CONSULTATION IN THE *NEW* NHS

GOOD PRACTICE

CONSULTATION IN THE *NEW* NHS

SUMMARY

1. This guidance aims to set out the present position on consultation as comprehensively as possible. It also offers practical advice on how consultations should be conducted and how, in the event of objection to a statutory consultation, referral to the Secretary of State should be handled.

CONTEXT

2. Guidance on consultation was last issued in 1990, under cover of EL(90)95. Since then the NHS has seen enormous changes in the way it is structured and how services are commissioned and provided. There has also been significant progress towards involving patients, carers and the general public in NHS policy formulation and in local decision-making about health care delivery.

3. Since the 1970's there has been a statutory requirement for CHCs, as representatives of their local communities' interests, to be consulted about substantial service changes proposed for their districts. There have been some changes to the relevant secondary legislation as result of the introduction of Primary Care Trusts (details can be found on www.doh.gov.uk/pricare/chcregs.htm , or obtained from Jessica Oldfield at the NHS Executive, Leeds, Tel: 0113 254 6111) but the basic consultation requirement remains the same.

4. In recent years public involvement and consultation have become key issues for NHS policy and decision making. The 1997 White Paper "The *new* NHS: Modern, Dependable" stated that:

> "The Government expects Health Authorities to play a strong role in communicating with local people and ensuring public involvement in decision making about the local health service. The maxim to which Health Authorities will work is simple – the NHS, as a public service for local communities, should be both responsive and accountable … the Government will take special steps to ensure the experience of users and carers is central to the work of the NHS … the Government attaches particular importance to strengthening public confidence in the way substantial changes in local services are planned".

5. Government initiatives such as "Service First: the new Charter programme" and the Modernising Government White Paper have pledged to put public involvement at the heart of public service delivery. More recently the Secretary of State has identified "quality" as one of his key priorities for the NHS. This means that the NHS needs to look beyond its statutory responsibilities and its traditional route to users' views via CHCs. It must adopt regular consultation with the public as an integral part of everyday work to influence local planning and decision making and to help raise standards of service delivery.

6. The rationale for involvement, the various areas of NHS activity where it is particularly relevant and issues deserving of special attention are dealt with in detail in the NHS Executive's "Patient and public involvement in the *new* NHS" document which was published in September 1999. It is, however, worth reiterating here the main aims of user and public involvement. It should help to:

    - develop greater openness and accountability in the NHS;
    - develop a greater local understanding of the issues involved in local service changes;
    - strengthen public confidence in the way substantial and other changes in local health services are planned;
    - develop a greater sense of local ownership and commitment to health services;
    - provide better quality and more responsive services through listening to and understanding the needs and wishes of health service users; and
    - enable local people to have access to better information about health and health services which can lead to more appropriate use of health services.

7. We are aware that some people are concerned that consultation may raise public expectations to levels that cannot be met. This should not be a problem if it is made clear from the start exactly what is on offer and the extent to which people can influence the outcome. If there are constraints on what can be done it is important to say so and to explain why.

WHEN STATUTORY CONSULTATION IS NECESSARY

Definition of "substantial"

8. Under Regulation 18(1) of the Community Health Councils Regulations 1996 (S.I 1996 No.640) it is "the duty of each relevant Health Authority to consult a Council on any proposals which the Health Authority may have under consideration for any substantial development of the health service in the Council's district and on any proposals to make any substantial variation in the provision of such service".

9. Of the various provisions in these Regulations it is the word "substantial" that has caused the most uncertainty. It is difficult to provide any definition of what constitutes a substantial variation in service. What may be considered substantial in one HA area may not be in another. No list or description could hope to be exhaustive and a proposed change falling outside a formal definition could well be challenged in Court if no consultation has taken place.

10. This is a matter that calls for common sense locally. HAs will have to evaluate the proposed change and its effect on health services and consider whether the change might properly be said to amount to a substantial service change. A wide range of factors may be relevant, for example, whether similar provision is made elsewhere and the effect on other services. The permanence of a proposed change is not, however, a guide as temporary solutions must be consulted on if the proposals are substantial.

11. If there is any doubt about whether a proposed change amounts to a substantial variation or development it is wise to consult. However, a regular dialogue and close involvement with relevant CHCs in the planning process may reduce the need for formal consultation.

Management changes

12. Changes in management structures and organisation which do not affect or arise out of actual substantial service developments or variations are not subject to the requirement to consult. However, it is good practice for CHCs and other interested parties to be kept informed of such changes.

Primary care

13. The requirement for HAs to consult also covers proposals that amount to substantial developments of, or variations in, those aspects of primary care in which HAs have a role to play, for example, strategic plans for primary care services, location of general practitioner premises, out of hours services. The requirement to consult does not, however, cover the way in which practitioners choose to organise their own practices.

REQUIREMENTS FOR A VALID CONSULTATION

14. Public law requires that in order to be valid a consultation exercise must have the following features:

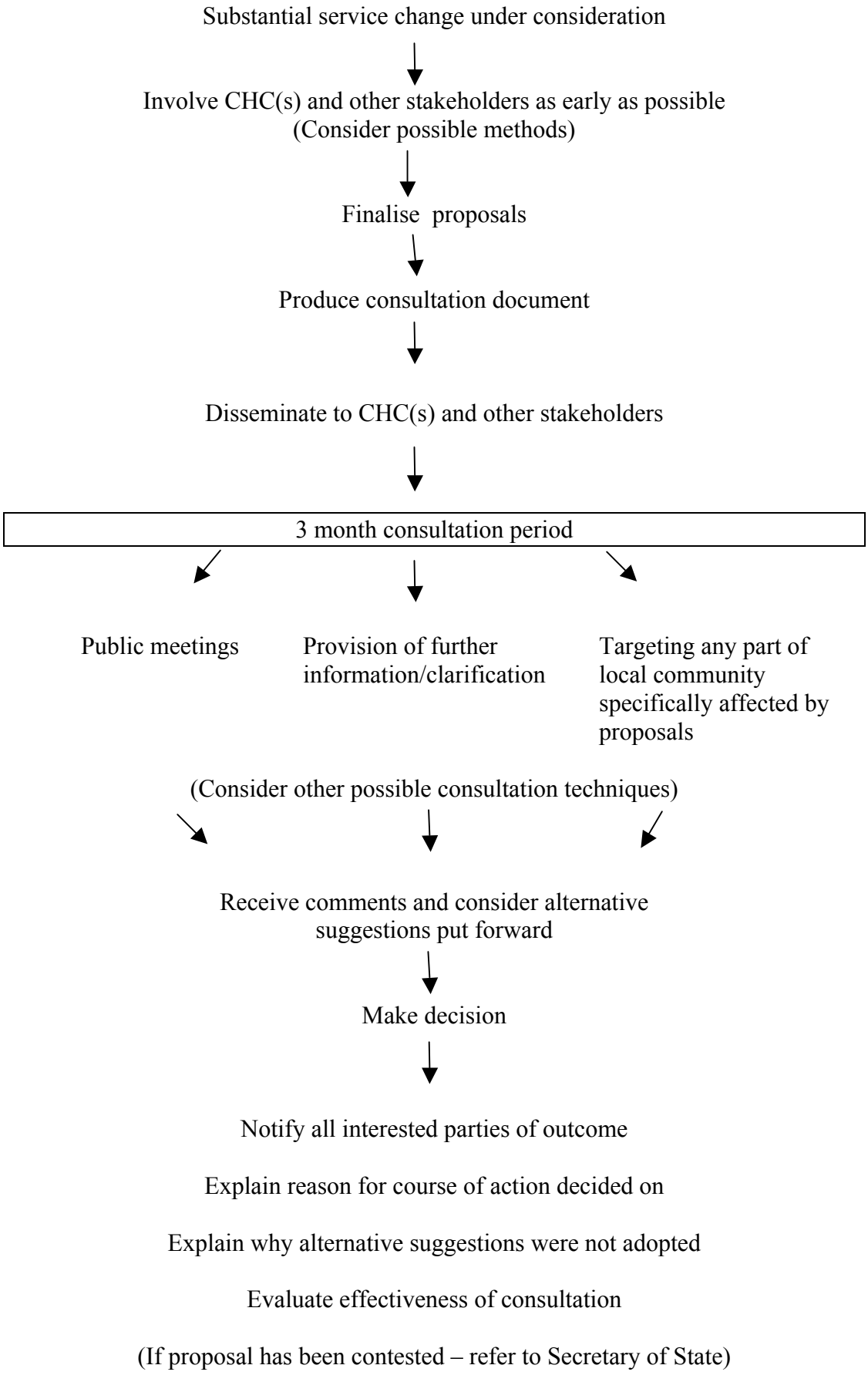
Adequate information

15. When formal consultation takes place a consultation document is produced. This must be easy to understand and must be readily available, particularly where the consultation involves members of the public. It must contain sufficient information for the reader to be able to understand the reasons for the proposals and to come to a fully informed conclusion. It needs to explain the benefits that are expected to flow from the change. It should also include information about contacts for further information or clarification and a list of those being consulted.

R v Brent LBC ex parte Gunning [1985]
The proposer must give sufficient reasons for any proposal so as to permit intelligent consideration and response.

16. As service change is an evolving process it may not be possible to provide all the necessary information at the beginning of the consultation process. If this is the case it should be explained at the outset and an indication given of what will be available and when.

PUBLIC CONSULTATION



Adequate time

17. There is no statutory period for consultation but it is clear that it should start as early as possible in the considerative process and allow sufficient time for those being consulted to consider and respond to the proposals.

R v Kingston & Richmond Health Authority ex parte Paxman and others [1995] Adequate consultation does require that the consultee be afforded adequate time for consideration, and opportunity for dealing with the merits of a proposal and adequate time to respond.

18. It is usual practice to allow three months for consultation exercises in respect of proposed substantial service changes. It may be reasonable to allow a shorter period where the circumstances justify it (e.g where the details of the proposal have been known to the CHC, and have already been the subject of public debate). However, a HA may lay itself open to judicial review if a CHC, or some other party which has a right to be consulted, contests the shorter time-scale and can argue that there are no good reasons for this. It should be noted here that even if information about the proposed change has been in the public domain and interested parties have made their views known, this does not remove the need for a formal consultation if there is a statutory requirement for this.

Genuine consideration

19. The consultation document must be couched in terms of proposals, i.e be a genuine consultation, rather than present an already-formed policy. A preferred option can be put forward but it must be clear that a genuinely open mind will be kept about the outcome until all the responses to the consultation have been considered. In particular the HA must give genuine consideration to any alternative suggestions that are put forward as result of the consultation.

R v North and East Devon Health Authority ex parte Pow and others [1997] The Authority should consult on the proposals and not wait until proposals have evolved into a final decision. The time for consideration is when proposals are still in a formative stage. It is not appropriate for an authority to reach a decision and then put it out to consultation, because the process of a consultation requires that the consulter have an open mind.

20. Although there is no statutory requirement for HAs to consult anyone other than CHCs about proposals for substantial service changes, it is good practice to consult any other interested parties and members of the public. A failure to do this could lead to a Court finding that the consultation process was flawed and declaring any decision taken in relation to the proposal invalid.

21. If a proposal is likely to affect the population of more than one HA then the CHCs representing each of those communities should be consulted. In these circumstances it is reasonable for one HA to lead on the consultation provided all

affected CHCs are consulted. If the patients in any CHC area would be substantially affected by the change and that CHC objects then the case should be referred to Ministers for resolution (see paragraph 37 below).

EARLY AND ONGOING COMMUNICATION

22. While a period of formal consultation on specific proposals may be appropriate at some stage, the key principles for consultation and indeed the ever evolving nature of modern health services, mean that it should be part of a broader ongoing process of HAs' communication with, and involvement of, users and the public.

23. As shown above, the Courts have ruled that consultation needs to begin when proposals for service change are at a formative stage and before they have become decisions. It is good practice to involve CHCs and other interested parties in discussion about the issues affecting local services both generally and in respect of specific areas. The process of developing HImPs will provide a good vehicle to engage local people and groups on general health service planning and development issues. It is also good practice to have ongoing discussions with CHCs and other interested groups as specific issues are explored and proposals are developed.

Rollo v Minister of Town and Country Planning [1948] and R v Secretary of State for Social Services ex parte AMA [1986]

The essence of consultation is the communication of a genuine invitation to give advice and a genuine receipt and consideration of that advice.

R v London Borough of Camden ex parte Cran [1995]

There is an expectation of dialogue between parties. Consultation is a two way process and the obligation is greater than one to receive and consider representations.

OPENNESS

24. One of the key principles of the Government reforms is to renew public confidence in the NHS. An important factor in achieving that will be open and clear processes for consultation on substantial service changes. It is good practice to publish a plan that sets out a clear process and timetable for consultation. It is also good practice to involve CHCs in the development of such plans. In addition to plans for specific consultations, some HAs have also developed more general protocols for consultation with CHCs.

METHODS OF CONSULTATION

25. Traditionally, consultation has tended to follow a regular pattern, based around the publication of a formal consultation document and formal public meetings. Such methods can play an important part in consultation, particularly in formalising

proposals and inviting responses. However, there are many others ways in which consultation can take place and which can help maximise user input to the process.

26. A number of documents have been published on this subject (see Annex). The following is just a brief overview of some of the techniques that are available. While some methods may be more successful than others for achieving a particular outcome or for reaching specific sectors of the community, there is no one method that can be said to be the best. Different situations will require different approaches.

R v Kingston & Richmond Health Authority ex parte Paxman and others [1995]

The demands of consultation may depend in part on whether the obligation (to consult) is statutory and absolute or implied in common fairness and upon the nature of the assistance that might be expected from those to be consulted. The consultation procedure adopted must be fair and reasonable in the circumstances.

Public meetings

27. These can be a good way to get information to people but can be of limited value in getting constructive feedback in return. Where strong feelings already exist such meetings may be hijacked by those just wishing to let off steam. They are also not always the best way to get less articulate and less confident people to put their views across.

Focus groups

28. This method is used when a very specific topic needs to be looked at. The main aim is to focus on perceptions rather than to arrive at recommendations. This means that follow-up work is usually required.

Case Study

Twenty women who had been treated for breast cancer were randomly selected from the hospital patient administration system and invited to two parallel focus groups. The purpose was to hear about the women's experiences of the treatment at Sandwell Hospital. One of the main topics considered was the quality of information given to patients throughout the care process. A clinical psychologist acted as facilitator and a nurse as observer. A report of the discussions, which had been approved by the participants, was distributed to staff for them to recommend changes to the service.

Citizens' juries

29. This method is useful where a matter needs to be looked at in depth and perhaps controversial issues are involved. The process is very participative. It does, however, take time to set up and so may not be appropriate if a controversy blows up suddenly. It is also very resource intensive.

Case Study

Portsea Island Primary Care Group commissioned a citizens' jury of 14 members to give an independent view about who should take responsibility for rationing medical treatment. The jury heard evidence from GPs, HA officials and MPs over a two day period. The jury recognised that GPs could face a conflict of interest between financial and clinical issues but concluded that GPs were best placed to make decisions about rationing as long as PCGs consulted widely and were open and accountable to the public.

Getting to 'hard to reach' people

30. Some people will simply not want to attend a meeting in unfamiliar surroundings. Others will not respond to written communications such as consultation documents or questionnaires. Where the views of particular sectors of the community are sought, particularly from traditionally hard to reach groups such as the young, the homeless, women from certain ethnic groups, etc., it may be more appropriate to talk to people at venues they frequent such as youth or night clubs, drop-in centres and community centres.

31. Another issue that should be addressed is why some sectors of the community may be more reluctant than others to participate in consultation about local services or to respond to health care initiatives.

Case Study

Lambeth, Lewisham and Southwark Health Authority found that women from the local Asian communities did not attend breast screening clinics and did not respond to general community consultation about health needs and the way that services were organised. By targeting consultation specifically on women in these communties, using materials translated into appropriate languages, the HA was able to identify the reasons why Asian women did not attend breast cancer screening clinics – largely because of taboos about healthcare and concerns about examinations by male doctors. By working directly with women from these communities the HA was able to educate local Asian women about the importance of breast cancer screening. It also made changes to ensure that medical examinations would be carried out in a culturally appropriate way.

Using local support networks

32. In larger towns and cities local support networks may exist that can be used for consultation. These can be particularly useful in helping break down some of the prejudices and misunderstandings that health care providers, and other public sector workers, may have.

Case Study

Greater Manchester police was concerned about the number of assaults on gay men and lesbians that were not being reported to the police. It therefore used its existing Community Consultation Groups to find out why gay people did not report attacks.

The result has been the introduction of bi-monthly open meetings in Manchester's 'gay village' and, in alternate months, detailed discussions are held with community leaders and a chief superintendent. Regular surgeries are also held in the village where gay people can talk confidentiality to a police officer. Because of the initiative new training has been introduced for police officers and the level of reporting of assaults has increased significantly.

Making results more representative

33. Consultation can produce results that do not represent the views of local people as a whole. Those responsible for setting up consultation exercises should avoid methods in which consultees select themselves and should instead look carefully at how a statistically representative sample of the population might be identified and targeted.

Case Study

Bradford Health Action Zone has set up a network called Partnership Health Action Link which operates in five areas, broadly coterminous with PCG boundaries. In each of these areas CHCs have recruited 20 members of the public who are willing to feed back to the CHCs their experiences, and those of friends and relatives, when using local health and social services. This has provided an initial minimum network of 100 participants, together with voluntary and community groups

34. It is also very important to consider the make up of the local community and to avoid the risk of token consultation or involvement. It would, for example, be a mistake to expect one person to be able to represent an area's black and ethnic minority community unless they can tap into the whole spectrum of cultures, interests and needs concerned. Also, when considering young people, boys will often have very different views and priorities to girls. Care should therefore be taken to ensure that when targeting consultation at these groups every effort is made to obtain the views of as wide a range of people as possible. Questions might be worded in a way that seeks to draw out the various perceptions and perspectives of a diverse target group.

Case study

Lambeth, Southwark and Lewisham Health Action Zone is conducting a project aimed at reducing accidental injury. Children and young adults (the target population) are being involved in the design and presentation of information and educational material to ensure it is attractive and accessible to their peers. All ethnic and cultural groups present in the area are included in the target population, and specific attention will be paid to ethnic and cultural issues that could affect the outcome of the project, including language, lifestyles and family structure.

CHANGES TO SPECIALISED SERVICES

35. Commissioning for specialised services raises particular issues around how consultations about such services should be handled. This has been looked at in

some detail by the Kent, Surrey, Sussex Local Specialist Commissioning Group and the following draws heavily on their work.

Key factors

- Planning for specialised services involves collective decision making by a number of HAs working jointly.
- Formal consultation is between each HA and its relevant CHC(s).
- The Regional Specialist Commissioning Group (RSCG) and Local Specialist Commissioning Group (LSCG) have no statutory base for consultation.
- CHCs have a local perspective and care has to be taken that a wider view does not lose local sensitivity.
- Local support groups and relevant voluntary organisations should be involved in the consultation process.

Good practice suggestions

Preparing for a review of services

- LSCGs should write to CHCs and other interested parties, e.g local support groups, setting out their priorities for the coming year.
- There should be a CHC observer on any group that is to review commissioning for a particular service. This should be someone with an interest in the service concerned who could act as a 'lead' in communicating with other CHCs. This person should not, however, be seen as representing CHC opinion nor as acting in the capacity of a lay/user representative.
- Clear terms of reference for the review should be available. The process must be seen to be open and transparent.
- Each review should have a clear communication plan issued early, setting out the process, time-scale and a checklist of how people will be involved and who will be involved.
- If a review is abandoned this should be announced.

Making the decision to consult

- If there is uncertainty about whether a proposed change is "substantial" CHCs should be invited to discuss whether the change feels substantial.
- A further discussion should take place when a site specific proposal has emerged with a view to determining whether a formal consultation is required.
- If in doubt, consult.

The consultation document

- must focus on the services, not the buildings;
- should explain the full patient pathway through primary, secondary and tertiary care and what will remain local and what will be centralised;

- be clear on what is being consulted on. Rarely will there be only one option but if there is, then be clear that the consultation is about how something will be implemented not whether it is done;
- must acknowledge the transport difficulties that will often arise in the event of centralisation;
- should recognise the implications for the unit losing services.

The consultation process

- The consultation process should be agreed with CHCs and other groups early on.
- There must be adequate time to enable interested parties to consult their colleagues – a full 3 months is recommended.
- The public must be given a chance to express their view, e.g by holding information events, meetings, focus groups as appropriate.
- Each HA is responsible for consulting its own population (the issues and implications of the proposals may be slightly different for different communities although there is no reason why these should not be set out in a single consultation document);
- The consultation should be led by one HA. This could be either the HA where the proposed future main provider of the service will be based, or the HA of the population most affected (usually where the service will no longer be provided).
- Although not formally able to consult, the LSCG could issue the consultation document on behalf of the local HAs. The lead HA could then lead the consultation with the other HAs.

The decision

- The LSCG will receive summaries of the comments received and agree a recommendation for each HA to consider.
- Each HA will need to convey the outcome to their communities with a view to formally agreeing the changes.
- Each CHC individually retains the right to have their objections referred to the Secretary of State.

AIDE-MEMOIRE TO GOOD PRACTICE

36. The following ideas are designed to assist those who are involved in consultations on substantial service changes. This aide-memoire is not designed to be used as a mechanical checklist, nor are the ideas in it an exhaustive list of good practice. However, they are drawn from the key principles of consultation and the experience of some HAs.

37. The statutory requirement is for consultation with relevant CHCs. It is however good practice to extend this to include other stakeholders such as local support groups, local patient participation groups and voluntary organisations. All references to CHCs should therefore be taken to include these as well.

Ongoing involvement and communication with local users, groups and the public

Do you have a strategic plan for systematic and continuous involvement and communication with service users, user representative groups and the public more generally?

Do you have good relations with local CHCs? Do they attend health authority, PCG and PCT meetings and are they generally engaged in discussions about local health service planning and development issues?

Do you regularly seek to publicise and invite debate about local health service planning and development issues?

Do you seek to listen to and inform local community and voluntary groups about service planning and development issues?

Do you know what issues are important to different groups of local people?

Consultation on proposals for specific service changes

Have you raised and discussed the underpinning issues before developing proposals for change?

Have you involved CHCs from the outset?

Have you actively sought the views of likely interested local groups?

Have you developed a consultation plan clearly identifying the consultation process and timetable? Were the CHC involved in its development?

Are any public meetings, conferences, focus groups etc well planned (e.g independently chaired and facilitated?

Have you built up relationships with the local media (newspapers, journalists, radio and television)?

Have you considered raising issues, publicising proposals in local newspapers (especially free papers)?

Have you enabled respondents to put forward their own proposals?

Have you allowed choice by presenting fairly argued options?

Have you explained why any particular option is preferred?

Information

Have you considered what information you might be asked for (what you have readily available or can easily provide may not be sufficient)?

If you know relevant information will not be available at the beginning of the consultation have you indicated when it will be provided?

Do people know whom to contact for further information or clarification?

Timescale

Have you allowed sufficient time for people to consider your proposals and to respond?

Did you discuss the timetable with the CHC?

Have you made allowances for problems arising from the time of year (e.g Christmas and the summer holiday months)?

Consideration of responses and feedback

Have you taken into account all responses to the consultation?

Have you clearly explained the reasons for final decisions, including why alternative proposals have been rejected? (It is good practice to publish a written explanation – this need not address each individual response, but rather cover general themes of responses).

Have you set up a process for keeping respondents briefed on progress with implementation?

CONTESTED MAJOR SERVICE CHANGES

Referral to the Secretary of State

38. Although not a statutory right, CHCs have a legitimate expectation (with consequent legal force) that contested major service changes will be referred to the Secretary of State for a final decision. If more than one CHC has been consulted, but only one objects, it may still be necessary to refer the proposals to Ministers if the service change is regarded as affecting services substantially in that CHC's district. There will need to be an element of judgement on the part of the HA involved.

39. The aim of a referral submission is to provide the Minister with a balanced view of the proposal, to enable them to make an informed decision. For this to be possible the HA that conducted the consultation exercise will need to pass all the comments made in response to the consultation to the relevant NHS Executive Regional Office (RO) who will prepare the submission.

40. All the arguments both for and against the proposal have to be presented, together with copies of all responses to the consultation. Where the proposal is for a closure, the Minister should also be briefed on any proposed PFI scheme, and any

consultation that has taken place on that. The submission must contain a balanced assessment of all the costs and benefits of the proposal. Particular care should be taken to ensure that public opinion is adequately represented and that sufficient account is taken of any alternative suggestions put forward.

Keeping interested parties informed

41. All representations received by ROs should be acknowledged. This is not only a courtesy but will assure people that their views have been received and will be taken into account.

42. Letters announcing the final decision should be sent to:

    Health authority chairman
    Trust chairman
    CHC(s) chairman
    Interested voluntary organisations
    Local MPs
    Regional chairman

43. A press release will not usually be required unless the announcement is likely to be particularly contentious.

Time taken to reach a decision

44. How quickly a Minister comes to a decision will depend on factors such as the amount of parliamentary business they have on hand, or if time is needed to ask for further information and to hear local representations, for example from CHCs. Also, if constituency MPs request a meeting to discuss the proposal the Minister will normally agree and will wish to let a little time elapse after the meeting before making a decision. Where there is a delay of any length we would expect ROs to keep interested parties informed about what is happening. Failure to do this can give rise to questions about the openness of the process.

Avoiding the need for a referral

45. Experience has shown that the majority of disagreements, and therefore the need to make referrals to the Secretary of State, can be avoided by an awareness of the following potential pitfalls:

    - unclear messages in the consultation process
    - uncertainty over whether it is consultation or information
    - insufficient information provided in the consultation document about the options (describing the situations that underpin them)
    - lack of clarity about people's roles in the consultation exercise
    - a suspicion that the "preferred option" reflects a foregone conclusion

EVALUATION OF THE CONSULTATION EXERCISE

46. As in many other areas of our work, evaluating the success, or otherwise, of an exercise is often sacrificed for the need to move on to something new. This is very much a missed opportunity where consultations are concerned as there will almost certainly be valuable lessons that can be learned for the next time. Wherever possible therefore an evaluation should be undertaken a few weeks after the consultation has been completed - after the dust has settled but before people have forgotten the issues.

47. Some feedback about the consultation process may have been included in the comments received in response to the consultation exercise itself. This should be supplemented by asking as many consultees as possible the following sorts of questions:

    - did the consultation reach all interested parties?
    - were the right methods and approaches used?
    - was the information accessible and appropriate for the local community?
    - did it give the message that the health authority thought it gave?
    - were any requests for further information or clarification dealt with satisfactorily?
    - did people have sufficient time to give a fully thought through response?
    - were responses to the consultation properly tracked and responded to?
    - did interested stakeholders receive a summary or copies of the responses and an explanation for the decisions made/changes which resulted?
    - were the staffing implications of the proposed changes handled well?
    - did respondents feel their views were sufficiently taken into account?

48. Ultimately the evaluation is about considering the objectives that were set at the beginning of the process and considering whether they were met and, if not, then why not?

IMPLEMENTING THE CHANGES

49. Major changes could well take some time to get off the ground and may continue over a long period. The project plan for implementation should be shared with consultees together with a realistic estimate of the time-scales involved.

50. Care must be taken to ensure that changes which were not part of the consultation are not brought in “through the back door”. Inevitably where large and complex changes are proposed unforeseen knock-on effects may emerge. If substantial changes which were not envisaged during the original consultation are necessary as result of the implementation pathway, it may well be necessary to conduct a second consultation exercise. Discussions with respondents to the original consultation may help identify the extent of this further consultation.

51. Even if everyone agrees that further consultation is unnecessary the effort will not have been wasted. By continuing to keep people informed and involved in a truly participative way we will ensure that their future involvement will be much more

constructive and they will contribute more fully to the development of the type of health services that people want.

ANNEX

FURTHER USEFUL READING

NHS Executive (1999) Patient and public involvement in the *new* NHS. NHS Executive, Quality and Consumers Branch, Leeds.

Cabinet Office (1999) Modernising Government White Paper. The Stationery Office, London .

Cabinet Office. (1999) Service First: the new Charter programme. Service First Unit, Cabinet Office, London.

Cabinet Office (1999) How to consult your users. Service First Unit, Cabinet Office, London

Chambers R (1999) Involving Patients and the Public – How to do it better, Radcliffe Medical Press.

National Consumer Council/Service First Unit (Cabinet Office) (1999) Asking your users… How to improve services through consulting your consumers. National Consumer Council/Service First Unit, London

National Consumer Council (1999) Representing Consumers: Information for people seeking appointment to consumer bodies.

Audit Commission (1999) Listen up! Effective community consultation, Audit Commission Publications.

Barker J, Bullen Mand de Ville J (1999) Reference manual for Public Involvement. Lambeth, Southwark, West Kent and Bromley Health Authorities.

NHS Executive (1999) Primary Health Care Teams: Involving patients – examples of good practice. NHS Primary Care Branch, Leeds.

NHS Executive Northern and Yorkshire (1999). Public Engagement Toolkit for Primary Care Groups. NHS Executive Northern and Yorkshire

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Department of Health (1998) Developing the Role of the Black and other ethnic Voluntary Sector in a Changing NHS, Department of Health, London

NHS Executive (1998) Report of a workshop on creating a modern and dependable NHS for black and minority ethnic communities. NHS Executive West Midlands Region, Birmingham.

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Sykes W, Collins M, Hunter D, Popay J and Williams G (1992) Listening to local voices; a guide to research methods. Nuffield Institute for Health.

Health Expectations: An International Journal of Public Participation in Health Care and Health Policy. Ed Angela Coulter. Blackwell Science/King's Fund.