government's Job Creation Scheme and with guidance from local doctors and the university they employed 6 interviewers and interviewed more than 2,000 elderly people. Instead of just complaining about inadequate services, instead of just echoing the health authority, which acknowledged that

there was 'a problem', they went out and researched it and wrote a booklet which describes what it is like to be an old person living in Worthing. The second stage, which they are now well into, is to persuade the health authority to act on the information collected.

CHCs can come up with information in other ways, too. David Owen, when he was Minister of Health, constantly reminded us that access to information is power in a democracy and he upbraided administrators who rebuked CHCs for uninformed criticism and at the same time denied them information on which to base informed criticism. But if administrators do not have information and can see no way of getting it, CHCs can sometimes help by digging around for officially published figures and putting them together so that their local relevance becomes clear. CHCs can supply information and pressure for change that would otherwise be missing.

And CHCs have not shrunk from going out and doing surveys. The subjects they have tackled range over the entire health service - from accidents to visiting chiropody to the effects of tourism on local facilities, health centres to haemophilia, rural problems to private practice. Some have launched national campaigns, such as those aimed at finding people affected by Eraldin and children possibly damaged by hormone pregnancy testing drugs. Many surveys have been informal and small-scale, others much more professional.

CHCs often feel that they are the only ones to question the assumption of health service planners and to question the data, or lack of data, on which plans are based. But as well as asking for facts and figures, it is clear that some CHCs have already contributed a great deal to the information available on health needs and services.

COMPLAINTS

CHCs were given the task of helping people who have a complaint about the NHS, but not of investigating that complaint. For many professionals, this was the last straw. But in fact, there have been no long queues of people marching to their CHCs to complain about their doctor. Nor have CHCs gone out to foment revolt.

What has happened is that, rather than complaints, CHCs have had requests for information and help from people trying to find their way around the health and social services obstacle course. And in the process they have built up a picture of the NHS in action, previously known only to those who ran the service, or not even to them.

One of the present points of debate is the status of the CHC secretary who acts as the "patient's friend". In the view of some family practitioner committees such a person constitutes a "paid helper" and as such should be ruled out.*

As well as helping individuals through the complaints procedures, the CHC can take up general issues from specific complaints. In Cheshire, Halton CHC found that many of the complaints they received related to receptionists. They decided to set up a meeting between the CHC and the receptionists. 21 came, none of whom had met before, and they discussed their lack of training and their ideas about their role. And Halton CHC joined with South Tyneside CHC and almost 100 others in urging the DHSS to provide more training for receptionists - something the Department has now taken up.

* Subsequently, the DHSS, on legal advice, stated that it does not accept that a CHC secretary is a paid advocate.

CONSULTATION ON CLOSURES

The procedures to be followed by area health authorities when proposing a closure or change of use were set out in a circular (HSC(IS) 207) in 1975. If the CHC wants to oppose a closure it has to produce "a constructive and detailed counter-proposal". If there is still no agreement, the decision has to be passed upwards to the Region and the Secretary of State. The effectiveness of this power is not to be measured only in terms of the closures the Secretary of State has refused to approve following CHC objections. These have been few. Between January 1976 and the present three such closure proposals have been rejected - St. Nicholas Hospital, London, Oakmere Hall Rehabilitation Centre, Cheshire, and part of Stoke Mandeville Hospital, Bucks.

More important are the number of proposals that have been reconsidered, modified or completely overturned at area or regional level as a result of CHC intervention. The DHSS knows of six closure proposals withdrawn before they reached the Secretary of State. One example was the decision in 1977 of the West Midlands RHA to defer until 1981 its plan to close St. Wulstan's Rehabilitation Hospital at Malvern, following a joint campaign by CHCs in the region, supported by other groups. The CHCs believe that until their intervention the hospital's pioneering role and unique expertise in industrial and social rehabilitation of psychiatric patients were not widely appreciated.

The closure procedures are by no means easy for CHCs, however. The requirement to produce detailed counter-proposals demands a great deal of time and effort. And many CHCs have asked how they can be expected to base their alternative plans on information supplied by the AHA when it is the AHA's plan they are contesting. Some

health authorities pay only lip service to the consultation procedures and use many devices (such as 'temporary' closures) to slip round them.

Brent CHC has waged a long and bitter campaign to establish its legal right to be consulted on the closure of Willesden General Hospital, during which the London Borough of Brent served writs on the AHA and RHA to enforce the Regulations on Consultation in the Statutory Instrument (SI 1973 No. 2217). Four days before the case was due to be heard the AHA agreed to initiate a new consultative procedure. But the CHC has still not succeeded in its attempt to keep Willesden General open as a community hospital. And it is disillusioned with the whole consultation business: the AHA may have to listen to the CHC, but it does not have to act on what is said.

THE FUTURE

CHCs do not have an exclusive claim on what the consumer thinks about the health service. Many doctors and administrators and other producers of services know only too well what is needed and fight very hard to get it. And many CHCs would wish to acknowledge the co-operation and support given to them by those working in the health service.

But despite their statutory basis and the existence of regulations and guidelines defining their activities, CHCs often have to struggle to establish their rights, *IN PRACTICE*, to be consulted, to get hold of information, to be represented on various bodies. And in taking on the professional expert - perhaps the biggest challenge of all - they have to tackle such thorny issues as the debate on access to information and safeguarding confidentiality.

CHCs have already demonstrated that their perspective is very important in getting the balance of services right. And it seems that the more they achieve, the more they are spurred on to do. They are still pushing forward the boundaries of what they can do and where they can be effective. In their short lives CHCs have aroused a lot of strong feelings; surely it is right to hope that they can continue to do so.

Postscript

Since Pat Gordon's article was written, the Royal Commission on the NHS reported in July 1979 and stated that "CHCs have made an important contribution towards ensuring that local public opinion is represented to health service management". The Royal Commission recommended that CHCs should be given additional resources to enable them to function more effectively. In *PATIENTS FIRST*, published in December 1979, the government invited views on whether CHCs would still be needed when district health authorities were introduced as part of health service reorganisation. There was considerable support for CHCs from a variety of different interests, and, as a result, in July 1980 it was announced that CHCs would be retained for the time being. Subsequently, a consultative paper on the role and membership of CHCs was issued, and in 1982 certain minor changes were made to the regulations governing CHC membership. At the same time the government stated that the longer term case for the retention of CHCs would be reconsidered in the light of the experience of DHAs.

It is likely that the difficulties encountered by CHCs in effectively challenging closure proposals will continue. Since publication of Pat Gordon's article, health

authorities have, on some occasions, used various methods to avoid consulting CHCs on closures. Despite protests by CHCs, it is probable that DHAs will resort to similar methods should the need arise.

University of Bristol

SCHOOL FOR ADVANCED URBAN STUDIES

HANDBOOK FOR COMMUNITY HEALTH COUNCIL MEMBERS

POLICY GUIDE

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

The following pages cover:

1. Health Service Priorities and Planning
2. Primary Care
3. Community Health Services and Prevention
4. Hospital Services
5. The Mentally Ill
6. The Mentally Handicapped
7. The Elderly
8. Maternity and Child Care
9. Inequality and Health

Appendix: Further Information

1. Health Services Priorities and Planning

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

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

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

1. *PRIORITIES FOR HEALTH AND PERSONAL SOCIAL SERVICES IN ENGLAND (1976)*
2. *THE WAY FORWARD (1977)*
3. *CARE IN ACTION (1981)*

Current national priority groups are elderly people, especially the most vulnerable and frail; mentally ill people; mentally handicapped people; and physically and seriously handicapped people. National priority services are maternity services and neonatal care; primary care services; and services related to the care of young children at risk and to the care and treatment of juvenile offenders. Since 1976 it has been the intention that general acute hospital services should be held back while priority groups and services develop.

The NHS Planning System is the main means by which national priorities are intended to be implemented by

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

The NHS planning cycle begins when guidelines on national priorities are issued by DHSS. These guidelines are modified by RHAs to take account of local circumstances, before they are passed on - together with information about available resources - to DHAs. DHAs then prepare proposals for submission to the RHA. RHAs are responsible for holding annual review meetings to discuss the Districts' proposals, and for preparing a regional strategic plan once every five years. RHAs also hold annual planning review meetings with DHSS. National guidelines may be modified in the light of the proposals coming up from DHAs and RHAs.

In line with the aim of delegating decision making to the local level, DHAs play a key role in the planning system. They prepare STRATEGIC PLANS covering developments over a ten year period or more, and these are reviewed every five years. DHAs also have responsibility for ANNUAL PROGRAMMING. The annual programme is in two parts: firm proposals for implementation in the following financial year, known as the OPERATIONAL PROGRAMME; and provisional proposals for the financial year after that, known as the FORWARD PROGRAMME. DHAs have been asked to prepare their first annual programmes by December 1982.

DHSS has emphasised that planning is a continuous process rather than an intermittent exercise. Planning is also a

collaborative process involving managers and professionals at all levels. Consultation is a key aspect of the planning process, enabling community groups like CHCs as well as staff and professional interests to contribute their views on how services should develop. Consultation occurs formally and informally. Informal consultation takes place during the preparation of plans and programmes through mechanisms like district planning teams. These teams are usually organised on a service or client group basis. CHCs have often found it useful to be included on planning teams, sometimes as observers rather than full members. An alternative arrangement is for the CHC's own working groups to 'shadow' planning teams and perhaps hold joint meetings. Formal consultation takes place on STRATEGIC PLANS and the FORWARD PROGRAMME.

FURTHER READING

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

2. Primary Care

Primary care is the first point of contact with the NHS for most patients. In the last 30 years GPs have increasingly combined to work together in group practices and health centres. At the same time they have come to work more closely with other health personnel, including health visitors, nurses and social workers, in 'primary health care teams'. Current policy is to continue these developments, except that it has recently been decided to slow down the building of new health centres. There have also been attempts to tighten up on various undesirable aspects of primary care, such as over-prescribing and

unsatisfactory deputising services. The ROYAL COMMISSION on the NHS particularly noted the poor state of primary care in declining urban areas and in parts of London, and this is another issue which is receiving increasing attention. The services of GPs are administered not by DHAs but by FPCs, and this works against the full integration of health services in planning and resource allocation.

FURTHER READING

PRIMARY HEALTH CARE, HMSO, D. Hicks (1976).

HEALTH CENTRE DEVELOPMENT, Health Circular HC(79)8, DHSS, 1979.

ACCESS TO PRIMARY CARE, (1979) Royal Commission Research Paper No. 6.

HEALTH CENTRE POLICY, Health Circular HC(80)6, DHSS, 1980.

PRIMARY HEALTH CARE IN INNER LONDON, (Acheson Report), DHSS, 1981.

THE PRIMARY HEALTH CARE TEAM, DHSS Working Party Report, 1981.

3. Community Health Services and Prevention

Included under this heading are various services outside hospital. Priorities here include the further development of family planning services, a renewed emphasis on vaccination and immunisation programmes, and in particular a re-orientation in favour of preventive health measures of all kinds.

Government policy has tended to focus on changes in individuals' lifestyles as the means of shifting the

balance towards prevention. People have been encouraged to give up smoking, drink less alcohol, eat the right foods, take more exercise, and generally "look after themselves". There has also been an interest by government in health education, fluoridation, the wearing of seat belts, screening programmes, reducing the amount of lead in petrol, and encouraging early and regular attendance for ante-natal care. A series of DHSS publications has given advice on various aspects of preventive health, including diet, safety during pregnancy and avoiding heart attacks.

FURTHER READING

PREVENTION AND HEALTH: EVERYBODY'S BUSINESS (1976), The Red Book.

PREVENTION AND HEALTH (1977), The White Paper.

PREVENTIVE MEDICINE (1977), First Report from the Expenditure Committee Session 1976/77.

PREVENTION AND HEALTH. REDUCING THE RISK: SAFER PREGNANCY AND CHILDBIRTH (1977), DHSS.

PREVENTION AND HEALTH. EATING FOR HEALTH (1978) DHSS.

4. Hospital Services

Policy on general hospital services is to establish a network of DISTRICT GENERAL HOSPITALS (DGHs), catering for all but the most specialised needs. This policy stems from the Hospital Plan of 1962. A DGH may be provided on a single site or by linked hospitals on separate sites. Where new building is needed "NUCLEUS HOSPITALS" are being developed, initially to provide 300 beds but capable of expansion to 600 and 900 beds. These are a quicker and cheaper way of building new

hospitals than the methods used in the past. Recently, government policy has moved against the provision of very large general hospitals. A consultative paper issued by DHSS in 1980 suggested that 600 beds should be the normal maximum for a main DGH serving a population of 200,000. The paper indicated that alongside these hospitals there might be developed small local hospitals providing casualty services, some acute services, out-patient clinics, day hospital facilities, geriatric services and some mental illness provision. This is an extension of the policy set out in 1974 of providing COMMUNITY HOSPITALS complementary to DGHs.

Resources for maintenance and renewal of buildings and equipment are very significant factors in spending on health buildings. Old stock means high maintenance costs while the accelerating application of technology to medicine and advances in basic engineering have brought additional demands in their wake. Pathology laboratories, radiology and radiotherapy, pharmacy and theatre departments have added enormously to the technological load on the works function. In addition there has been a tremendous expansion in such services as piped medical gases, lifts, nurse and staff call systems and fire alarms and simple, reliable, long-life equipment (for example, Lancashire boilers of low efficiency) have been replaced by complex short-life products. Demands for additional resources and trained staff to maintain the 'estate' are likely to grow as this trend intensifies. Also it is important that health authorities ensure that their building stock is no greater than service needs require, and that any surplus should be disposed of to turn liabilities into capital assets.

FURTHER READING

STATEMENT OF POLICY ON PROVISION OF HOSPITAL SERVICES, DHSS Circular DS85/75, 1976.

COMMUNITY HOSPITALS, Health Circular HSC(IS)75, DHSS, 1974.

THE FUTURE PATTERN OF HOSPITAL PROVISION IN ENGLAND, A Consultative Paper, DHSS, 1980.

A CODE FOR MANAGEMENT OF THE HEALTH SERVICE ESTATE (ESTMANCODE), DHSS, 1974.

5. The Mentally Ill

Policy since the 1962 Hospital Plan has been to run down the large old mental illness hospitals, and replace them with a much smaller number of beds in psychiatric units in DGHs, together with improved out-patient and day care facilities. A comprehensive statement of government intentions was contained in *BETTER SERVICES FOR THE MENTALLY ILL*, published in 1975. This reiterated the need to phase out existing psychiatric hospitals, develop district-based services, and above all build up services in the community.

However, it is likely that a considerable number of mental illness hospitals will remain in use for many years to come. Within these hospitals, the aim has been to improve staffing ratios and standards of patient care. The work of the HEALTH ADVISORY SERVICE (HAS) is relevant here, for by visiting and reporting on conditions at mental illness hospitals, HAS provides a stimulus to change. The problem of organising and managing mental illness hospitals was examined in the *NODDER REPORT*, published in 1980, which recommended a clearer management structure for psychiatric services. The Report suggested the establishment of district psychiatric services management teams and hospital

management teams to provide leadership in the development of local services and facilities.

A minor but nevertheless important category of patients is those needing treatment under secure conditions, including mentally abnormal offenders. These patients are currently accommodated in either the prisons or the special hospitals: Rampton, Moss Side and Broadmoor. DHSS policy is to provide a secure unit within each region, but although funds have been set aside for this purpose, progress in building these units has been very slow.

FURTHER READING

BETTER SERVICES FOR THE MENTALLY ILL, DHSS, 1975.

HEALTH ADVISORY SERVICE, Health Circular HC(76)21, DHSS, 1976.

REPORT OF THE WORKING GROUP ON ORGANISATIONAL AND MANAGEMENT PROBLEMS OF MENTAL ILLNESS HOSPITALS, (Nodder Report), DHSS, 1980.

VARIOUS PUBLICATIONS BY MIND (The National Association for Mental Health).

6. The Mentally Handicapped

Current policy for the mentally handicapped is based on the White Paper *BETTER SERVICES FOR THE MENTALLY HANDICAPPED*, published in 1971. The main aims are to reduce the role played by hospitals in the care of the mentally handicapped and to increase services provided in the community. It is envisaged that hospital care will be needed by only the severely handicapped, and

that this care will be provided in small units near to patients' homes. Within the community it is intended that local authorities should build up residential and training services.

A review of progress made in meeting these objectives, carried out in 1980, suggested a further reduction in the targets for hospital provision. The review stated that fewer beds were needed than envisaged in the White Paper, and that these should be provided in smaller units. The JAY COMMITTEE on Mental Handicap Nursing and Care in a report published in 1979 went further and recommended a model of care based outside hospitals. The report emphasised the importance of enabling mentally handicapped people to live a normal life within the community. The Government has accepted in principle the model of care proposed in the Jay Report, but has indicated the need for further discussion of the needs of severely mentally handicapped people. In 1981 a consultative document was published by DHSS making suggestions for the transfer of patients and resources from the NHS to local authorities. The Development Team for the Mentally Handicapped assists authorities on service development in their own areas by carrying out visits and writing reports.

FURTHER READING

BETTER SERVICES FOR THE MENTALLY HANDICAPPED, DHSS, 1971.

REPORT OF THE COMMITTEE OF ENQUIRY INTO MENTAL HANDICAP NURSING AND CARE, (Jay Report), HMSO, 1979.

MENTAL HANDICAP: PROGRESS, PROBLEMS AND PRIORITIES, DHSS, 1980.

HELPING MENTALLY HANDICAPPED PEOPLE IN HOSPITAL, DHSS, 1978, National Development Group.

IMPROVING THE QUALITY OF SERVICES FOR MENTALLY HANDICAPPED PEOPLE, DHSS, 1980, National Development Group.

CARE IN THE COMMUNITY (distributed with Health Circular HC(81)9, DHSS, 1981).

7. The Elderly

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

A consultative document, *A HAPPIER OLD AGE*, was published in 1978, setting out ideas on the way in which services might develop. Subsequently, a White Paper, *GROWING OLDER*, was published in 1981. This stressed the need for statutory services to be complemented by support from families, friends and neighbours.

FURTHER READING

A HAPPIER OLD AGE, DHSS, 1978.

GROWING OLDER, DHSS, 1981.

PROFILES OF THE ELDERLY, 1977, Age Concern.

8. Maternity and Child Care

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

* *Perinatal mortality* = *stillbirths and deaths in the first week of life*

Infant mortality = *deaths in the first year of life*

Childhood mortality = *deaths between 1 and 14 years.*

FURTHER READING

FIT FOR THE FUTURE, Report of the Committee on the Child Health Service, 1976, The Court Report.

COURT REPORT ON CHILD HEALTH SERVICES, Health Circular HC(78)5, DHSS.

PREVENTION IN THE CHILD HEALTH SERVICES, DHSS, 1980.

PERINATAL AND NEONATAL MORTALITY, Second Report from the Social Services Committee, Session 1979/80, HMSO, 1980.

9. Inequality and Health

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

FURTHER READING

INEQUALITIES IN HEALTH, Report of the Working Group (Black Report), DHSS, 1980.

P. Townsend and N. Davidson, *INEQUALITIES IN HEALTH*, (Penguin, 1982).

Appendix

FURTHER INFORMATION

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

YOUR OWN CHC

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

KING'S FUND CENTRE LIBRARY

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

DHSS LIBRARY

This library has produced over 100 detailed bibliographies on health related topics, e.g. hospital staffing, day care of the mentally ill, and battered women. Each bibliography contains a comprehensive list of suggestions for further reading. Individual

bibliographies or a complete list of topics covered can be obtained from: DHSS Library, Alexander Fleming House, Elephant and Castle, London SE1 6BY.

CHC NEWS INFORMATION SERVICE

This service will try to answer any queries you have about CHCs or the NHS (telephone: 01-388-4943) - 362 Euston Road, London NW1.

VOLUNTARY ORGANISATIONS

MIND (National Association for Mental Health)
22 Harley Street,
London W1N 2ED.

Campaign for Mentally Handicapped People
16 Fitzroy Square,
London W1.

Age Concern (England)
Bernard Sunley House,
60 Pitcairn Road,
Mitcham, Surrey CR4 3LL.

National Association for the Welfare of Children in Hospital
Exton House,
7 Exton Street,
London SE1 8VE.

Association for the Improvement of Maternity Services
West Hill Cottage,
Exmouth Place,
Hastings,
Sussex TN34 3JA.

The Patients' Association
11 Dartmouth Street,
London SW1H 9BN.

Royal Society for Mentally Handicapped Children
and Adults (MENCAP)
117-123 Golden Lane,
London EC1Y ORT.

HANDBOOK FOR COMMUNITY HEALTH COUNCIL MEMBERS

FURTHER READING

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

1. EXAMPLES OF GOOD PRACTICE BY CHCs

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

A CASE STUDY IN CONSULTATION, March 1977, page 9.

CHC TAKES TO THE ROAD, September 1977, page 3.

PATIENTS' COMMITTEES ARE HERE TO STAY, July 1978, page 5.

CHECKLIST OF CHC's SURVEYS, April 1978, pages 9-10:
May 1981, pages 10-11.

CHC BAKES A HEALTH CAKE, August 1977, page 1.

CHC AND REALISM, May 1979, page 5.

WHERE THE CLOUT REALLY IS, May 1979, page 5.

CONSULTATION OR ..... , July 1979, page 5.

COMMUNITY HEALTH WORKERS IN HACKNEY, March 1980, page 13.

COMING AND GOING - A CHC SURVEY, November 1980, page 5.

WHEN A SURVEY BRINGS RESULTS, January 1981, page 12.

THE BIRTH OF A COMMUNITY PLAN, August/September 1981, page 5.

2. OBSERVATIONS ON CHCs

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

THE PEOPLE'S VOICE IN THE NHS - CHCs AFTER FIVE YEARS,
R. Levitt, King's Fund, 1980.

CHCs IN ACTION, Nuffield Provincial Hospitals Trust 1976, J. Hallas.

THE POLITICS OF CONSUMER REPRESENTATION, Centre for Studies in Social Policy 1976, R. Klein and J. Lewis.

ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE, Report - especially Chapter 11, HMSO, 1979.

3. OFFICIAL INFORMATION ABOUT CHCs

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

Statutory Instrument SI 1973 No. 2217 The National Health Service (Community Health Councils) Regulations, 1973.

National Health Service Act 1977 - Section 20.

Statutory Instrument SI 1982 No. 37 The National Health Service (Community Health Councils) Amendment Regulations, 1982.

DHSS Circular HC(81)15, Community Health Councils.

DHSS Circular HSC(1S) 207, Closure or Change of Use of Health Buildings.

4. THE ORGANISATION AND FINANCING OF THE NHS

DHSS Circular HC(80)8, Structure and Management.

DHSS Circular HC(81)6, The Membership of District Health Authorities.

DHSS Circular HC(82)6, The NHS Planning System.

DHSS *PATIENTS FIRST*, HMSO, 1979.

Report of the Royal Commission on the NHS, HMSO, 1979.

SHARING RESOURCES FOR HEALTH IN ENGLAND, Report of the Resource Allocation Working Party, HMSO, 1976.

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

CHC News

Health and Social Service Journal

Hospital and Health Services Review

The Health Services.