The consumer hits back

Tony Smythe, the new secretary of the Association of CHCs, believes that the role of the NHS's consumer watchdogs should be extended rather than contracted. Here he talks to Andrew Cole

TONY Smythe, the new head of the Association of Community Health Councils, seems to collect good causes in the same way that other people collect stamps or old coins.

Probably best known as the former director of MIND and before that general secretary of the National Council for Civil Liberties, he is currently chairman of both the Campaign for the Homeless and Rootless and the National Peace Council as well as being treasurer of War Resisters International and co-secretary of a project for disabled children and their families in Haringey.

And that is not counting the job as secretary of the Association of CHCs which he took over from Mike Gerrard at the beginning of July and which, he admitted when I spoke to him in the association's tiny office in Euston Road, is more than a full-time job in itself.

The cramped offices which house Mr Smythe, his assistant Chye Choo, and the two full-time staff of CHC News, are symptomatic of the position the CHC movement finds itself in at the moment.

Set up as a part of the ill-fated 1974 reorganisation, its entire future was placed in the balance in 1979 when the government issued *Patients First* which suggested that CHCs might become superfluous following restructuring and reminding everyone that they cost around £4 million a year.

Despite the fact that, after widespread consultation, the government decided to make only minor adjustments, there is clearly a continued sense of unease both at headquarters and in the localities.

This anxiety was lifted to some extent by health minister Kenneth Clarke's announcement at the recent annual general meeting that 'the future of CHCs is not at any risk whatsoever — we value your role as watchdog'.

Tony Smythe . . . benign tolerance not enough

But he went on to add that the government would be reviewing the CHCs' role — and especially their relationship with DHAs — once they had settled into the reorganised structure.

Mr Smythe may only have been in his new post for a couple of months, but he already has trenchant views on such matters. 'The minister's statement shows that we now have some breathing space,' he acknowledged, 'but that kind of benign tolerance is not actually enough. If the CHCs and the association are only going to be allowed to play their relatively minor role under constant review and without adequate resources, then quite clearly their ability to prove their worth within the NHS is so much reduced.'

So are community health councils a spent force? Have the local watchdogs lost their teeth?

Mr Smythe remains optimistic. CHCs are, after all, part of one of the most popular social institutions ever established in Britain — the NHS. With so many DHAs now composed of newcomers, their knowledge and experience of the local scene is more valuable than ever. And while their effectiveness is variable, their impact in many districts is remarkable, he claims.

Nor is that impact confined to the more obvious functions such as monitoring hospital and ward closures, keeping a check on staffing levels and maintaining the pressure on health authorities to provide the best service.

Many CHCs are involved in health prevention, some are producing health booklets for ethnic minorities in their own language, while others have launched research projects on particular health problems relevant to their locality. Other initiatives are even more imaginative. In Manchester, for example, they organised a special 'thank you' month last year in which members of the public were invited to nominate individuals or units which had done something beyond the call of duty. The response was so overwhelming that most CHCs in the North Western region are participating in a similar scheme this year.

Mr Smythe waxes enthusiastic as he talks about these projects. 'I don't think the CHC movement should be defensive,' he states. 'My own preference is to talk about the areas where the CHC role should be extended.'

A number of CHCs, for instance, believe that if they are to be true representatives of the community they should be the ones who receive and follow up individual complaints about the health service — a role currently carried out by the health service ombudsman.

There could also be a case, Mr Smythe believes, for the establishment of parallel CHC organisations for the social services. So often the problems of the NHS spill over into the social services — and this always artificial dividing line will become increasingly blurred, he predicts, as the numbers of elderly ill grow.

The purpose of all this is not self-aggrandisement, he insists, but simply that if CHCs are to have any chance of success in their appointed role of

consumer watchdogs they must be both visible and accessible to the public, and they must have some teeth to add to their bark.

Yet the reality is very different. Instead of increasing, CHCs' powers seem to be contracting. The number of members on each CHC has been pared as a result of the government's review while the costs of the council's journal *CHC News*, estimated at £74 000 a year, is no longer met by the government but by the CHCs.

More ominously, he claims that a number of CHCs are now complaining that the new-style health authorities are effectively neutralising the CHCs' statutory right to be consulted over hospital closures and changes of use. The authorities, led by chairpeople who often hold disproportionate power because of the lack of experience of the rest of the members, are unveiling proposed changes in their operational plans, but releasing so few background details that informed opposition becomes impossible.

Now, to add insult to injury, at least one RHA has decided that CHCs, who are funded by region, come within the remit of the latest round of cuts. If their budgets are reduced, Mr Smythe predicts, one of the first things the CHCs will jettison will be their contribution to *CHC News* and their membership of the association — and so the cycle of deprivation will take another turn.

And yet this is clearly not the full story. Even before *Patients First*, CHCs were facing their problems — this was, after all, why they were included within the reorganisation remit in the first place. The plain fact is that in most districts the majority of residents have never heard of their CHC and even when they have, many do not know where to contact them or what services they offer.

Mr Smythe acknowledges there is some truth to this criticism. 'The NHS is a great mystery to many people,' he observes. 'We erect these massive institutions which through their sheer size are difficult to comprehend.

'What's more worrying is that many people who work within the NHS have very little idea of what the role and function of the CHC are. Yet the fact is that CHCs need people within the health service advising them, feeding them with information and using them.' They also need to involve more actively the public at large.

This is partly a matter of individual CHCs promoting themselves more effectively at local level. But there is also a need for national promotion — and this is where the association comes in.

The association has already produced a series of brochures informing the public about the innovative things being done up and down the country, and in November it is staging the first-ever CHC Week, which will, in Mr Smythe's phrase, help to 'network' CHC achievements across the country.

'WHAT'S MORE WORRYING IS THAT MANY PEOPLE WHO WORK WITHIN THE NHS HAVE VERY LITTLE IDEA OF THE ROLE AND FUNCTION OF THE CHC'

Somewhat heretically, he also believes that the association serves a political role in co-ordinating CHC concerns which have national implications — the most obvious example at the moment is the latest NHS cutbacks — and bringing pressure to bear on the Department of Health.

What effect the association actually has on national policies is another matter. 'This association has no real power apart from the power of persuasion,' Mr Smythe admits. 'It is a matter of how successful we can be in creating relations and developing influence at the DHSS.'

There is also the small matter of establishing a consensus within the CHC movement — differences of opinion inevitably blunt the impact of national representations. 'But when you are in a position to move forward, that is when the association becomes a lobbyist and a pressure group — the means of posing a dilemma or problem to the public and then to the people who make decisions.'

And if anyone is to succeed in this tactic it must surely be Tony Smythe. While director of MIND in the 1970s Mr Smythe acquired a reputation as one of the most effective exponents of pressure group politics, and the Mental Health Amendment Act bears many of the hallmarks of MIND's lengthy campaign on behalf of mental patients.

His account of that campaign is a fascinating one. 'When I went to MIND the Butler committee was meeting and I anticipated thet were about to recommend some changes in the Mental Health Act of 1959. It seemed to me that if that was the case it was time to look at the whole thing,' he says.

'Larry Gostin (MIND's legal director) came to work for us at around the same time and he provided a conceptual framework for mental patients' rights. Then we used a careful strategy of searching out test cases, going to the European Commission of Human Rights, winning our cases and creating media interest which led ultimately to that spate of TV documentary programmes on the subject.' Out of that, he believes, sprang much of the philosophy of the new Act.

His analysis of the powers and the limitations of the pressure group is equally illuminating. 'I learnt early on that pressure groups are most effective when dealing with peripheral issues that don't affect too many people — and here you can be very successful. But when it comes to doing something that touches the funny bone of those in power then you have got to have stamina and a strategy, and you have got to be prepared to hammer away at the same thing for many years.'

Mr Smythe insists that the association, being a statutory body, is not really a pressure group in the normal sense of the word.

However, he does not deny that part of the association's role is that of a pressure group, and that if the normal channels of communication between the assocation and the department become clogged up, it will be left with little alternative but to pursue pressure group tactics to achieve its goals. With Mr Smythe's formidable past record, the government should be warned. NT

A healthy life?

Smythe: out of MIND and into ACHCEW.

How a body reached a critical condition

A VITAL meeting for the future of Community Health care in this country takes place this weekend in the wake of accusations and rumours—so far private—over budget mismanagement.

The controversy centres on Tony Smythe, director of the Association of Community Health Councils, the statutory body that coordinates the country's 205 CHCs.

Smythe is a former director of the National Council for Civil Liberties and the mental health organisation MIND, which he left two years ago after a disagreement with staff there over budgets.

Until recently the ACHCEW received DHSS funding for its monthly magazine *CHC News*. But when this source dried up it became necessary to operate entirely on a subscription basis—each council paying £275 a year. This money had to pay Smythe's £14,500 salary, running costs of the small Euston Road offices as well as *CHC News* itself.

But the budget worked out to operate the organisation has proved so unsuccessful that a Special Delegates' Meeting has been called at Commonwealth House in the West End this Saturday to thrash out the future—if it has one—of the ACHCEW.

Among possible options are the complete winding up of the organisation—leaving the nation's CHCs without a central means of organisation, and of information-sharing—and the scrapping of *CHC News*, which has sometimes been critical of the way Smythe operates. The magazine currently employs three people who would, of course, stand to lose their jobs in such an event.

Is the winding-up of ACHCEW likely, we asked Smythe this week. 'Every option is open,' he told us. Was the closure of the magazine likely—it has been suggested he was in favour of this course. 'It's OK, it does its job.'

So would he be supporting it? 'I'm not going to support anything. I can read accounts.' The chair of the Association, John Austin-Walker was not available for comment as we went to press, but one delegate predicted a stormy meeting. (Duncan Campbell)■

■Unexpected culinary crafts at dawn last Wednesday when Labour councillors and the Greater London Council's new director general **Maurice Stonecroft** were seen serving breakfasts. It was still hours before the 7am end to the GLC's longest meeting, brought about by a Tory filibuster during the debate on the GLC's next budget.

What GLC finance chair **John McDonell** calls 'creative accounting' scored again for the Labour administration against the vocal but vanquished Tories. Former financial comptroller Stonefrost is believed to be the brains behind the GLC's propaganda coup, which involves making a 7½% rate cut.

Before the budget meeting Tory leader **Alan Greengross** threatened the filibuster and said the Tories wanted to cut the budget by a third, without cutting a single *real* service. They'd have to raise council tenants rents, though. They'd find another £220 million or so from reserves and they'd use up £35 million profit made by London Transport.

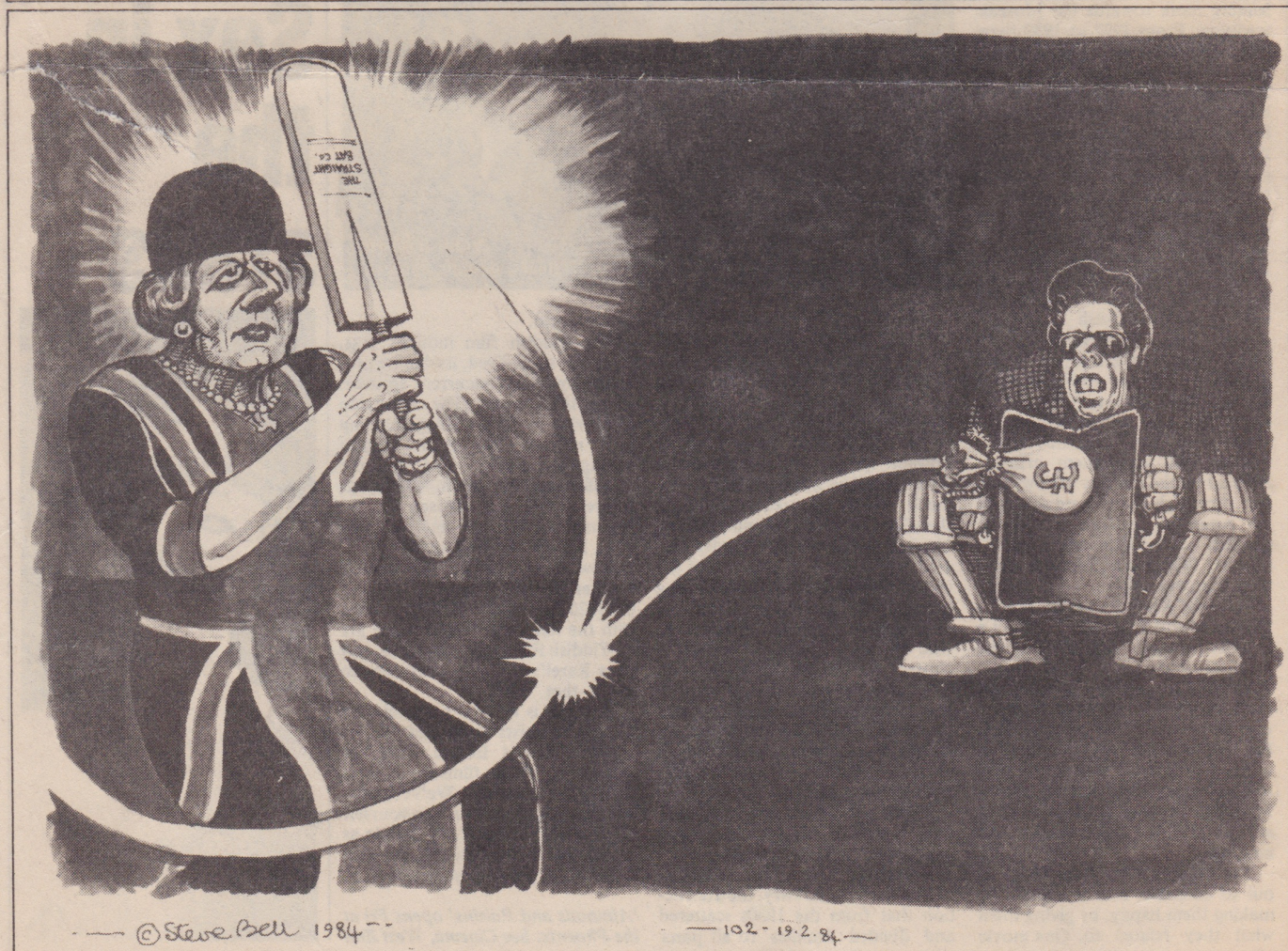
Speaking for the campaign to save LT, former Labour MP **Les Huckfield** described it not as profit but additional revenue, a windfall raised on the successful travelcard.

The GLC managed to cut the rate because previous underspending by County Hall—a great embarrassment to the government—wins a £100 million reward, due any day now. County Hall also cut back on it's external debt by a system of 'pay as you go.' Instead of borrowing for capital expenditure, thus incurring huge interest charges, the GLC paid for capital expenditure on London Transport, highways and the Thames barrier directly out of the rates.

■**Twit of the Week Award** (a slightly weedier version of Creep of the Week) goes to Tory Camden councillor **David Neil-Smith**. Asked to comment on why he was objecting to Camden Council's slightly odd decision to name dustcarts after people like Nelson Mandela as part of the GLC anti-racist year David said, when interviewed on LBC: 'I understand he (Mandela) is jail for quite serious offences.' Gosh.

■Rumbles from the Royal Borough of **Kensington and Chelsea**. Fraud Squad investigations into the Engineering and Works Department has led to the suspension of two council officials. The Council, is reticent over the whole affair. They told us 'investigations are still going on'.

(Tammy Hall)■



Continued from previous page

worked out and a new partnership of ministers, authorities and professions must be forged.

The Institute will play its part in this to the full as the professional body devoted to health care policy and management. Professional health service administrators already fulfil the general management role in the private sector and overseas and even — to a greater extent than the formal arrangements would suggest — in the NHS.

The Institute is taking radical initiatives to improve the opportunities for professional qualification, continuing education and access to Institute membership and affiliation for all involved in management including administrators, doctors, nurses and paramedical staff. Given the challenges and demands of the task ahead, investment in the people we have in the NHS is essential.

As the report says, NHS staff need motivation — not easy in view of the considerable distrust generated by the handling of the Griffiths inquiry and other recent ministerial action. It is not clear what the Government intends in this respect, or whether there exists any realistic assessment of the feasibility and time scale for a further reorganisation.

Perhaps ministers should start by indicating how they will deal with the problems which Griffiths identifies as particularly inhibiting to good management. The report cites excessive processes of public and internal consultation, interference by the apparatus of the DHSS which, the report recommends, should largely be dismantled, and the lack of clarity about the role of authorities.

Consultation is promised. Possibly the most positive next step will be for a consultative paper to be issued quickly, making clear the real extent of Government commitment.

The professions must not let the country think that Griffiths resolves the real issues of choices and priorities about health care in the UK. But it is vital that the service does not throw away by internecine wrangling the opportunities which Mr Griffiths offers. □

Barry Akid is secretary of the Institute of Health Service Administrators but writes in a personal capacity.

Enter the Oxfam boy of NHS

Tony Smythe, the man who turned Mind the mental health organisation, into a powerful force for change, has become secretary of the CHCs national body. His aim is to turn a low profile organisation into a focus of consumer power. He explains how to Nick Davidson

WE ARE likely to hear a lot more about community health councils in the future. 'I feel like the Oxfam boy of the health service,' says Tony Smythe, as he sits in the small and rather sparse office of the national association of CHCs, a couple of blocks away from Euston station in London.

It cannot have escaped his notice that the office is overshadowed, nay dwarfed, by the neighbouring Euston Tower office block, an outpost of the DHSS and a powerful visual reminder of the relative insignificance of CHCs on the national health scene.

'There are two full-time staff at the moment,' he goes on. 'Myself and my assisstant. It wouldn't be unreasonable though to aim for a core staff of a dozen or so.'

As chief architect of the rise in influence of Mind, the mental health pressure group, Tony Smythe became something of a national figure. He is still pretty new as secretary of the Association of Community Health Councils for England and Wales or ACHCEW (pronounced achoo), as it's known to the cognoscenti.

But he believes he was appointed to make CHCs more visable and has clear ideas about how to do so. 'When I was interviewed for this job I was asked whether I didn't think that, given the Government's rather paternalistic disdain for CHCs, the best tactic wouldn't be to lie fairly low until such time as somebody in government decided CHCs were a good idea. My answer was that it may be a good tactic but then don't appoint me.

'I think the time has come for the consumer movement in general, and CHCs more particularly, to become visible in the great debates that are occurring nationally. You don't get muscle or influence at political and administrative level by being totally invisible. They obviously agreed with me or I wouldn't be sitting here.'

By tradition ACHCEW has been a hard-working but low profile organisation perhaps best known for its once-a-year conference and the magazine *CHC News,* with which it is loosely associated. It is the product of a national movement of CHCs which has had difficulties reaching a consensus on national policy issues and which has had profound doubts about the wisdom and value of creating any national organisation at all.

Tony Smythe believes this reluctance is now changing. 'The measures announced by the Government over the last few months have produced a cohesion inside the CHC movement which wasn't there before. It is simply the perceptions of people across a wide spectrum of society that something is now going wrong.'

By way of evidence he cites the national emergency conference for NHS consumer groups which ACHCEW has organised for November 15. 'It would not have been possible six months ago to call a national conference to discuss national government policy regarding the NHS. Now it is,' he maintains.

'I think people are now realising that, while retaining the local function of CHCs, it is about time they developed national and regional presences.'

It will be a steep uphill climb. Tony Smythe is struck and perhaps not a little anguished by the fact that not a single newspaper or magazine contacted him for comment when the Griffiths report was published. Nor did Labour's new leader Neil Kinnock mention CHCs when he led for the opposition in the recent health debate in the House of Commons and reeled off a list of organisations and sectional interests concerned about the future of the NHS. 'We have got to do something about that,' he says.

The climb will be no less because more resources, staff and influence cost money and the present government, even if it liked CHCs and there aren't many signs that it does, would find it politically difficult to put more cash into them. Tony Smythe accepts this, but appears undaunted.

'I'm very optimistic. The Government is certainly not going to give us any extra resources unless it changes its mind about our role and importance. My first job is therefore to make it change its mind.

'I think it is essential that the DHSS reconsiders what its relationship to us should be. In a way it's humiliating not only for us but also for the Department to have a statutory network that is allowed to languish in the way we are. It would be more sensible, frankly, to kill the whole thing off if that is the attitude. I want to persuade the Department that it needs to reinvest in ACHCEW and CHCs.'

He believes one way of doing this may be to take on board more thoroughly an issue raised by Griffiths, who has shown himself keenly interested in trying to find measures of patient satisfaction and unmet consumer need. Perhaps he could be persuaded that CHCs have a role for the NHS not unlike the function that the market place plays for Griffiths' own organisation, Sainsbury's?

'CHCs all over the country undertake surveys on these very issues,' he points out. 'They go

Tony Smythe . . . 'I don't have the resources to even keep a card index of surveys issued by the CHCs'.

and find out what people need and think of the services they are being offered. But I don't have the resources to even keep a card index of what surveys and reports have been issued by CHCs over the year, let alone the resources to pull them together, divide them into subjects and write them up as national perceptions.

'Now that's a shame and I'm sure if I could present that kind of thing to Norman Fowler, who is a reasonable man, he would capable of being convinced.'

At the same time he is aware that he is looking for more money than the Government, any government, however persuaded by his sweetly reasoned logic is ever likely to come up with and he is also looking to trusts, foundations and other business sources for additional support.

Tony Smythe has set himself six priorities. They range from streamlining what he calls the 'slightly cumbersome' organisation of ACHCEW, through promoting CHCs in the media, Parliament and to the public to fund raising, organising training courses and in the very long term possible expanding the role of CHCs to cover social services as well, a tentative and unexplored idea at this stage.

Behind this lies a strongly held commitment to consumer power and the desire to push CHCs towards the wider consumer lobby. 'I believe there is a fund of knowledge about health and health issues in the community and a deep commitment to the NHS,' he explains. 'The job of CHCs is to locate that knowledge, to concentrate it, to mobilise it and to input it into the NHS.' □

Letters

Prejudice threatens the general manager proposal

Sir — The tense atmosphere now prevailing within the National Health Service makes the timing of the publication of the Griffiths Report unfortunate.

It would be regrettable, however, if anxieties over the Government's policies on staff cutbacks and financial restraint within the service prevented a full and constructive debate on the report. As chairman of a health authority I believe there is much merit in Griffiths findings, on two distinct levels.

First, by describing national practices, Griffiths is by implication inviting health authorities to look long and hard at each management and operational system. The most recent reorganisation of the health service was concerned with reducing levels of authority and encouraging more local decision making. It was not essentially about management or the way it performs.

The style of decision making and the manner of communication are now in need of scrutiny and the Griffiths inquiry shows how and why. Whether for immediate or long term implementation, the mechanism for doing so is shown honestly in the report with much supporting evidence to facilitate any initiative which any district or regional authority may feel inclined to take.

The second aspect of the report which, I believe, provides a refreshing view of the health service is the way the commerical/business area of experience is introduced into the evidence and the conclusions. Much has been made of the proposal for a general manager and it can only be prejudice or protection of individual vested interests which would reject such an obvious but important suggestion.

Again, the whole area of staff selection, appraisal and training in the National Health Service would benefit from the use of operational techniques used in industry.

If the health service is to meet the challenge of the next decade, whether at the level of budgetary restraint or of political interference, it is essential that it has a strong management sense which can stand up to the tests rightly demanded in other enterprises — whether State owned or private.

Eric Moonman,
1 Beacon Hill,
London.

Political masters are to blame

Sir — As a member of Bromley Community Health Council I note with interest your news story (October 27) concerning Bromley health authority's planned programme of spending through the current financial year and on through 1984-5 to 1985-6.

Despite the 'leeway' which allows a £500,000 'overspend' in this current budget I should like to make it absolutely clear that Bromley has set in motion a series of 'savings' and cutbacks which will have a real and severe effect on patient care.

Indeed, this district, in common with many others throughout the country, faces the frightening prospect of the permanent closure of at least one NHS hospital. Those of us who depend on NHS care can be relied upon to resist steadfastly any closures or asset stripping.

While I entirely accept that the DMT will implement orders in a sensitive manner which 'hopefully will have the least effect on patient services', I cannot but condemn the political masters in the DHA and in central government.

Perhaps those who do not use the NHS should not prescribe the levels of service for those who rely on it.

I would call upon all those of moderate and rational views (whatever their political hue) to lobby in defence of the NHS.

Sean McManus,
28 Valley View,
Biggin Hill,
Kent.

The editor welcomes letters for publication. Please write to the Editor, Health and Social Service Journal, 4 Little Essex Street, London WC2R 3LF.

Stafford hospital design

Sir — I have been recently sent a copy of Pauline Drummond's article on hospital design concerning Stafford DGH (September 8). I was a little concerned by the comments regarding the engineering services. 'The 8in thick towers in the hospital street' do not enclose the boilers nor have we reduced the section height envisaged in the Harness design.

James Chapman,
Building Design Partnership,
24 St John Street,
Manchester M3 4FB.

Correction

The illustration which accompanied the article by Stuart Haywood and Christoper Day in the Centre 8 last week was inappropriately presented. Due to a studio error the axes were placed incorrectly. We apologise for any confusion caused.