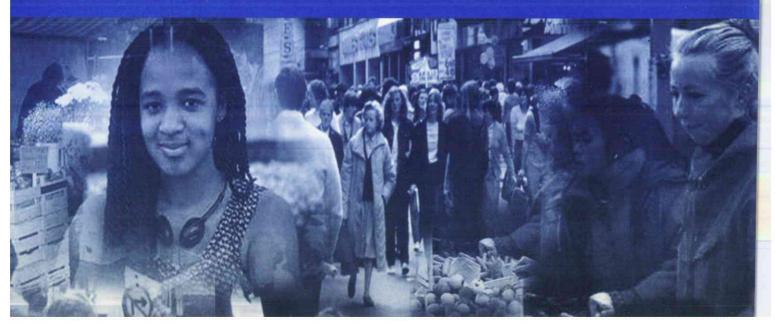
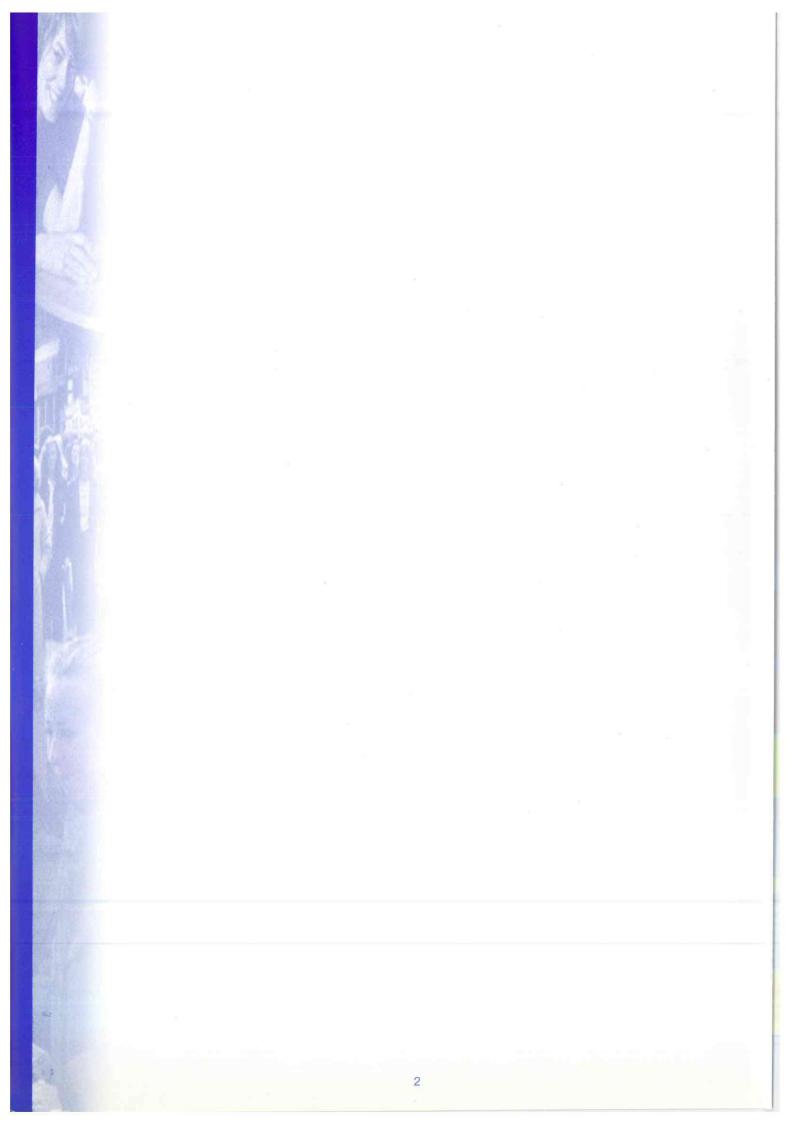
## Reflecting the public interest

Focused, Professional

A Strategy for
Community Health Councils
to plan their own future

Mick Rolfe
Denise Holden
Howard Lawes





## **Preface**

The publication of the White Paper, "The New NHS. Modern Dependable" initiated a wide-ranging debate about the role, contribution and performance of CHCs. This debate built on many of the performance issues raised in the "Insight Report", published in the Autumn of 1996, and subsequently rejected by the, then, new Government.

In the absence of any national progress on these issues, CHCs in the South and West Region developed a framework that was designed to evaluate the performance of local CHCs, including feedback from those working within and alongside the CHC.

The content of this paper takes what the authors believe to be the logical 'next steps'. It considers the options for restructuring CHCs in the future so that they are in a position to play a full and appropriate role in the new NHS. It would be wrong however to automatically assume that CHCs have a part to play in the new NHS. Their capacity to 'add value' needs to be tested and demonstrated. Many CHCs are already seeking to do this, recognising that complacency and 'no change' is not an option.

The paper takes as its starting point the fact that it is the job of CHCs to represent the interests of health service users, individually or collectively. In this context, CHCs are service providers. Just as with other providers, it is important to ask whether the sort of representation and service that the CHCs want to give is in fact what is in the interest of those being represented or provided with a service. So, whilst it is clear that the unique contribution of CHCs - to represent the public interest within the NHS - should remain unchanged, there is a need for clarification of the way in which CHCs interpret, understand and exercise this role. There is also an equally important need for CHCs and others to understand what is meant by "the public interest", as opposed to public involvement, patient participation or democratic representation.

There is no doubt that some CHCs are becoming better able to define their role and functions within the new NHS. They will need to be equally explicit about their aims and objectives as well as the means by which they can effectively demonstrate their contribution to the public/patient involvement agenda. This is a complex and challenging area of work that will evolve along with CHCs and the NHS, over time. Consideration also needs to be given to the potential for other service providers to make a legitimate contribution to this agenda.

Community Health Councils exist in the public domain to serve local communities. Yet the lines of direct public accountability are at best tenuous and at times non-existent. This issue now needs to be addressed.

Being seen to be open to criticism, suggestion and change, where this is thought to be in the public interest, can make CHCs vulnerable. It is though another unique characteristic of CHCs that can give confidence to a community, however this is defined, that their interest is represented within local health services.



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## 1 Executive summary

- 1.1 The publication of the White Paper, "The New NHS. Modern Dependable" initiated a wide-ranging debate about the role, contribution and performance of CHCs. This debate built on many of the performance issues raised in the "Insight Report", published in the Autumn of 1996, and subsequently rejected by the, then, new Government.
- 1.2 In the absence of any national progress on these issues, CHCs in the South and West Region developed a framework that was designed to evaluate the performance of local CHCs, including feedback from those working within and alongside the CHC.
- 1.3 Initial evaluation indicated some surprising results. On the one hand there were a number of significant issues relating to the perceived variability in CHC performance, and confusion about the role of the CHC within the NHS.
- 1.4 There was also though recognition that some CHCs provided a valued and effective contribution to the NHS. More important, there was a clear consensus that although 'life would be easier without CHCs' this would not be in the interest of the public or the NHS establishment itself.
- 1.5 Given these conflicting views, and the emphasis on quality improvement, public involvement and partnership working that has characterised recent policy documents, the authors have sought to critically appraise the current function of CHCs within the NHS. They have then suggested options for transforming the role of CHCs in a way that will contribute, demonstrably and positively, to the new NHS.
- 1.6 The starting point for this work was the rather uncomfortable notion that CHCs may not have a meaningful role to play in the NHS of the future; that their roles and responsibilities duplicated work being undertaken by others who were better placed to represent the views of patients or the wider public. Further, the introduction of new national organisations such as the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI), would replace many areas of work previously considered to be the 'bread and butter' of CHC work.
- 1.7 These factors, when placed alongside the perceived and actual variability in individual CHC performance, together with the charge of lack of accountability of CHC members, seemed to paint a very bleak picture for any CHC looking to the future. Further scrutiny, however, challenges this view and highlights the potential contribution that CHCs, or similarly constituted organisations, could make.

- 1.8 There is widespread agreement that CHCs will need to change if they are to contribute in this manner. This will include the need to challenge some conceptions that have previously been considered as absolute regarding the role of CHCs, for example, that 'CHCs represent the public' or that 'CHCs are the democratic voice of the people'. This might prove uncomfortable for some.
- 1.9 Further, there is a need to move away from the political approach adopted by some CHCs which, combined with a perception of vested interests, has undermined legitimate criticisms and contributions.
- 1.10 These changes may be difficult for some in the CHC community, but there is also no doubt that the wider NHS cannot avoid its responsibility towards CHCs. Despite the massive changes that have taken place within the NHS over the last twenty years, CHCs have remained almost untouched, some might say sidelined, as successive policy shifts have been implemented. This has resulted in a sense of marginalisation and isolation, which in turn has led to some CHCs refusing to face up to some of the difficult issues that the NHS is facing. When this happens CHCs make easy targets for criticism.
- 1.11 On a more positive note, there is evidence that where they are working well CHCs can and do make a real contribution to the delivery of local health services that is of benefit to all concerned. This does not duplicate the role of others nor does it ignore the reality of working within the new NHS. The fundamental responsibility of CHCs, enshrined in statute, is to represent the interest of the public within the NHS. This function is distinct and unique within the NHS and as such represents an appropriate starting point for testing future options for revitalising CHCs.
- 1.12 Accepting this assessment of the current position of CHCs, the question that the authors had to address was, 'where to now?' Building on the premise that there are both strengths and weaknesses in the current CHC repertoire, the following points were considered and arguments around them were developed.
- 1.13 Elements of CHC roles and responsibilities to retain:
  - Statutory responsibility to represent the public interest in the NHS at a local level.
  - Remain as part of the NHS but independent from local health services.
  - Contribute to planning and evaluation of health services, in accordance with current legislation.
  - Lay leadership, flexible enough to be responsive to local circumstances.
  - A service wide perspective.
  - Continue supporting the NHS complaints process.
  - Input into policy and decision making.

#### 1.14 Changes required:

- Clarification of role and responsibilities.
- All CHCs work programmes take account of national policy and key local issues.
- The title of the organisation will need to change to reflect the developing role.
- Review of current structure of CHC membership, including appointment procedures and accountability.
- Review of the role of the CHC Chief Officer and the contribution of CHC staff.
- Establish 'best fit' with others working within and alongside the NHS, including identification of a national focus for CHCs, within the NHS.
- 1.15 Given these points, what can be expected of CHCs, or their successors, in the future? A number of options are considered, including:
  - Contribution to service quality monitoring, possibly as the local partner for CHI.
  - Real input into decision making regarding the best use of NHS resources.
  - Strengthening public accountability and facilitating conflict resolution.
  - Raising public awareness, increasing the public's knowledge base and rebuilding public confidence in the NHS.
  - Provision of an independent, informed, local lay focus to a national public service.

- 1.16 By reinforcing the role of the CHC in representing the public interest and strengthening the responsibility of the lay membership, CHCs should find themselves well placed to provide a strong and credible perspective on the NHS and other health related issues that would balance a wide range of views. Two principal functions would support this role:
  - The development of locally appropriate mechanisms for enabling others to express their view about service provision. This may take the form of facilitating consultation groups on issues that arise, working with different patient groups on specific topics or contributing to voluntary organisation networks.
  - Quality evaluation of local services to complement national performance data and assure public confidence in health service delivery. This would include the development of locally determined, and therefore locally sensitive, complaints processes.
- 1.17 The authors have concluded that the best configuration to allow these functions to be performed would be one that included CHCs, or their successors, as local independent partners that are part of the national performance evaluation and health improvement mechanisms.
- 1.18 Further, the paper reflects the authors' conviction that there is a clear role for CHCs in the NHS of the future. That role will be legitimate, valued and beneficial to all. Inevitably, this will require changes to take place, some of which will challenge a status quo that has existed since 1974.
- 1.19 Nevertheless, these changes will be in the interest of patients, the wider public, professionals and managers within the NHS. There is a real opportunity for CHCs to lead on building new partnerships between national and local interests within the NHS. Those partnerships will unite previously competing interests and enhance the ability of the service to move quality improvement from desirable theory to deliverable practice.
- 1.20 As important, the proposals would not require significant new financial investment in CHCs or major adjustment to existing legislation.
- 1.21 CHCs have shown that there is a need for an organisation that can represent the public interest in the NHS. At present, no other organisation fulfils this function. Meeting this need in the future requires a number of changes to take place.

- 1.22 CHCs, in effect, will have to become new organisations. These new organisations will have:
  - Smaller, more tightly focused lay membership, with clear accountability and no formal links to local political, NHS or voluntary bodies.
  - A professional staff team.
  - Recognised formal links with the Commission for Health Improvement.
  - A dynamic organisational structure that will enable joint working, formal and informal partnerships, project work with, and secondments from, all local stakeholders.
  - Work programmes that take account of national and key local issues.
- 1.23 The authors believe that in order for CHCs to truly reflect the public interest within the NHS and be seen to be focused and professional, further work is required in the following areas.
  - Understanding what is meant by the public interest, (see Appendix 1)
  - Evaluation of the different models that currently exist in England and Wales, Scotland and Northern Ireland.
  - The model that is proposed in this document is piloted to identify its feasibility.

### 2 Introduction

- 2.1 For a number of years, Community Health Councils (CHCs) have attracted criticism regarding their role within the NHS and the effectiveness with which they fulfil that role.
- 2.2 The debate centred on the argument that CHCs are not uniformly effective; many work well to reflect the public interest within local health services; some spread themselves too thinly and as a consequence their effectiveness is diluted; some are simply mediocre.
- 2.3 The debate was brought sharply into focus with the publication of the ill-fated "Insight Report" in the autumn of 1996 which, although widely viewed as a flawed and mechanistic attempt to critically review CHCs, did highlight an important issue. This was the need for CHCs, in line with Health Authorities (HAs) and NHS Trusts, to develop a clear and objective framework against which to measure their performance. This view was supported by the Secretary of State for Health, the CHC community, and the wider NHS.
- 2.4 In the absence of any national progress on this issue, CHCs in the South and West Region collaborated to produce a performance evaluation mechanism.
- 2.5 In February 1997, the South and West Association of Community Health Councils published "A Performance Evaluation Framework for Community Health Councils". The framework was based on self-assessment and peer review and was aimed at promoting the sharing of good practice in delivering a clearly defined local agenda.
- 2.6 The approach taken throughout the Framework paper built on the mutually inclusive concepts of self-development and quality improvement. This approach proved to be flexible enough to be sensitive to variations in local circumstances whilst remaining capable of demonstrating to local people and the NHS Executive that CHCs could deliver challenging, relevant and rigorous work programmes.
- 2.7 Early results from the peer review process produced some surprising findings. Contrary to the often negative portrayal of CHCs, feedback from external sources indicated that they performed a distinctive and necessary function, from not only the perspective of local people, but also the wider NHS establishment.
- 2.8 There was recognition that, where they were working well, CHCs provided a valued and effective contribution to the NHS on behalf of both patients and the public. There was also deserved criticism, and a degree of frustration, about the lack of clarity regarding the role of CHCs, including the wide variability in quality, performance and accountability.

- 2.9 Inevitably, there will be variation between CHCs due to the different communities they serve. This does not however absolve CHCs from their duty to demonstrate effectiveness and quality of service provision.
- 2.10 The lack of clarity regarding their role and perceived variability in performance supports other anecdotal evidence that whilst CHCs can be a valuable resource to the NHS, the rights provided by regulations and the flexible way in which these allow CHCs to determine their own agenda can inhibit the way in which their views are both received and acted upon by the wider NHS.
- 2.11 The NHS White and Green papers, with their emphasis on developing patient/public involvement within the NHS, further helped to sharpen the realisation that CHCs will need to look critically at how they can best contribute to the new NHS.
- 2.12 Many CHCs recognise that their unique combination of statutory powers, informed lay membership and strong community networks can help to make the new NHS, at a local level, patient centred and publicly accountable. To achieve this however they will need to be prepared to consider critically how to build on existing good practice and face the fact that they will have to change.

## 3 The starting point

- 3.1 The White Paper, *The New NHS. Modern. Dependable* and the following Green Paper, *Our Healthier Nation* had little to say about the future of CHCs in the 'new NHS'. This was both quite deliberate and quite correct. The question of whether CHCs have a role within the NHS in the future still needs to be debated fully and inclusively.
- 3.2 It remains the fact though that CHCs are the only lay organisations within the NHS that have a right to enter and inspect premises where NHS services are provided. In addition, they have a number of unique statutory rights and responsibilities. However, the interpretation of these responsibilities varies widely from one CHC to the next, and historically it has been more comfortable for some CHCs to offer superficial commentary rather than a public interest perspective.
- 3.3 This variation can be viewed both positively and negatively. Dealing with health issues from a local perspective keeps CHCs in touch with community voices and ensures that a range of interests and user experiences are reflected to local purchasers and providers. The statutory framework supporting CHCs is able to give focus and legitimacy to these different commentaries as well as providing a medium for giving feedback on action taken.
- 3.4 On the other hand the lack of 'clarity of role' regarding CHCs can leave members of the public, the wider NHS establishment and indeed even CHC members and staff themselves unclear about the purpose of the work being carried out.
- 3.5 It is also the case that many of what some CHCs regard as their core functions are being carried out by other, perhaps better placed or more competent, bodies. As Pickard noted "HAs up and down the country are experimenting with ways of involving the public which, in bypassing CHCs altogether, would seem to contain the possibility of making their role redundant. Health panels, focus groups and citizens' juries all involve members of the public directly in consultation and debate." <sup>2</sup>
- 3.6 As well as this the Patient Partnership Strategy has been developed, largely without formal CHC input, and the proposed National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI) will both carry out a range of activities involving lay representatives which previously might have been considered as falling within the remit of CHCs.
- 3.7 The Patients' Association, the Long Term Medical Conditions Alliance, MENCAP and MIND are further examples of organisations that play a major role in representing different constituencies of NHS patients at a national, and in some instances, local level.
- 3.8 It is more difficult however, to sustain the argument that nationally based organisations, which may or may not have local group networks, can influence the local health care decision making process in the public interest, *in toto*.

- 3.9 Similarly, whilst management initiatives to improve and/or monitor service quality and quantity are to be welcomed, their impartiality cannot be guaranteed.
- 3.10 Indeed, in some cases their particular perspective as part of the NHS establishment makes it difficult to identify the correct questions or correctly interpret the answers. CHCs are well placed to carry out both of these roles and can either endorse or challenge local performance indicators from an independent, public interest viewpoint.
- 3.11 In some health districts CHCs have established a good working relationship with HA and NHS Trust management and are respected for their informed input, that often derives from their day-to-day involvement with patients and dialogue with their local communities.
- 3.12 When working effectively CHCs can and do influence the delivery of local health services, providing informed lay comment and a consumer focused knowledge base that is not available elsewhere in the NHS.

# 4 Current performance and issues for consideration

- 4.1 The effective and positive contribution of CHCs in reflecting the public interest within local health services remains distinct and legitimate, not only from the perspective of local people but from also the wider NHS. In an increasingly complex service environment, characterised by ever-increasing numbers of competing stakeholders and interest groups, there is a specific role for a body that is able to fulfil the function of CHCs within the NHS.
- 4.2 In 'representing the public interest' rather than 'representing the public', the issue is primarily one of accountability in public sector services, rather than a misplaced, and probably insupportable, notion of democracy. Changes in service delivery will take place and a wide range of influences may be brought to bear by different stakeholder interests. From a public/patient standpoint the question should not be "should those changes take place?" but rather, "are those changes fair, reasonable and in the interest of local people?"
- 4.3 Professional interests in the NHS have traditionally been organised to influence the way in which funding is directed. In some instances this has led to the development of world-renowned centres of excellence, in others there has been a proliferation of services that represents duplication and dilution of best practice. This latter factor is increasingly inappropriate in the modern NHS, not only from a financial perspective but also in the quality of care being delivered.
- 4.4 The provision of health services, and decisions regarding future services must be open to public scrutiny and, to the fullest possible extent, take account of a range of views from the voluntary sector, service users and the wider public. CHCs are already well placed to act as the vehicle for ensuring that these are articulated alongside professional, managerial and political interests.
- 4.5 Another point to consider is that CHCs are fundamentally local organisations, and whilst management accountability and support is provided through the various Regional Offices of the NHS Executive, there is no formal regional or, in practice, national presence enhancing the statutory responsibilities of CHCs within the NHS. Some co-ordinated work takes place at a regional level but this is, at present, often sporadic and frequently ignored outside the region concerned.
- 4.6 The contribution to national policy/work is even more fragmented with initiatives normally driven by individual Chief Officers or the CHC members' representative Association. It is difficult to establish a national policy focus because of the very different approaches and policies adopted by individual CHCs. This must be addressed if the full potential of CHCs is to be realised. This policy support role is different to the administrative and managerial support currently provided by the NHS Executive via the various Regional Offices.

### 5 Elements to retain

- 5.1 Given the arguments developed above the question remains "what do we do now?" The views of the authors, based on the findings from completed peer reviews and comments from colleagues, highlight a number of elements of CHCs that should be retained or strengthened.
- 5.2 It is becoming increasingly inappropriate for CHCs to duplicate functions more expertly carried out by others, for example, Mental Health Act Commissioners. Similarly, the fact that CHCs have been in existence for almost 25 years is no argument for their retention.
- 5.3 Notwithstanding this, no other organisation is able to represent the public interest in the NHS at a local level. This feature of CHCs, often lost in the debate around public representation, public profile and democracy is truly original and should not be discarded.
- 5.4 CHCs were established to advise the NHS. They do this from a position that is integrated into the mainstream NHS but with an external perspective that balances professional/management opinion and maintains the much-heralded "independence from local health services". Many CHCs can point to very clear evidence that this independence from local health services is an important facet of CHC life. This is made clear to CHCs repeatedly, both from the NHS establishment and from the public. The public view generally is that HAs and other NHS bodies are still part of the NHS establishment, and as such are not well placed to reflect their interests. CHCs do not have these conflicting responsibilities.
- 5.5 A central objective of the White Paper is that public confidence in the NHS must be increased. This can only occur when the public believes that an organisation exists to represent their interest, and not that of managers, doctors or nurses. Maintaining public confidence is as much a part of the NHS as is the provision of clinical care. CHCs, because of their proximity to the population they serve and their independence from local health services are frequently perceived as 'champions of the people' and as such can build patient confidence in a system that for so long has been changing so much.
- 5.6 Hostile media coverage and a series of major lapses in quality have detracted from much of the work undertaken by the NHS. Additionally the public is increasingly willing to challenge professionals and managers about their actions. The presence of CHCs provides a vehicle 'on the inside' for directing and acting on these concerns effectively and appropriately.
- 5.7 CHCs can also prevent tokenism in the way in which public/patient comments contribute to the decision making process. There are good examples from around the country of CHCs that have worked in partnership with HAs to develop effective public participation, and ensure the patient view is heard.

- 5.8 Unfortunately however, variability in performance and local working arrangements can lead to the CHC view being ignored, belittled or taken out of context.
- 5.9 Many CHCs have established a good working relationship with HA and NHS Trust management and are respected for their informed input, which often derives from their day-to-day involvement with patients and dialogue with their local communities.
- 5.10 The key point that must not be lost here is that CHCs can and do influence the delivery of local health services, providing informed lay comment and a consumer focused knowledge base that is not available elsewhere in the NHS.
- 5.11 CHCs are the only organisations that carry out a full range of independent support to NHS complainants. Indeed, the contribution of CHC staff to the smooth and effective process of dealing with NHS complaints was acknowledged and welcomed in the "Wilson Report", and continues to be endorsed by the current NHS Ombudsman. There is no need to implement a change in primary legislation to enable this role to be retained by CHCs.
- 5.12 Many CHC staff have become expert in handling patient complaints and they are able to make a constructive and demonstrable contribution to the resolution of issues that is beneficial both to the patient and to the service itself.
- 5.13 From a patient perspective, the involvement of the 'independent' CHC staff can have a twofold benefit. It helps to promote user involvement in their own care, as active partners with professionals; and it enables patients to become informed about their treatment and care and to become involved in making decisions and choices if they wish. Clinicians and staff within the NHS have acknowledged the value of CHC input into this process, not only from a complaints perspective but also from an advisory/evaluative viewpoint.
- 5.14 CHCs currently give a degree of impartial input into NHS policy and decision-making, and can give a different and informed perspective to this process locally and nationally. This work, although difficult for CHCs themselves, will become more important as the public involvement programme is developed.
- 5.15 The Secretary of State for Health has set an agenda which, whilst being incredibly challenging, also presents enormous opportunities for CHCs to contribute to the delivery of that agenda.
- 5.16 CHCs, because of their broad role, have developed a wide perspective on health service issues. This has led to arguments that CHCs spread themselves too thinly and thus limit their effectiveness. Whilst this argument has some validity it should not be used to undermine this unique quality. A great strength of CHCs is their ability to use that perspective to draw up relevant local priorities when evaluating services.

- 5.17 It is also a weakness in as much as it clearly represents a significant challenge in terms of resources, both human and financial. Some CHCs are well placed to meet this challenge, having staff and members who are intellectually capable of taking part in the debates generated by increasingly complex issues. Others are not so fortunate.
- 5.18 Despite the variations in performance, CHCs have an affinity with the public that is in keeping with the lay view of a public service, i.e. open access, friendly, caring, "on our side". This relationship with local people is usually a product of a confident and well-motivated staff team. This strength at a local level is not readily transferable to others within or outwith the service and is unequalled across the whole health sector.
- 5.19 The current legislative framework should be sufficient to ensure that the public interest function of CHCs is retained, and even strengthened, and could allow any reformation of CHCs to take place. This will however need to be regularly reviewed.

## 6 Changes required

- 6.1 It is a truism that form follows function. The identification of the role(s) and purpose(s) of CHCs is therefore crucial to the development of a 'best-fit model'. With the introduction of robust performance evaluation processes, CHCs will be able to clarify those roles that are considered to be of value to themselves, the wider NHS or the public.
- A flexible approach to local needs is essential and must be retained although this has led to a proliferation in the interpretation of roles nation-wide. If CHCs are to help, rather than hinder, the operation of local health services, they will need to have a good working relationship with all sectors of the NHS. This relationship has always relied upon local personalities but it will help to have a clearer definition of the role of CHCs so that all parties start out with similar expectations. A sharper focus on those areas in which the CHC has the required skills, or can develop those skills, is necessary.
- 6.3 The rights provided by regulations, and the flexible way in which these allow CHCs to determine their role, can combine with the political element of their membership to produce an inappropriately hostile attitude to health authority or national policies.
- 6.4 CHCs should not be sidetracked into overtly political activities. The issuing of clear guidelines to CHCs and their appointing bodies on what activities are acceptable or not may help to prevent this occurring.
- 6.5 The greater involvement of Local Authorities in planning, developing and commissioning health services raises questions about the involvement of Local Authority members on the CHC. In the new NHS, there will be clear conflicts of interest for CHC members who are also local politicians. Further, the public perception of the independence of CHCs could be jeopardised.
- 6.6 The increasing involvement of voluntary organisations in planning and providing services also means that their contribution to CHCs needs to be considered. If the role of CHCs in representing the public interest is to continue, the current structure of the CHC membership must be carefully reviewed, evaluated and if necessary altered.
- 6.7 Having said this, no CHC could credibly claim to represent the public interest without the input from lay members. This reflects not only the need to demonstrate accountability to the public, but also the need for staff within the CHC to be accountable to a lay 'policy board'.
- 6.8 In order to sustain some of the widely held, positive views about the contribution that CHCs can make, there needs to be absolute confidence in the selection of appointees to the 'policy board'.

- 6.9 Some current CHC members have shown that they can be resistant to changes imposed by the dynamic agenda being set within the NHS, and this can perpetuate the poor impression of CHCs that is held in some sections of the NHS. The challenge here is for CHCs to shed the perception of 'meddling amateurs' whilst at the same time retaining the lay overview of local health services.
- 6.10 HA and NHS Trust non-executive members have for some years been recruited by an appointment panel following public advertisement. Those appointments have been made subject to a strict set of criteria laid down centrally. Whilst some CHCs might believe that the process itself has not been conducted as openly as it should have been, or that the criteria themselves were misconstructed, it should not prevent CHCs from asking whether this is a process which should be followed in relation to the appointment of CHC members.
- 6.11 The status quo with regard to CHC membership is not an option, and those who argue for it are generally those who do least. With the development of Health Improvement Programmes and the partnership working plans for the future, the CHC appointment process will need to be very closely examined. Advertising openly for CHC members, with equal access to all who are interested, should be considered an acceptable and egalitarian option to appointing politicians and those with a vested interest onto CHCs.
- 6.12 For those who have not done so already, it is time for CHCs to get off the fence, put ideological objections to one side and actively take part in discussions on issues such as Private Finance Initiatives and demand management. CHCs have to be prepared to engage in some of the difficult discussions that are taking place within the NHS. This will necessarily mean that the public are involved and will lead to more informed debate.
- 6.13 The realities of a cash-limited NHS have not been fully understood by some CHCs and this has led to some of the more important consequences not being taken into account during the formulation of CHC policy. CHCs do have original and relevant ideas on many difficult issues although the bulk of these may originate from a dynamic Chief Officer and some well informed members, rather than from the membership as a whole.
- 6.14 Too often important issues are dealt with in an impulsive manner. This is neither in the best interest of the public, nor the service provider/purchaser, which may well be looking for an objective steer from the CHC.
- 6.15 The raising of public awareness regarding CHCs is often put forward as a mechanism for ensuring their continuity, hence, "..the more people who know about us, and the more they know about the work we do, the less likely we are to be replaced." This is a difficult argument to sustain and, indeed, could in itself be a double-edged sword.

- 6.16 Raising the profile of CHCs will often have the effect of increasing their workload, but very little else. It will not necessarily have the effect of improving or focusing their work, and may in fact dilute it. Therefore the value of the drive to increase public awareness of CHCs needs to be critically examined.
- 6.17 Perhaps this energy would be better channelled into specifically focusing the role of CHCs and improving the overall quality of work, and to developing the mechanisms for genuine patient involvement. This would have the consequential and deserved effect of raising the public profile of CHCs.
- 6.18 Any contemplation of changes needed to make CHCs fit the new NHS must include a thorough examination of the role of the Chief Officer as a senior health service manager. A clear understanding of the necessary attributes for the post will also help to clarify what CHCs are and what they should be doing.
- 6.19 Findings of the peer reviews in the South and West Region appear to indicate that the Chief Officer role has evolved into a more executive function with the Chief Officer actively contributing to, and advising members on, key issues.
- 6.20 In part, this reflects the more complex environment within which the CHC exists, as well as the organisational changes that have taken place in the NHS since the inception of CHCs. In exercising a more explicit executive function, a CHC Chief Officer can expect to be fully supported by a professional staff team.
- 6.21 Again, the form that this support could take would be shaped by local circumstances. The staff team could for example be expanded to allow community development specialists to be employed to develop community research projects involving local people.
- 6.22 Formal epidemiological studies carried out under cover of a service level agreement with either purchasers or provider units would help to cover any additional resources resulting from increased staff or activity. Alternatively the CHC could act as a facilitator, providing public views on key issues, creating a local 'centre of excellence' in this area, reducing duplication and building on best practice.
- 6.23 CHCs are not academic institutions, yet the opportunity now exists to increase the knowledge base of local people by supporting local CHCs that have developed strategies for representing the public interest based on research grounded in local communities. New funding need not underpin this work but instead better use could be made of existing resources.

## 7 Future contribution

- 7.1 Having set out the current position of CHCs, the role and functions of a CHC in the future need to be considered. From this perspective, there are a number of important areas within which CHCs represent the public interest in the health and social services sector. Whilst accepting that they should not duplicate the work being carried out by others, there remains a valuable role for an independent local body that can contribute to the decision making processes of public sector managers and professionals.
- 7.2 The scope for this body, whether or not it is called a Community Health Council, to work alongside other complementary national interests within the NHS needs to be considered further. The benefits that would result from this approach could include the following:
  - 7.2.1 The creation of transparency within a complex system many members of the public have little or no knowledge of the way in which health and health care issues are managed. Further, when they seek to influence this system, either strategically through formal consultation, or operationally through comment or complaint, there is little support available to enable them to do this as effectively as possible. CHCs already perform this function in many areas and are well placed to ensure that follow-up action is initiated when required.
  - 7.2.2 **Continuing contributions to improving services** The emphasis by the previous Government on creating an internal market for health care has left elaborate monitoring arrangements that have proved to be largely ineffective and bureaucratic. There still remains a continuing emphasis on those criteria that can be easily measured rather than those that are important. Frequently the patient perspective is absent or tokenistic.
  - 7.2.3 CHCs are able to bridge this gap through their monitoring activities and work programmes. The extent to which they do this, and ensure that services are responsive to local need, could easily be strengthened as part of their current remit.
  - 7.2.4 This would include more formal arrangements for quality monitoring and support to audit processes in all sectors of the NHS. This work could potentially inform the development of the role envisioned by CHI, in terms of building confidence regarding the systematic application of agreed quality standards and identifying areas that require more professional scrutiny. As importantly, this also provides an opportunity for identifying excellence and innovative good practice on a local basis.

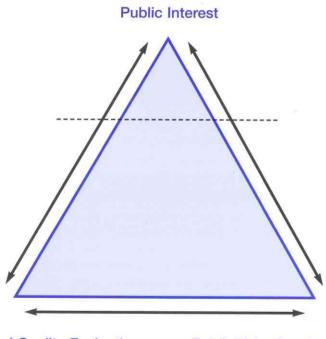
- 7.2.5 **Development of new services** available resources inevitably do not match public expectations. With increasing demand from the population, statutory agencies are finding themselves in the position of having to make difficult and controversial decisions regarding priorities. There is a role for a lay/public interest view in these discussions in terms of choices and planning decisions. Links with NICE would enable CHCs to be confident that changes to services were in line with good practice and counter public suspicion caused by competing clinical interests in a given area. Complementary to this work is the CHCs' ability to help ensure that public expectations of health services were realistic.
- 7.2.6 Creating and encouraging collaboration across agencies the benefits of working in partnership rather than competition have now been centrally recognised. Many organisations have cultures that will need to change and develop over time. CHCs have a real input into this change process giving a public perspective that is at the same time locally sensitive and informed. This includes creating and supporting a network of professional and lay people, drawn from a wide range of health related and other relevant backgrounds to tackle specific issues and share information. The PACE programme, (Planned Approach to Clinical Effectiveness), supported by the Kings Fund, is a good example of the means by which this process can be managed to the benefit of all concerned.
- 7.2.7 Accountability and conflict resolution the ability of CHCs to play the role 'honest broker' or the 'patient's friend' in resolving issues regarding complaints has already been well demonstrated and acknowledged by the Health Service Ombudsman. Where this function is fulfiled effectively there is a clear benefit to the complainant, the practitioner and, on occasion, the wider NHS. Further, CHCs can identify patterns and trends that may indicate an issue requiring further attention by service providers. There is scope for CHCs to strengthen further their contribution to the complaints process, in order to make analysis and feedback much more systematic.
- 7.2.8 Raising public awareness and re-building confidence in the NHS a central tenet of the White Paper, securing feedback from local people that is informed and pertinent, is also an increasingly important feature of public services. The complexity of current arrangements has already been recognised as an inhibiting factor in this process.
- 7.2.9 Moreover, many individuals, particularly those with complex or chronic conditions, are often reluctant to be frank with those responsible for providing immediate or long-term care. CHCs perform a valuable function in this regard by ensuring that people are realistic in their expectations of services, and by raising the skill and confidence of the public to highlight issues of concern.

- 7.2.10 As locally based resources, CHCs are accessible to, and informed about, the communities that they serve. This presence, together with the independence from the local NHS, represents a powerful measure of political commitment to the involvement of the public and patients in the running of the health service. By creating a link for partnership working with a body such as CHI, which will influence change nationally, this commitment can be further endorsed, whilst at the same time the accountability of CHCs to their local population will be demonstrated.
- 7.2.11 **Presenting a local focus** the changing role of Health Authorities and the setting up of a number of national monitoring bodies, will increase the sense of remoteness that local populations feel. The potential for CHCs to help bridge this gap, without the need for a proliferation of new, costly local outposts for organisations such as NICE and CHI is significant. There is also a need for an agency that can articulate and help reflect the views of members of the public and patients back to the health establishment.
- 7.2.12 This role can be extended to take on the full agenda, yet to be developed, regarding patient involvement in Primary Care Groups (PCGs). Equally important, this approach is consistent with the emphasis placed on partnership working and quality improvement by current policy documents. By focusing on the public interest, and enabling others to express their views effectively, CHCs will be able to provide support and a local presence to the national bodies whilst at the same time reflecting a perspective to the NHS that is informed and distinct.

### 8 A model for CHCs

- 8.1 Community Health Councils have unique statutory powers, and the combination of functions that CHCs perform in furtherance of the public interest within the NHS is also unique. To construct a model for future working that did not reflect that combination would be against the wishes of both the public and the wider NHS.
- 8.2 The reality of creating a 'democratic' NHS is that the most vulnerable, who are often the most in need of the NHS, would be further marginalised. Again the question should not be, "are CHCs democratically accountable?" but rather, "how can CHCs best represent the interest of their local population, and be held accountable for this?" Being constructed in a 'more' democratic fashion will not change any CHCs ability to do this.
- 8.3 When considering the way forward for CHCs it would be prudent to reflect that they are part of the NHS and should therefore expect and receive the same support as other component parts of a national public service. The ability to meet quality and performance targets are as relevant to CHCs as they are to any other part of the NHS or public sector, but they will often need active support to achieve these. It is misleading to suggest that CHCs, because of their independence from local health services, should be excluded from the support mechanisms that are available to other NHS stakeholders.
- 8.4 If CHCs are to continue to play a role in the NHS of the future, they will need to continue to move away from the historic tendency to focus on local issues solely determined by members' interests and perceptions. This should not detract from the excellent work that many CHCs do locally but, as a statutory body within the public sector, account needs to be taken of the way in which services are developing nationally as well as being aware of local circumstances. This will require a significant shift in organisational working by some CHCs.
- 8.5 Natural partnerships in this area would be between the CHC and the developing National Institute for Clinical Excellence or the Commission for Health Improvement, creating new alliances between national monitoring bodies and local interests that do not, at present, exist.
- 8.6 CHCs ability to act as the link between a variety of different networks should provide a significant resource within the developing partnership arrangements in health and social care. This may occur nationally, through NICE or CHI, or through exploiting local opportunities and circumstances. Although independence from local NHS services will remain an essential feature of their effectiveness, arrangements do need to be in place to ensure that CHCs work in collaboration with a range of different groups to build meaningful measures of performance.
- 8.7 This type of partnership working would take the best of the current contribution of CHCs and give unparalleled impetus to the ability of local people to raise issues of concern, building public confidence and professional accountability. From the perspective of both NICE and CHI, Community Health Councils could provide a network of intelligence and informed lay comment that would give local flavour and immediacy to otherwise remote from a public perspective national quality organisations.

- 8.8 This would be an effective mechanism for validating the aggregated data provided on the performance of the public sector services, and for providing a route through which reported performance can be endorsed or challenged. Specific issues of local concern could be flagged for further investigation and examples of good practice readily identified and disseminated.
- 8.9 Developing a best-fit model for CHCs will add clarity, provide a focus and give CHCs the room they need to prove themselves as a credible and accountable body within the NHS.
- 8.10 The model in Figure 1 represents a basic view of the functions that CHCs perform and the relationships between them.
- 8.11 Figure 1



Local Quality Evaluation

Public Voice/Involvement

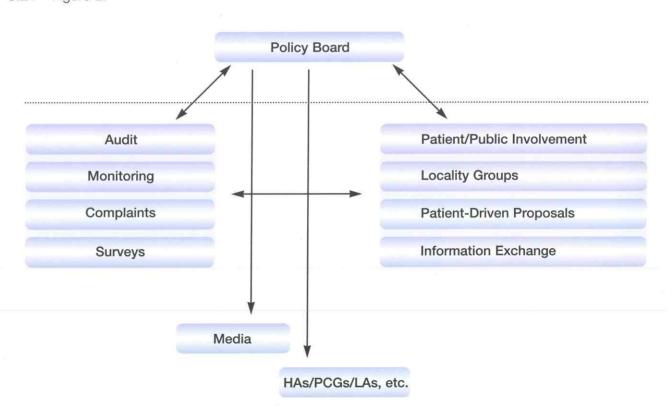
- 8.12 Those functions below the dotted line are currently performed by both staff and members. They should in future be performed by staff only, although staff structures and competencies will need to be reviewed to enable this.
- 8.13 The public interest function above the line is, and should continue to be, a lay function. We discuss how this can be achieved below.
- 8.14 A CHC's principal role is to represent the public interest. In carrying out this role the CHC lay members are informed by the two other functions: promoting the public voice and involvement, and local quality evaluation.

- 8.15 In the future each CHC must be able to fulfil each function in order to demonstrate the following imperatives:
  - to prove effective performance;
  - to show a consistent approach to representing the public interest in the work that they do;
  - to be able to contribute to the National and Regional agenda of the NHS;
  - to gain the confidence of the public, and in turn to build public confidence in the NHS;
  - to gain the confidence of both the local NHS and the Local Authorities in the fulfilment of their duties; and
  - to project a clear and unambiguous understanding of the role and functions of a CHC.
- 8.16 An increase in confidence within CHCs, and those working with them, will support and promote partnership working. This might include HAs, PCGs and even Local Authorities devolving their public involvement function to CHCs. As detailed above, included within the notion of joint working would also be the possibility of CHCs as the local partner of CHI, with clear lines of communication to NICE.
- 8.17 The duty of partnership being placed on the public sector has to include CHCs. There will inevitably be those who will claim that CHCs are excluded from this duty by virtue of their independence from local health services. This paper has consistently argued that CHCs can comply with the duty of partnership whilst retaining their independence from, and continuing to represent the public interest within, the new NHS.
- 8.18 The proposed model looks not only at the functions of a CHC but also the skills necessary to fulfil those functions. The core role and functions of a CHC, as detailed above, can be further developed by breaking down each function into a series of tasks.
- 8.19 **The public interest role** this is clearly the most important feature of a CHC and each task carried out will impact on a CHCs' ability to represent the public interest. In order for the public to have confidence in their CHC, and for the public interest to be truly represented within the NHS, a core group of lay people, (we have termed this a 'policy board'), should be at the heart of the CHC, independent and informed.

- 8.19.1 The public generally does not have confidence in the ability of health or social care professionals to represent their interest, in the face of a plethora of competing demands and conflicting interests. There would be a similar lack of confidence in a CHC that claimed to carry out this role but was itself made up only of health or social care professionals. Such an organisation would be seen as a mini-health authority and would have difficulty in persuading anyone that it was an independent organisation.
- 8.19.2 As noted above, lay members of a CHC should be appointed following an open selection process. The members would be accountable, through an appointed Chair man, directly to the Secretary of State for Health. The criteria upon which their appointment is based will need to be clear and unambiguous, detailing both the public's expectations and those of the Secretary of State. Those criteria should include the ability to take a broad view of the development of local health services, a willingness to accept that some difficult decisions will have to be taken and an enthusiasm to become informed about the NHS at an operational and strategic level.
- 8.19.3 A CHC constructed in this way would enable members to focus on strategic issues and make a real contribution to cross-health authority equity. The 'policy board' would be the level at which a lay opinion would be voiced. The board should therefore be well informed and this would be a product of the other functions of a CHC, the public voice and the quality evaluation roles.
- 8.20 **The public voice function** This is fundamentally a local activity helping people who are 'outside' to make their views heard as effectively as possible by those 'inside'. Staff with the requisite professional skills should exercise this function. As discussed above, the model of a CHC acting as a local partner to the CHI, should be thoroughly explored. With various national bodies being established, it will become increasingly important that a local voice is added and local links between CHI and NICE created.
  - 8.20.1 The involvement of local people in real decision making is recognised by all those who attempt it as a difficult process. Many CHCs do this in a competent and cost effective way, although they are generally those that have a dedicated member of staff involved in a public participation programme.
  - 8.20.2 CHCs have much to offer in regard to allowing the public voice to be heard, both as a mechanism for educating people about local health services and providing a conduit for information both in and out of the 'establishment'. Using skilled community development/involvement professionals to continue this work will enable the public to become involved at all levels of the local health and social care services.

- 8.20.3 Imaginative use of secondments from HAs, PCGs or Local Authorities to CHCs would enable this role to be fulfiled without any major resource implications. The independence of the CHC would not be compromised as the role of these staff would be to set up, manage robust links with local people, and develop networks of interested stakeholders. The separation of the public interest from the public voice and quality functions will also be seen to promote a CHCs' independence.
- 8.20.4 In this manner the CHC 'policy board' would have a demonstrable mechanism for involving the public, and decisions relating to the commissioning of services, demand management and the appropriate use of the health and social care resource, would be fully informed by the people to whom those services will be given.
- 8.21 **The quality evaluation function** this role demands increasingly professional skills from those who carry it out. The complexity of the NHS of today, and in the future, means that the quality of services provided or planned needs to be evaluated in a proactive and strategic manner. This is in contrast to the quality strategies and ad hoc projects generated as a reaction to operational service requirements, contract specifications and consumer pressure, although all of these will need to inform the quality agenda. Included on that agenda are issues relating to clinical effectiveness, clinical audit and the new clinical governance arrangements.
  - 8.21.1 These are matters that the NICE will focus on and it has been argued above that CHCs need to input this process.
  - 8.21.2 The evaluation of quality across all aspects of the NHS should cover the structure, process and outcomes of care provision to enable achievement of standards to be demonstrated and to pinpoint areas of concern. This is becoming an increasingly skilled task and one which CHC staff are being called upon to perform.
  - 8.21.3 This could and should continue within the model of a new CHC. This would not preclude patients or the wider public from having input into this process. Coote argued that "... it is important to stress the value of systematic monitoring ... based on specifications negotiated with the public and using methods of review which take full account of users needs and experience." That is a view that all CHCs would support and Figure 2 below facilitates this.
  - 8.21.4 The involvement of CHC staff in more formal quality evaluation would put an end to haphazard visiting programmes and focus the CHC work on specific service issues. Again, this work would feed up to the policy board enabling the CHC members to form a view regarding all aspects of service quality. That view would reflect the public interest.

- 8.21.5 The involvement of CHCs in complaints work is one of the most powerful ways of demonstrating the value that the public put on their CHC. CHCs should therefore forcefully argue for the retention of the role they play within the NHS complaints procedures. This is, in the very great majority of CHCs, a task carried out by staff, and this should remain the case. CHCs have shown that they can have a positive and powerful effect on the ability of the NHS to resolve complaints.
- 8.21.6 Often the successful resolution of complaints is a product of the relationship between CHC staff and local NHS management. Whilst this relationship needs to be constructive, open and robust, it does not impugn a CHCs ability to remain independent.
- 8.21.7 Complaints can also be strong drivers for change, and when linked to formal quality evaluation programmes can be used in the most positive of ways. This information can be used to inform and strengthen the public interest within the NHS, using the independent and well informed CHC, both staff and members, to achieve this.
- 8.22 Figure 2 breaks down the functions of a CHC and shows their relationship to each other. Those roles and functions below the dotted line represent the roles that will need to be carried out by staff, whilst the 'policy board' above the line is the level of lay input.
- 8.23 This represents a model of a CHC that will combine the best of the old with the requirements of the new.
- 8.24 Figure 2.



### 9 Conclusion

- 9.1 This paper has deliberately taken a radical and critical look at CHCs. This stance has been adopted not because of any doubt about the future role and contribution that can be made by CHCs to the future of the NHS but to attempt to draw together all the relevant issues and put aside many of the unhelpful comments that have been made about CHCs in recent months. The conviction of the authors is absolute that, to lose the input of an independent local body, charged with representing the public interest in the NHS, would be a disservice to the public, patients and professionals alike. Having said this there is no doubt that this role and contribution needs to be reviewed and considered in the light of recent policy changes. This evaluation must take account of the track record of CHCs objectively and focus on the established strengths of CHCs as well as the areas in which their performance could be improved.
- 9.2 The widespread variability in the performance of CHCs is as much a part of the lack of direction and focus within the CHC community and wider NHS as a measure of individual CHC capability. The opportunity now exists to address this issue and restate the importance of a clearly defined mechanism for reflecting the public interest in the modern NHS.
- 9.3 In line with recent policy direction any review of CHCs should seek to build on what works well as well as addressing issues of concern. This should be seen as a real opportunity and not a threat. Although change is required evidence from the grass roots does not support the anecdotal comments that CHCs are not relevant in the NHS of the future, rather that it is timely to adjust their contribution to reflect the changing environment within which they function.
- 9.4 There remains a legitimate and distinct contribution from an independent body that is able to represent the public interest in the NHS at a local level. Not only does this provide a counter to the professional, managerial and political viewpoint, but also provides a definable mechanism for building public confidence in service quality, planning health care and shaping public policy. The contribution made by this local body would be significantly strengthened by the establishment of clear links with a national body such as CHI.
- 9.5 Although the current legislative framework is appropriate for supporting the contribution of the public interest, further consideration should be given to the structure of the lay membership that leads this work and the staff support that is available. This needs to take account of the increasingly complex environment that characterises healthcare provision as well as probity and governance issues.
- 9.6 Appointment systems for the 'lay boards' need to be fair, open and accessible with a clearly defined role and accountability framework. The lay perspective in representing the public interest is essential. To enable members to fulfil their responsibilities effectively the NHS must ensure that appropriate selection procedures and training are in place.

- 9.7 CHCs will, in effect, have to become new organisations. More importantly these new organisations will build on the strengths of CHC members and staff that have already been identified. As such they will have:
  - A smaller, more tightly focused lay membership, with clear accountability and no formal links to local political, NHS or voluntary bodies.
  - A professional staff team that reflects the refocused role, new working relationships and partnerships.
  - Recognised formal links with the Commission for Health Improvement, providing a national focus for the public interest in the NHS that is supportive of the quality improvement agenda.
  - A dynamic organisational structure that encourages joint working, formal and informal partnerships, project work with, and secondments from, all relevant stakeholders, be they local, regional or national.
  - Work programmes that take account of national and key local issues.

Mick Rolfe Denise Holden Howard Lawes

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Mick Rolfe is Chief Officer of Southampton & South West Hampshire Community Health Council.

Denise Holden is Chief Officer of East Dorset Community Health Council.

Howard Lawes is Chief Officer of Bristol & District Community Health Council.

Thanks are extended to the NHS Executive South and West for their support in producing this document.

## Appendix 1

#### Authors' note:

#### Representing the public interest

Like the concept of quality, 'public interest' is difficult to define prospectively, although we all recognise its contribution in hindsight, or in relation to a specific topic. If CHCs are to represent the public interest, it is important that they have some idea of what it means, even if this varies according to local circumstances.

For the purposes of this document, the authors have defined "the public interest" in the following way.

The public interest in the NHS is represented by an independent, lay body that provides informed, objective views on the quality, reliability and acceptability of health care services. This will provide a balance to managerial, professional and political interests in the NHS.

Work undertaken in the public interest will:

- Relate to the evaluation, planning and delivery of health care.
- Act as an assurance to local people that decision making is fair and that resources are used appropriately.
- Support others seeking to comment on NHS provision.