THE IMPACT OF CHCs ON NHS ADMINISTRATORS - Erica Bates, Ph.D.

AIMS & OBJECTIVES

The aim of this research project was to see whether CHCs had any impact on the NHS administrators with whom they dealt; and if so, just how that impact was effected, and if not, where the CHC failed. It is clearly one of the aims of the CHCs themselves to influence the administrators, since it is only the administrators who can make changes in the health services which would make them more responsive to consumer needs and wants.

Past research (see ref. list) has not generally dealt with the interface of CHC: administrator relationships, but, instead, has mainly dealt with the composition and the activities of CHCs, and argued the questions of their legitimacy and representativeness. For the sake of comprehensiveness, I also included some questions along these lines, but my main interest was in the "upward" look towards administrators rather than the "downwards" look towards the CHC itself and its community.

LIMITATIONS OF THE PROJECT

Since my resources consisted of six months time for the whole project, and only my own labour, it was obvious that I would have to restrict myself to a reasonably compact geographical area and sample within that. After discussion with a number of people, I decided to follow Professor Brian Abel-Smith's suggestion that I study the CHCs in the four Thames Regions, choosing a random sample stratified into inner urban, outer urban and rural CHCs. In this way I would obtain an idea of how three types of CHCs functioned and though the resulting survey is vulnerable to the criticism, often made by Northerners, that Londoners believe that England ends at Watford (or, in my case, Hemel Hempstead), there are many commonalities between urban, outer urban and rural CHCs all over England. Indeed, my experience at a number of ACHCEW meetings, talking to CHC members and Secretaries from all over England and Wales, has been that though each Secretary begins by saying "Of course, we're quite different from all other CHCs in the way we work", when it actually comes down to a description of what Secretaries and Members do, and one reads their Annual Reports,

CHCs are quite similar in how they set about their tasks though of course, they differ in the detail of their activities, personalities and relationships. Hence I feel reasonably confident in saying that my sample is typical within the limitations described. In particular, District and Area administrators do not say that they go about their business quite differently from every other District and Area, and it is to their reactions, rather than to the CHCs, that this research is focused. The methodology is described in Appendix 1.

DESCRIPTION OF RESULTS

In describing the results of this survey, I shall, wherever possible, tabulate the various responses together, so that the comparisons and contrasts between the various interviewees can be seen clearly. In the case of those questions that were asked as broad questions and not as a series of forced choices, I have had to compile the data into meaningful units. In general, this has not been difficult and the responses fell into reasonably clearly defined categories.

1. AIMS OF CHCs

While the CHC Secretaries had little trouble in answering this question, the Administrators found it very difficult. Almost invariably the response began with a value judgement, "Well, I approve of their aims", or "They're quite compatible with ours", and it was only after some repetition of the question that they were able to begin to formulate some answers. Perhaps as a result of this difficulty, their answers are more diffuse than those of the CHCs, and fall into a larger number of categories.

TABLE I

AIMS OF CHCs. - MAIN AIM CITED

Aim	CHC		DA		AA		FPC	
	No.	%	No.	%	No.	%	No.	%
1. Improve service locally	12	50%	4	17%	3	17%	3	17%
2. Represent public's needs and views to administrators and make them more responsive	10	42%	5	21%	3	17%	5	30%
3. Influence the public to be more aware	2	8%	2	8%				
4. Speak for special groups			3	13%	4	24%		
5. Make managers aware of service defects as the community sees them			7	29%				
6. Politics, mischief			1	4%	3	17%		
7. They don't know themselves, try to be managers, interfere			2	8%	4	24%	2	11½%
8. Support patient vis a vis bureacrat							5	30%
9. I don't know							2	11½%

Thus the main priority as seen by CHCs was not seen as such by the various Administrators, though DAs came very close to the general CHC view. CHCs had two quite clearly defined aims: to improve the service locally, and to represent the public's needs and views to the administrators and so make them more responsive. Indeed, if one adds the DA's two most similar responses together, i.e. to represent the public's view to administrators, and make managers aware of the service's defects as the community sees them, then the DA's response becomes very similar to the CHCs' own views of their aims. The FPC administrators

saw the CHC partially in these terms, but also in terms of the role in which the CHC most often confronts the FPC - that of patients' friend in complaints. The AAs on the other hand, see the CHCs mainly in the role which they assume via their Voluntary Body nominees, that of speaking for the special and neglected groups. And a comparatively high proportion of AAs gave negatively slanted responses, saying that CHCs were mainly interested in politics, or were trying to interfere in management's role, or that the CHC really didn't know its own aims.

The second part of this question asked whether the CHC was succeeding in the aims it had set itself.

TABLE 2.

	CHC		DA		AA		FPC	
Yes	8	33%	11	46%	5	30%	4	24½%
Yes, to some extent	11	46%	9	37%	5	30%	2	11½%
No	5	21%	4	17%	7	40%	7	39½%
Don't know							4	24½%

In all cases, the positive responses here outweighed the negative. But it is worth looking at the negative side too, which shows that of the 4 groups, the DAs are the most positive in their assessment of the success of CHCs, even more positive than the CHCs themselves. And the FPC Administrators, who had least contact with CHCs, have the highest "don't know" score.

Some of the comments, both positive and negative, made by administrators, are worth noting here. On the positive side, are such statements as "Without someone protesting against ambulance reorganisation and closures and so on, things would be far worse. Somebody has to scream against the automatic decisions of administrators that could have adverse effects on the health service" (FPC), and "CHCs have matured, they've become catalysts. The CHC has become more lively and searching in the last 12 months. They

highlight the issues we administrators would otherwise ignore. They force us to look away from hospitals sometimes, towards the community, and the Authority members are coming round more to the CHC view". (Combination of 2 AAs comments), and "They bring things to notice that we haven't adequately thought about. They make us aware that things aren't as they should be". (2 DAs). On the negative side, "They can't seem to grasp that doctors are independent contractors and we can't force them to do things" (Almost every FPC Administrator said this). "They can't fight us and succeed - they haven't the resources, the expertise, or the insight". (AA) and "They can't seem to deal with priorities. They want everything". (A number of DAs and AAs). "We are unable to make any impression on the NHS managers; they just write polite letters and ignore us".(CHC)

2. IMPACT OF CHCs ON DECISION MAKING

Perhaps the most important series of questions related to the impact on NHS decision making. Table 3 summarizes the results briefly and the discussion below elaborates the results.

TABLE 3

DOES THE CHC HAVE AN IMPACT ON DECISION MAKING OF YOUR DMT, AHA, FPC?

*Coded out of 24 AAs and FPCs because at times they wanted to differentiate between CHCs in their area, so referred to them separately.

	CHC		DA		AA		FPC	
Yes,definite impact	20	84%	15	63%	9	37%	3	12%
Some, minor	1	4%	2	8%	8	33%	1	4%
No	2	8%	6	25%	7	30%	20	84%
Don't know	1	4%	1	4%				

In 5 cases the AA said that the CHC had no impact while the DA said it had an impact; in 3 cases the DA said the CHC had no impact while the AA said it did.

In general, a 2/3 majority of DAs consider that the CHC does have a definite impact, with a small additional number who say there is only a minor impact. This opinion is only half as strong at Area level, where only about 1/3 of AAs consider that the CHC has a definite impact, and at FPC level that impact shrinks to only about 12% believing that the CHC has any impact on FPC decisions.

This general opinion is not to say that Administrators believe this effect is always beneficial for the health service. Four AAs who said the CHCs did have an impact, said that this was the problem, and that time had to be spent on educating CHC members and the CHC secretary, explaining why decisions were necessary and had to be made even if both Administrators and CHCs did not like them; and that sometimes the CHC's pressure was counterproductive and merely annoyed Area members. However, the great majority of Administrators who believed that CHCs did have an impact, believed that it was an impact that worked for the benefit of the health service and the patients, and spoke strongly in favour of the CHC's contribution.

(i) Impact at District level.

The DAs, as usual, were the most positive in their comments, saying that the CHCs had a strong and beneficial influence on the DMT and giving a number of reasons why this was so. They said that the CHC influenced planning and the need to explain the reasons behind the DMT's decisions pervades all planning that is done. The DAs believe that the CHC helps the members of the DMT formulate their views and provide more of a service the public want. Such a service may not always be the most efficient from a management point of view, but it will be closer to what the public prefer. Two examples will illustrate that point. In one District, at the CHC's insistence, a Nursing First Aid Station was retained when the Hospital's casualty department closed. Administrators see this as irritating, administratively untidy, and even dangerous, and inconvenient for the public too since they can't get treatment there - but the public still want it and so the administrators put up with it. In another situation, an AA discussed the chiropody service from this viewpoint, saying that he had wanted the Chiropodist to stay in the central town so that he could see more patients. The CHC wanted him to travel round the

(fairly large) area so that the patients in more outlying districts could get attention more easily. The decision was made in favour of travel for the Chiropodist, but this means, of course, that the shortage of chiropody services shows up even more acutely.

The DAs regarded the CHCs as being a very useful early warning system for problems about to surface. Their very existence was said to be perhaps their most important effect, because they made the DMT continuously conscious of the public view and the public interest. Naturally, there is sometimes an element of fear in this reaction; one DA said "The DMT is slightly afraid of the CHC - they're intelligent, well informed, have close ties with local groups, and can find out all our weaknesses and force us to straighten our ideas and clarify our thoughts."

Many DAs had previously been hospital administrators and said they found that they often unconsciously reverted to the hospital model in their thinking. They appreciated being forced by the CHC to widen their horizons. They said that there is now far more emphasis on the previously neglected services, because of CHC pressure being kept up month after month, so that eventually the DMT begin to feel guilty at CHC meetings if they yet again have nothing to report.

In some cases the DMT was beginning to use the CHC more politically and tactically, in their own battles with the Area and Region. The CHC has the power to see the local Members of Parliament and the Minister, if the issue is important enough. On occasions, when CHC and DMT are at one in feeling badly done by, for example in a non-teaching District in a teaching Area, the DMT will make common cause with that CHC to gain what they regard as a more equitable distribution of resources.

There is, of course, another side to this increasing political sophistication. Since DAs have had to learn to deal with CHCs, the DAs have become much more adept at rephrasing their plans, at keeping other things quiet, and at clever manipulation of language. The CHCs know and resent this, but are powerless to prevent it. So if relationships are not good, especially between the CHC Secretary and the DA, and the CHC Chairman and the DMT members, the CHC is in a very poor position to exert influence. The CHC's powers are real but very

limited, and their resources meagre, and if the DMT will not play ball, the CHC ends up frustrated and almost totally ineffective. In such cases, the CHC can either relapse into apathy - as had happened to one or two in my sample - or reach out into the community and attempt to stir up action there, in the belief that concerted community action is very hard for a Health Authority to ignore. Even if the CHC's representations are not taken seriously, MPs take notice if many voters seem to be discontented.

Indeed, a great deal of the impact of CHCs is clearly dependent on the quality of the working relationship between the CHC Secretary and the various people at the District with whom she or he has to interact. All the administrators who spoke in favour of CHCs mentioned the importance of their working relationship with the CHC Secretary. Qualities appreciated in the Secretary and Chairman of the CHC were reasonableness, willingness to learn and listen, and an interest in patients rather than politics. Indeed, when DAs were asked what they liked best about the CHC with which they had to deal, the most frequently mentioned quality was the good working relationship the DA had built up with the Secretary; and second, the CHC Members' genuine concern for patients regardless of politics. What was disliked most was when CHC members were superficial and ignorant.

One important and frequently mentioned way the CHCs have of influencing the planning process, is by their membership of the various District and Area Planning Teams. Membership is most common at District level, and a number of Areas did not even have planning teams as such. Table 4 shows the representation of CHCs on Planning Teams.

TABLE 4

Represented on all DPTs	18 CHCs	75%
On most DPTs	3	13%
On one or two DPTs	1	4%
Not at all	2	8%

Thus all but 2 CHCs were able to influence the planning process at the outset. The status of the CHC delegate varied, but was mostly referred to as "Observer" status, and sometimes as "Full member". However, the distinction between these two categories was not very clear, as all Administrators said that such teams did not vote anyway, and the CHC

member was free to speak and contribute as much as any other member. However, apart from this contribution, the CHCs' contribution to the NHS Planning cycle seems particularly ineffective. CHC Secretaries as a group said this; they felt the plans are too complicated for their members to understand ("we are rather bemused by the planning cycle") they felt that most plans were not being implemented anyway, because there was no money available; the final plan is too set to be influenced and can be twisted into almost anything by Administrators if they don't want to take notice of the CHC. One CHC's comments in its Annual Report are typical: "Informed comment is impossible when, in addition to plans being constantly modified, insufficient time is allowed for consideration of proposals ... the whole exercise seems farcical ... a planning exercise that is so complicated and so rushed that it is grossly wasteful of the time of the staff ..."(N.W. Herts. Annual Report 1977).

(ii) Impact at Area level.

At Area level, it was clear that there was a far more remote relationship and a lesser impact by CHCs. This is obvious from the figures in Table 4, where only a third of AAs said a definite "Yes" and a third said that the CHCs impact was only marginal. The main impact at this level was the CHC's power to prevent a hospital closure which the Area wanted, and this power forced the Authorities to think very carefully before suggesting a closure; to test out all possible alternatives, and to see what compromises and compensations could be offered to the CHC to induce it to agree. The CHC's agreement was seen as very important by the AA, because if that is forthcoming, the whole closure procedure is speeded up and this can mean considerable saving in money as well as time. However, the AAs spoke of the effect of the CHC in general as being veiled, or indirect; as being important during informal stages before decisions are reached. All AAs agreed that the formal consultation procedure was largely routine and token and CHCs could have little impact on decisions other than closures at the formal consultation stage..

The CHC observer at AHA meetings can have considerable impact if she or he cares to use the opportunity, although the CHC has no vote. But in all cases the CHC observer sits with the Area members, has a full agenda and minutes for Parts I and II of the meeting, and can speak, quite forcefully, on issues in which the CHC has an interest. One Administrator referred to the CHC influence as being a decided one, on the margin; but this can be negated if there are several CHC observers from different CHCs in the one Area and they do not agree, as sometimes happens when the interests of different Districts conflict. In 3 cases, the CHCs' arguments were felt by the AA to be counter-productive, because the CHC was said to base its case on prejudice and emotion and not facts, and the AHA members sometimes felt the CHC was trying to take over the management role. It was also counter-productive to be seen, as three CHCs were, to oppose <u>any</u> reduction or rationalisation of the services. If the CHC totally opposed all rationalisations and reductions of service; defended what they had and only asked for changes in the form of more services, the AHA members became all the more determined to make the changes they thought were needed, regardless of CHC opinion.

However, those AAs who did believe that the CHCs had a significant impact were very positive in their comments, saying that the CHC produced influential papers, that its presence forced Areas to think and rethink, and forced Administrators to give a little less weight to hospital matters and more to community problems. When asked what they liked best about CHCs, the most common answer was that the CHC was constructive, civilised, prepared to listen and be responsible; and the least liked were those occasions when a CHC took up a political, conflict stance, as if the NHS administrators were trying to wreck the service and the CHC alone stood to protect it. AAs frequently pointed out that CHCs fail sometimes to realise what can be achieved with available resources. The CHC thought that if only the Area would fight harder, more resources would become available, whereas AAs were not interested in making fools of themselves by writing a series of futile letters to Region and DHSS. However, 4 AAs mentioned that CHCs had matured over time; that they now understood some of the AHA's problems, and that they no longer asked for unreasonable or useless services.

(iii) Impact at the FPC level

The overwhelming majority of FPC Administrators said that CHCs had no effect on the decision making of their FPC. Any effects that were mentioned were minor, such as impact on branch surgeries, or on leaflets that the FPC issued; or that the CHC gave background information to the FPC. Indeed the impact and contact between FPCs and CHCs was so slight that my interviews with FPC administrators at times became embarrassingly short; the FPC Administrators had no comments to make, they neither liked nor disliked the CHC, and in fact the existence or not of the CHC was a matter of general indifference at this level of the NHS. No FPC Administrator had built up any sort of working relationship with CHC Secretaries.

(iv) CHCs' Own view of their Impact

The CHCs themselves had quite a realistic view of their own impact. Although the overwhelming majority believed they had some impact on NHS Administrators, they were well aware that their main impact was at the District level. Their view was that the DMT was willing to listen and discuss ideas, and that the CHC's role was mainly preventive, in that CHCs stop some decisions from being made, and reduce the scale of reductions of services. CHC Secretaries said that by now, more people in the District Office, and at AHA meetings, talked of "the community" rather than concentrating exclusively on hospital services. A subtle process was mentioned here: CHC reports and papers are written, and gradually over time, similar suggestions occur in DMT papers. It is not a matter of whose idea it was originally (both sides would probably lay claim to it), but as a result of frequent discussions, a general synthesis of ideas occurs, which is eventually incorporated into District and Area plans. The CHC Secretaries, too, valued greatly the good working relationships they were building with District officers. The qualities they liked best in their DMT were accessibility, approachability, willingness to discuss issues with the CHC, and an openness to new ideas; while the least liked - and this was overwhelmingly the case - were those occasions, and those administrators, who were seen as devious, wily, dishonest, withholding relevant information and distorting the truth by telling only a part of it ("the game is to find the right question").

(v) Examples of CHCs' impact

All interviewees were asked to give specific examples of services influenced by CHCs. My aim was to see whether the same examples were mentioned by the CHC, DA and AA. This did indeed happen in 11 cases, or 46%, which is really a very high proportion. These cases included three Day Care Abortion services; changes and replanning of 2 maternity services; the inclusion of a casualty section in a new hospital; the provision of extra psychiatric beds because of a CHC report; the provision of a walk-in clinic to deal with drug problems as a result of a CHC survey; the CHC's contribution to the planning of two units for the young chronic sick: these were all examples cited by CHCs and NHS administrators. The following examples were cited by DAs, AAs, and FPC Administrators, as being particular examples they credited to the intervention of the CHC.

In one district the planning and development of a complete community centre was totally credited to the CHC, since it had been begun over the opposition of the NHS administrators who wanted the site for staff accommodation, but were now in favour of the community centre concept. In another district, the DA said that the CHC had accelerated the provision of a VD clinic by about 3 years. "Every time I went to a CHC meeting I felt guilty when I had to say I hadn't done anything about it." One CHC did a detailed survey on the deficiencies of the local hospital's accessibility to the disabled, and the DMT is modifying the hospital in total accordance with their suggestions, including some major modifications. In another case, the DA told the following story: the DMT claimed that they had a nurse night-sitting service, but GPs were not using it because they said it was inadequate. The DMT would not improve it, saying that it was their policy to provide it and the service was there and was just not being used. The CHC broke through this knot by advertising the existence of the service, saying it was DMT policy to provide it and urging GPs to use it. Then the DMT was forced to provide the service effectively.

The visits made by CHCs to long-stay institutions were praised by AAs and DAs, who said that they were good for staff morale and often showed up problems that had been missed. In one district, priorities for the young chronic sick were upgraded as a result of CHC arguments; and in another, the CHC persisted until the DMT provided adequate information for parents of mentally handicapped children. The DA

here said "Without the CHC, the identification of such needs would not be so clearly made, or so firmly pressed."

This last example in fact demonstrates one of the main strengths that CHCs have, and a main value they have for administrators. Administrators want to know what particular needs there are in the Community, and especially if these needs can be met without incurring much expense. Those CHCs who do accurate, relevant survey work within their District and come up with information the DMT can use, are greatly valued by their District and Area administration.

3. HOW IS THIS IMPACT ACHIEVED?

As shown in Table 4, almost all CHCs are represented on District Planning Teams. A smaller proportion (only 8 CHCs, or one-third) are represented on the Joint Care Planning Team which spans the AHA and the Local Authority. Of the 16 CHCs not represented on the JCPT, all but two have asked to be represented but have been refused, for unstated reasons. At the DPTs, the CHC delegate is usually the nominee from the Voluntary Organisation which is most connected with the particular topic - e.g. when the DPT is planning for the elderly, the mentally handicapped, the mentally ill, the disabled, etc., there is always either a relevant CHC member or a copted member who is knowledgeable on the subject. The situation is not always problem-free, of course; there are times when the CHC delegate's view does not coincide with the view of the CHC as a whole, and then the matter requires extensive discussion. But on the whole, CHCs and DMTs are very satisfied with the way the CHC members have performed on DPTs.

Contact between CHCs and the various NHS offices proceeds on many fronts. All administrators were asked how much time they spend on or with CHCs, and how they rate the value of that time. Tables 5 and 6 show the results.

TABLE 5

TIME SPENT ON CHCs PER WEEK

	DA		AA		FPC	
Less than 1 hour	17	71%	9	52%	15	88%
1 to 2 hours	3	12%	8	48%	2	12%
More than 2 hours	4	17%				

TABLE 6

VALUE PLACED ON TIME SPENT WITH CHC MATTERS

	DA		AA		FPC	
Very worthwhile	9	37%	1	6%	5	29%
Worthwhile	13	54%	9	52%	5	29%
Somewhat wasted	2	9%	5	29%	5	29%
Completely wasted			2	13%	2	13%

Obviously, it is not only the Chief Officer with whom the CHC has contact and who spends time on the CHC's business, but by most standards, these officers do not spend a great deal of time on CHC matters, and overwhelmingly they consider the time so spent to be worthwhile. Indeed, 91% of DAs considered it to be worthwhile or very worthwhile, and so did a clear majority of AAs and FPC Administrators.

In order to structure their relationships, meetings have to be scheduled regularly between the CHC and DMT, the CHC and ATO, and the CHC and FPC. The most frequent and regular schedules were those that were arranged between CHCs and DMTs. In all but 4 cases there were regular and frequent meetings between various members of the CHC and officers of the DMT. Table 7 shows the general pattern.

TABLE 7

MEETINGS BETWEEN CHCs AND DMTs

(Various combinations of DA, DMT, CHC Secretary, CHC Chairman, or Vice-Chairman, and Committee Chairmen and members).

Every 3-4 weeks	5 Districts
6 weeks	3 Districts
2 months	2 Districts
3 months	4 Districts
4 months	2 Districts
6 months	1 District
Annually - about the Operational plan	3 Districts
As necessary	2 Districts
No meetings - relations bad	2 Districts

In addition, 15 CHCs receive the DMT minutes, in 3 cases for the Chairman and Secretary only, and in 2 cases the version sent is an expurgated one. In 8 cases the minutes are not sent out, and the Single District Area, of course, has no DMT.

The most noteworthy aspect of the meetings between CHCs and DMTs, listed in Table 7, is that they are held in private. CHCs generally set great store by the fact that the whole of their regular meeting is held in public, and that they do not believe in the sort of secrecy which tends to be preferred by Administrators. But no service, public or private, can run wholly in the open, and CHCs have had to recognise that, if they want information and co-operation from Administrators, they have to make some compromises with their principles and meet in private for informal briefings and confidential issues. In this way, many of the problems that DAs would have in dealing with CHCs, are overcome.

Members of DMTs in general, also see it as their role to attend CHC meetings in order to answer questions and also to find out how the CHC is thinking, to clear up misunderstandings and to educate the CHC. The CHC in turn, see the attendance of the DMT as an opportunity to educate the DMT, so the DMT's presence is seen as mutually beneficial.

In 18 out of the 24 CHCs, i.e., in 75% of CHCs, there is at least one member of the DMT present at every CHC meeting. Table 8 shows the distribution of attendances.

TABLE 8

ATTENDANCE OF DMT MEMBERS AT CHC MEETINGS

	Every Meeting		Every 6 m. or so		DMT never attend	
1 member of DMT	8 CHCs	34%	2 CHCs	9%	4 CHCs	17%
2 members of DMT	5 "	20%	--		--	
3 or more members	5 "	20%	--		--	

Very few CHCs ever receive visits from members of the AHA, RHA or FPC, but there are a few CHCs which do have them. Some areas and Regions delegate their members to "do the rounds" of CHCs, so that there is an occasional such visitor at a CHC meeting.

At Area level, there are already structured opportunities for CHCs and AHA members and officers to meet, because all CHCs are entitled to send Observers to the AHA meetings and all say they mostly send someone to each meeting. Particular Area officers and members can be tackled informally on these occasions. In addition, a few Areas hold regular meetings between the Area Chairman and the CHC Chairmen, with various combinations of officers present.

And of course, there is the much mentioned Annual Statutory Meeting, which is not very highly regarded either by CHCs or AAs. It is generally attended by about 2/3 of members of the CHC and 1/3 of members of the AHA, and in 4 cases in the last year, the AHA did not manage to raise a quorum but the meeting proceeded anyway. All the ATO and all the DMT attend always, frequently with additional officers in attendance. In 2/3 of cases the CHC decided the entire agenda and in the other 1/3 the AHA and CHC decided on the agenda jointly. The Administrators said that in 20 of the 24 cases, no change had occurred in AHA-CHC relationships as a result of the Annual Statutory Meeting; but in 3 cases relationships were better and in 1 case they were worse after the meeting. 2/3 of CHC Secretaries saw the meeting as a waste of time,

dull, and predictable, while 1/3 saw it as useful and an educational experience for members of both bodies.

FPCs and CHCs meet only rarely. 13 of my 24 CHCs had permission to attend Part I of the FPC meetings; in only 5 of these cases was the CHC delegate allowed to speak at the meeting. Four FPCs held meetings with the CHCs in their Area, 3 of them once a year and one every three months. The other 13 FPCs held no meetings with CHCs at all.

In general, there is remarkably little problem alleged between CHCs and Administrators. In selecting adjectives in answer to "What effect have CHCs had on your life" (Question 13) the most frequently used adjective was "more interesting", followed by "more irritating" and "more stimulating". Many of those who said "Irritating" emphasized that this was not necessarily a negative effect. They liked the irritation because they found it stimulating.

SUMMING UP: IMPACT AND VALUE OF CHCs

The final question to Administrators was really a critical one: the answers to it are summarised in Table 9.

TABLE 9

DO YOU THINK CHCs GIVE VALUE FOR THE NHS MONEY SPENT ON THEM?

	DA		AA		FPC	
Yes	19	79%	7	41%	8	47%
No	5	21%	10	59%	5	29%
Don't know					4	24%

From the previous responses, the summing up shown above was fairly predictable. The DAs overwhelmingly, by a majority of 4:1, believe that the CHCs are worth having and give value for money. The AAs and FPC Administrators who agree with the DAs are in a minority, though it is a substantial minority in both cases.

It is, I believe, important to get these responses into perspective. It was very clear to me that Area Administrators had comparatively little to do with the CHCs in their Areas, and were not fully aware of the relationships that have been built up in the Districts over the last 5 years or so between CHCs and District staff. Indeed, several AAs said that it is hard, at Area level, to know how effective CHCs really are.

In discussing the issue of value for money, I invariably brought up the question of the usefulness of CHCs after the impending reorganisation has been completed when instead of AHAs, there will be DHAs.

All of the Administrators, DAs, AA, and FPC, who gave a clear, positive response to this question, believe that CHCs will be as much needed when AHAs become DHAs as before. One or two of those who were slightly ambivalent said that while they still believed CHCs would be needed, they were not sure whether there would be available enough people of the necessary calibre to fill both bodies, and thought that perhaps the proportion of Local Authority members on CHCs should be reduced in favour of more members from Voluntary Bodies. But the case for CHCs, which rests essentially on the "formidable case" stated by the Rt. Hon. Patrick Jenkin (CHC News March 1980, No.52, page 1) was made out by each Administrator and stated to be as strong after the proposed reorganization as before, or indeed even stronger. As one AA said, it would be impossible for a RHA to keep track of 17 DHAs and the CHCs would be needed to fill that role.

On the other hand, those Administrators who believed that CHCs were not giving value for money now, or who were quite ambivalent, believed that CHCs should be abolished in the new reorganization, and again, their case rested substantially on the case against CHCs as cited by Mr. Jenkin (CHC News ibid.).

The CHC Secretaries themselves laid most weight on their members' local knowledge, and on their independence from management. They believed that CHC members knew more than District teams, and far more than AHA members, about what was going on locally, and that this knowledge was very important to be fed into decision making at both District and Area

level. Further, their independence makes them a credible source of both criticism and praise of the NHS, since the public believes that CHCs have no axe to grind other than their concern for the best health service possible to be made available to the local people.

The CHCs also believe that since the advent of CHCs there is much more openness in management, but that it needs the continual pushing of the CHC presence to keep the door propped open. This was particularly evident to the two CHCs in the Lambeth, Southwark and Lewisham area where the AHA had been dismissed 6 months before my survey interview. These CHC Secretaries believed that the whole climate in NHS offices had changed radically since that time. Obtaining information was now very difficult - everything had become internal, private. Decisions were made and implemented before the CHC even knew the items were on the agenda. Because decisions did not have to be justified in public, the Administrators were ignoring CHC requests for information, and because there were no AHA meetings where the CHC representative could complain about such problems, the difficulties were not remedied. It required far more persistence than before, even to obtain public information about plans. Thus it seems that openness and accountability are hard to establish, need firm maintenance, and are very easily destroyed - they are rather like trust in that respect. If the NHS is meant to be a service that should be visible and accountable (and Ministers' statements in Parliament lead one to take it that this is the policy), then some sort of public body to receive this accounting on a continuous basis would, it seems, be essential.

This was not only a case made out by CHC Secretaries. Seven Administrators (5 DAs; 2 AAs) made similar comments without prompting. They said that it was important that there should be a body to which the public can go for meaningful, objective advice and help, without bias by management considerations. The CHCs were clearly not under the thumb of NHS officials, and therefore, if the CHC can be persuaded a certain course of action is right, it is far more useful in convincing the public of the necessity for certain actions, than any NHS source can be. The necessary compromises with CHC wishes are part of the price that has to be paid to make the NHS acceptable to the public.

These Administrators all believed that the NHS was grossly officer-managed, and that patients felt very unimportant when receiving NHS services (or not receiving them). They believed that the NHS has a very poor way of relating to its consumers and of doing consumer surveys. Any multi-million pound business does far more consumer surveying than the NHS, and CHCs should be far better used by Administrators to test community reactions. They should be given the information they want, and given help in using and understanding it, to enable them to look outward to the community and test administrators' ideas for them. Almost every Administrator, including those who wanted to see CHCs abolished, said that he had to admit that the professionals are taking far more notice of eonsumer views because of the presence of CHCs for the last 6 years. "One is conscious all the time that they will make comments on what you do or don't do, and one modifies one's behaviour accordingly." The administrators do not actually enjoy having to be open and accountable, but say that this is what democracy is about, and they really would not have it otherwise.

The problem of the Representativeness and Legitimacy of CHCs.

Every Administrator who was doubtful or negative about CHCs, and even some of those who were in favour of them, brought up the problem of their representativeness and legitimacy as having the right to speak for the community.

Much has been written on this issue (See ref.list for Klein & Lewis; Hallas; Bochel & MacLaren; Ham.)

The argument put forward by the Administrators was, generally, that CHCs are an appointed, not an elected body, and except for those of their members who have been elected to a Local Authority, have no right to speak for the community or to regard themselves as representative.

This report is not meant, at this stage, to become a focus for lengthy theoretical discussion of this issue. Hence I shall merely state that the whole argument seems to me to be irrelevant. It is impractical to suggest that CHCs should be elected bodies, since the likely voter interest reflected in turnout figures, would probably be farcical; and in addition, the Voluntary Body delegates who are generally regarded

as being the hardest workers on the CHCs, would be almost totally unknown to voters, and would have to politicise themselves, which would probably mean that many of the most valuable workers would not stand for election.

It seems to me, rather, that CHCs should not defend themselves on this ground at all. They are not representative of the community as a whole - they are not a microcosm of it in any sense. This has been shown in all past studies (Klein & Lewis; Bochel & MacLaren) and can be seen in my figures too. CHC members are more ethnically white, middle class, older (in my survey, the modal age is 50-59 years), and better educated than the population as a whole. While the previous researchers found a higher proportion of male CHC members than female (Klein & Lewis 57% male; Bochel & MacLaren 61% male), I found the reverse (47% male) so perhaps the sex imbalance is becoming redressed - but that is only one aspect and quite insufficient to enable CHCs to qualify on the grounds of being typical of the community.

But judged by their actions and administrators' perceptions of their role, it seems that their function has been to make managers aware of defects in the health service, as the users see them; and to represent the public's needs to the managers. These are pressure group activities, and the fact that a substantial proportion of Administrators saw CHCs' roles as being to speak for the "special groups" in the community, shows that this is how the CHCs have actually found themselves working. Indeed, though CHCs have occasionally shown an interest in waiting lists, only a few CHCs in my sample, have a sub-group for acute hospital services, while every CHC that has sub-groups at all, has one on mental handicap, the elderly, and mental illness/health.

It is evident, from reading CHC News, as well as from the comments of Administrators and CHC Secretaries in my survey, that CHCs concentrate on keeping the primary sector in the forefront of their submissions, not the acute hospital services. Hence, rather than being over-concerned with the very low public awareness of CHCs (CHC News, May 1979, page 3), which a number of administrators also mentioned as an argument against the success of CHCs, this should be regarded as a marginal problem. The important roles, valued by administrators, which CHCs have been performing, can be effectively performed without wide public awareness of CHCs. The CHC's greatest assets are its members' wide-ranging

knowledge of particular issues in community care, their orientation towards the patient's view, and their independence of management. As pressure groups, the CHCs' legitimacy does not rest on their "representativeness" or wide public awareness, though there is no doubt that it would be an improvement if CHCs were more widely known than they are at present.

This argument does not, of course, solve all the problems of legitimacy. There are groups which do not have a voice on the CHC: with about 10 voluntary bodies represented, there must be large numbers which are not able to have their opinion heard. It is therefore mandatory that CHCs remember that there are other groups out in the community, and that they do regular surveys and have structured contacts with these groups so that their interests too may be represented. It is fair to say that most CHCs emphasized that they see this as a major part of their task.

THE VALUE OF CHCs TO ADMINISTRATORS

Since the overwhelming majority of DAs were in favour of keeping CHCs and thought them a very valuable institution, and almost half the AAs and FPC administrators agreed with them, what is it about CHCs that is most valued by Administrators? What is most disliked? This can be discussed under 4 headings: informed discussion, feedback about the Community, an independent body, and articulation of the needs of vulnerable groups.

1. Informed discussion

"The CHC brings to light gaps in our own thinking, though it isn't always admitted". (DA)

All the Administrators said they valued good ideas and that CHCs were a fertile source for these. This was not always so; indeed, 8 Administrators commented that CHCs used to be uninformed, overcritical, irritating and interested only in minor matters, but they have now learned and are very useful and helpful. Indeed, the two most common adjectives used by Administrators about CHCs' suggestions and ideas

(in answer to Question 7) were "sensible" and "helpful".

Considerable emphasis was laid by Administrators on the value to them of informed discussion about health services. They use this as giving ideas to themselves, which they will in turn develop into plans and actions, and give back to their Authorities in the future. Without outsiders with whom to discuss their ideas, they are afraid of "that well-known tendency of the bureaucratic machine to turn inwards and block off the outside world." They enjoy being challenged and kept on their toes, and indeed, several Administrators criticised their CHC for being too tame, too accepting of management's ideas, and too uncritical because this meant a gap they had to fill for themselves. On the other hand, when a CHC was lively and intelligent, this was greatly valued, even if there were occasional strong disagreements between the CHC and the administrators. "They keep my view of the service balanced and prevent my getting complacent" said one, while another said "Going to their meetings and reading their reports, provides a significant dimension that was not there before."

In discussion with AAs, it was clear that they used the AHA members, rather than the CHC, for this purpose. In both cases, CHCs and AHAs varied a great deal in the level to which they could help bring about such informed discussion. Some AHAs were said to be too passive, as were some CHCs, and some AHA members were said to be "too political", just as were some CHC members.

Those CHCs which took the easy path and just went on visits without grappling with issues of priorities, are seen as far less useful to the Administrators, though visits are not seen as unimportant. But it is as the providers of outside ideas that the CHCs are most valued. In order to do this, however, CHC members have to do some work and become informed about health issues. Those CHCs which cannot ask the right questions and challenge administrators were regarded as being a waste of money - a sleeping watchdog. These CHCs merely demanded enormous amounts of information and time, and then came to no conclusions. Such CHCs were seen as having power without responsibility ("which is the hallmark of the harlot" said one AA), and were not only unproductive but counterproductive.

A frequent distinction was drawn between "political" and "active" CHCs. "Political" CHCs were generally disliked, even by the Administrators who were in principle in favour of CHCs. The posturing of some L.A. Councillors, and the publicity seeking of some pressure groups, were a source of intense annoyance for Administrators. Nor was much of the publicity-hunting effective in changing the health service, according to the Administrators unless it was based on solid and sensible reasoning. A headline is only a temporary event, and the public emotion aroused by it is as quickly forgotten, so unless Administrators can be persuaded that there is a solid basis for the claims of the political CHC members, they refuse to respond to what they see as manipulation.

Over time, Administrators have learned to cope even with these "political" members. Most DAs spoke reasonably tolerantly (though some, particularly at Area level, were extremely hostile) and said that it might even be useful to have the political activists in the open, on CHCs. "Society has changed", they said, "We're going to get them anyway, so they may as well all be centred in one place, on the CHC."

2. Feedback about the community

Administrators particularly felt the need for information about the community's reaction to the health services and to planned changes in the health services. Administrators frequently singled out for praise the reports done by CHCs on maternity services or services for the elderly, disabled, or mentally handicapped. When CHCs pinpointed, with adequate evidence, a problem or a deficiency, administrators were very appreciative. One CHC showed, for example, that there was a higher perinatal mortality rate and a higher maternal death rate in an outlying maternity unit, which was regarded as highly valued information.

However, the administrators repeatedly complained that CHCs were not willing to set priorities for the needs they uncovered. It was not enough, said Administrators, for CHCs to do research and say "Here is a need we have shown to exist. Meet it." They had to go further and say what they were prepared to reduce or eliminate to release the resources to meet the new need. CHCs who wanted everything they had, plus more, were rapidly discredited among administrators and Health Authorities alike, because their responses become so totally predictable. A

particularly disliked phrase (even written in some CHC Annual Reports) went as follows: "This CHC rejects the idea that it should become involved in deciding priorities. Its task is not to manage the service, but to identify local health care needs." (from an Annual Report, 1978/9).

On the other hand, those CHCs which have recognised that the name of the game is to decide priorities and make hard choices are highly valued by their administrators. One CHC has in its Annual Report for 1978 the following sentence. "To press for priorities is a serious matter for CHCs - we would all like to see the ideal but finance and staffing and building availability are major deciders in how far development can go". Such hardheadedness is an example of the change Administrators see and value in CHCs.

One Administrator felt that Administrators had not yet learned to make full use of CHCs to get community feedback. He thought that the Authority should go to the CHC and say "We are planning homes for the mentally handicapped. We think the mentally handicapped would prefer several small homes to a big unit, but we would like you to brief us. However, remember that if we have a big unit we shall be able to fund accommodation for 100, while in small units we can only afford to build accommodation for 60. What should we do?" The CHC would then be funded to do the research, with the proviso that they could not say "We want accommodation for 100 in small homes" unless they could come up with a wholly new scheme which could do the job for the funds available.

3. An independent body

Almost every Administrator who favoured CHCs regarded their independence as being a particularly valued quality. They thought this was important to give validity to those occasions when the CHC was at one with the Administrators, because there were many other occasions when the CHC was not in agreement with them.

Administrators believed that patients who had a grievance would prefer to go to an independent body such as a CHC rather than complain to those people who were also responsible for providing the service which had led to the complaint, viz. the Health Authority or the hospital

management. This same series of arguments also applies to the FPC Service Committees, which were the target of much attack by CHC Secretaries, though they were vigorously defended by FPC Administrators. But their secrecy and the fact that they are not bodies independent of the providers of the services, makes them vulnerable to this criticism, and some Administrators at District and Area level said as much: indeed almost all FPC administrators agreed that the professional members did dominate the discussions at all levels of the FPC, including the service committees, and that therefore it could seem as if the patient was in a very weak position.

DAs also believed that the CHCs saved them a lot of time in sifting complaints. Most CHCs are by now fairly sophisticated and if they take up a complaint it generally has some substance, and is worth the DA's while to investigate. When a solution is found for the problem, the complainant is far more likely to accept this when both CHC and DA believe it is fair. Without their independence, CHCs could not fill this role effectively.

4. Articulation of the needs of vulnerable groups

Administrators were very conscious of the role of CHCs in developing a forum for discussion of the needs of groups which have been neglected and deprived of their share of resources. They valued the CHCs pushing them into giving a fairer share to such groups. Particularly in Teaching Districts, the temptation was to do something which would be useful for teaching, instead of something useful for the community services, and the CHCs would not let this happen. The CHCs force the Administrators into making decisions they are sometimes trying to avoid, because they are too hard and will mean conflict with established interest groups in hospitals - but the Administrators like being kept on the ball and being forced into such decisions, even while they become annoyed about it. DAs and AAs spoke of being forced to do what they know they ought to do, and that this is good for the service and will eventually change the character of the service, though it is too soon as yet to see these changes overall. One DA summed this up by saying "It is important that the interests of the users - and especially of

the most vulnerable users - of the NHS should be as clearly articulated to managing authorities as those of professionals, staff, and technical and financial interests."

This articulation can become extremely important in AHA meetings. One AA pointed out that it is hard to get AHA members to go against a Consultant unless someone outside the system gives contradictory advice. DMT and ATO members cannot do this; they are inside the system and cannot openly support one group of AHA members against another. But the CHC can do so; it can help push for change by arguing for different services to be provided, not more of the same. The only way Authority members get a choice of policies is by getting a different view from the CHC. This situation will be no different when AHAs become DHAs.

In another direction, the NHS is highly professionalized. As various administrators said, the officers have a tremendous grasp of what is happening as compared to AHA members. The service is now so complex that AHA members find it very hard to question policies supported by the ATO. It is therefore important to have an organised consumer voice which will have the twofold function of forcing officers, in public, to take account of and respond to consumer views, and of bolstering the confidence of those AHA members who secretly agree with the minority view but who would not dare to speak up unless they have the backing of the CHC. Particularly if an AHA member is in the minority against the more powerful medical or nursing interests on the AHA, it can be very useful to have the CHC assisting him in pushing for a policy of more support for groups in the community instead of in the acute hospitals, and this process occurred several times at AHA meetings I attended.

CONCLUSION

It is clear that CHCs are having a significant and beneficial impact on the Administrators with whom they mostly deal - the DMTs. That impact is greatly valued and regarded as a strong and positive advantage by both parties. Regardless of their legitimacy and representativeness CHCs have clearly succeeded in turning the minds of Administrators far more outwards to the community and to the hitherto neglected groups of patients. Administrators have also become far more open in their management of the NHS, and are prepared to be regularly and frequently questioned on their policies and the reasoning behind their policies and actions. CHCs are gradually becoming allied with DMTs in changing some of the past emphases of the NHS, and their abolition at this stage would be a major blow to the beginning of this development.

APPENDIX ONE

METHODOLOGY

The CHCs in the four Thames Regions were subdivided into 16 Inner London CHCs, 20 Outer London CHCs and 27 Rural CHCs. A proportionately sized sample was chosen from each group, so that 6 Inner City, 7 Outer London and 9 Rural CHCs were selected by random numbers. In addition, I decided to do a pilot study of two CHCs located near my home in north -west London, since these two had a very different political orientation from one another and a consequentially different view of their role. I followed this pilot study by a more intensive study of these two CHCs by attending four of each of their meetings and the meetings of the relevant AHA.

Thus the following list of CHCs was selected into the sample:

Barnet	Kensington,Chelsea & Westminster(South)
Basildon & Thurrock	Kings
Bexley	Maidstone
Brent *	Mid Essex
Brighton	Newham
City & Hackney	North Bedfordshire
Cuckfield & Crawley	North Hammersmith
Ealing	North Surrey
Edgware and Hendon	NW Hertfordshire
Enfield	St. Thomas'
Harrow *	Wandsworth & East Merton
Hillingdon	W.Surrey & NE Hampshire

* Pilot

I was fortunate that the sample happened to include one CHC from a Single District Area, since that is likely to be the shape of things to come.

I decided that the only manageable way was to interview, for each sampled CHC, the following people:

The CHC Secretary
The District Administrator
The Area Administrator
The Family Practitioner Committee Administrator
The Regional Administrator

As it happened, this was not possible in all cases, though I had no refusals for the sample. In the end I saw:

23 CHC Secretaries and 1 Acting Secretary (+ 3 CHC Chairmen)
19 District Administrators
1 Assistant District Administrator
1 District Planner
3 District Community Physicians
1 District Nursing Officer (additional to DCP in same District)

13 Area Administrators
1 Acting AA
3 Area General Administrators

} The 24 CHCs fell into 17 Areas

15 FPC Administrators
2 Deputy FPC Administrators

3 Regional Administrators
1 Regional Officer in charge of relationships with CHCs.

Thus in each case, I saw a relevant Senior Officer, either the Chief Officer or the Acting Chief Officer, or a very senior colleague. I am extremely grateful to all of them for so generously giving their time, which was often under considerable pressure. Each CHC Secretary's interview took about 1½ hours; the interviews with DAs, AAs and RAs about 3/4 hour and those with FPC Administrators about ¼ hour.

THE QUESTIONNAIRES

While I tried to cover the same basic ground in talks with the CHC and the Administrators, I included some additional questions in the CHC schedule, to enable some comparability with earlier research. These results are not generally reported here, as this project deals with the CHC/Administrator interface. The Questionnaires are attached for reference (Appendix 2 and 3).

APPENDIX TWO

CHC SECRETARIES' QUESTIONNAIRE

Name of CHC:

1. (a) List the three activities on which you spend most of your time over the year.

   (b) List the three main activities you regard as most important from the list below:

PROBES:
- (i) Talking to community groups
- (ii) Visiting health care establishments.
- (iii) Assisting complainants & giving advice to the public.
- (iv) Preparing information for your CHC
- (v) Trying to get information from your AHA
- (vi) Continuing education for yourself.
- (vii) Preparing publicity and your Annual report.
- (viii) Writing reports about your subcommittees' work.
- (ix) Liaising with other CHC Secretaries.
- (x) Contact between yourself & District, FPC & AHA.
- (xi) Servicing monthly meetings and working parties.

2. (a) What do you think are the broad aims of your CHC?

   (b) Are these aims achieved?

3. (a) What exactly do you do to find out what your community wants you to say on various issues?
   - Surveys - what kind? on what issues? How often?
   - Asking opinion leaders?
   - Nothing, we regard ourselves as representative
   - Following local/national Press?

   (b) On what issues in the last 3 years has this CHC taken a public stance? What did this public stance involve? On what issues have you negotiated quietly?

   (c) Do you have (regular) contact with your MPs? How - meetings, letters, phone?

4. (a) Do you believe your CHC has any specific effect on decision making in your area? What?

   (b) Can you give examples of any specific issues or decisions during the past 3 years which have been affected by your CHC?

   (c) Would you like CHCs to play a greater role in decision making?

5. Apart from your Annual Report, have you prepared any other material for your constituency on the past 3 years? May I have copies of Annual Report, leaflets?

6. (a) What determines how much money you get each year?

   (b) Do you submit a Budget to your Region?

   (c) How many sub-heads of finance do you submit to the Region? e.g. publicity, annual report, travel, etc.

   (d) Are you allowed to decide how much to spend on individual Budget items, e.g., Report.

   (e) Do you get from your Region anything other than money, e.g. premises, staff? What quality, size of premises are you allowed?

   (f) Who pays travel expenses for yourself?
   Who pays travel expenses for the CHC members?
   Are any other reimbursements made to members?

   (g) How many staff are on the payroll? Have you considered appointing a Research Assistant instead of a P/T typist?

   (h) Have you over or underspent in the past 3 years?

   (j) Do you or your Members engage in money raising activities? If yes, how much have you raised in the past 3 years? For what purposes is it used? How is it raised?

   (k) Do you get any free services e.g. volunteer help? How much such help do you receive (other than your CHC Members)?

   (l) Do you get donations from any outside source, e.g. Kings Fund? How much?

   (m) Does the Region interfere with you in any way re. finance or other matters?

7. Does your CHC see itself as having mostly local interests or national ones? If national, how do you operate - through ACHCEW or informal link-ups?

8. List of membership.

9. Why was the Chairperson selected for that duty?

10. When decisions on recommendations to the Area are made by the CHC are there any particularly influential members? Does the Secretary regard him/herself as having influence? If so, describe. If not, why not?

11. How are the Voluntary Body members chosen for this CHC?

12. <u>The Secretary</u>:

   (a) Age. (b) Sex. (c) Qualifications. (d) Previous occupations.
   (e) How long in this job? (f) Was your job advertised? (g) When?
   (h) Who was on the Selection Committee?
   (i) Do you regard this job as beginning, middle or end of your career?
   (j) What are your aims for the future, if the beginning or middle?

13. (a) What Subcommittees has your CHC got?
    (b) Degree of activity.
    (c) Involvement of Secretary - how much?
    (d) What achievements have they had?

14. (a) Can you give me a case study of your input into the planning cycle?
    (b) What comments did you make about the last plan?
    (c) How much time did you get to make comments? Was it adequate time?

15. (a) Who generally initiates contact with Area and District? You or they? About what matters? How often?
    (b) How often do you meet the DMT? Who goes? Do you receive DMT minutes?
    (c) Are observers sent to RHA, AHA, and DMT meetings? FPC meetings?
    (d) Does your CHC have reps on any Planning Teams of DMT or AHA, JCPT?
    (e) Do DMT, FPC, AHA attend CHC meetings?

16. What do you like (a) best about your District and Area officers?
    (b) least?

17. (a) Who from your CHC attended the last consultation with the Area?
    (b) Who determined the topics to be discussed?
    (c) Were there any noticeable effects as a result of that consultation?
    (d) Did you regard the consultation as (i) interesting? (ii) useful? (iii) waste of time? (iv) dull? (v) predictable?

18. What is your comment about the criticism that the community is already represented by AHA members and therefore there is no need for CHCs at all?

APPENDIX THREE

NHS ADMINISTRATORS' QUESTIONNAIRE

1. (a) What proportion of your time is taken up with CHC generated questions/ and problems?

   (b) Do you regard time spent in this way as very worthwhile? worthwhile? somewhat wasted? completely wasted?

2. What are the main questions and problems the CHCs have generated for you in the last 3 years?

3. (a) What do you think are the broad aims of the CHCs you deal with?

   (b) Do you think they achieve these aims?

4. Do the CHCs you deal with have any specific effect on decision making of your AHA, FPC, DMT?

   What kind of effect? examples ...

5. Do you believe that CHCs are

   (a) overfunded? about right in funding? underfunded?

   (b) overstaffed? about right in staffing? understaffed?

6. Would you like to see CHCs play (a) a greater role in decision making?
   (b) lesser?
   (c) about right now?

7. Have you found the suggestions made by your CHC sensible? uninformed? helpful? extravagant? useless? unoriginal? predictable?

8. (a) Can you give me any case study of a recommendation by a CHC that had some impact on decision making in this area, district? Was this impact a good one, or not?

   (b) Have the CHCs in your area used the media to try and influence your decision? How effective was this method?

9. <u>(For AHA ADMINISTRATORS)</u>

   (a) What comments did the CHC make on the last plan?

   (b) How much time was given for these comments?

   (c) Were any of the comments put into effect?

   (d) What is the composition of the AHA?

   (e) Are CHC members represented on Planning Teams? Which ones?

   (f) Do CHC observers attend AHA meetings?

   (g) Do CHC observers speak at AHA meetings?

   (h) Who from the Area attended the last annual consultation (officers and AHA members)?

Question 9.(For AHA ADMINISTRATORS) - Continued...

(i) Who determined the topics to be discussed?

(j) Did you regard the consultation as interesting? useful? waste of time? dull? predictable?

(k) Were there any effects on the health system in your area as a result of that consultation?

(l) Do you attend CHC meetings?

9.(For FPC ADMINISTRATORS)

(a) Are CHC observers allowed to attend your meetings?

(b) At what times are meetings held?

(c) Do CHC observers in fact attend?

(d) Do you have regular meetings with CHC members? How often? Who comes?

9. (For DISTRICT ADMINISTRATORS)

(a) Are CHC members represented on planning teams?

(b) Do DMT members attend CHC meetings?

(c) Do you send minutes?

10.(a) Who generally initiates contact between you and the CHC? You or they? How often? About what matters?

(b) How often you you meet? Regularly?

(c) How formal is the contact?

(d) Do you get invited to speak to CHCs either at full meetings or working groups? Is your advice sought by working groups of the CHCs?

11.(a) What do you like best about your relevant CHC? (b) least?

12.(a) Do they have an effect on the speed of decision making? (b) quality?

13. In what ways have CHCs affected your life? Have they made it

Easier? More difficult? More interesting? Duller? Irritating? Exciting? Stimulating? Unbearable? More troubled? More enjoyable? More varied?

14. Do you regard the CHCs as giving value for taxpayers' money spent, or would there be a better way of spending that money?

NOTE: Question 8 is always asked after Question 4.

APPENDIX FOUR

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