ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND AND WALES

The public and the NHS

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CONTENTS

INTRODUCTION

Community Health Councils have represented the public interest in the National Health Service since 1974. Has the system worked? What has been achieved and what remains to be done? The NHS and health needs are constantly changing. Can CHCs adapt? Are we, as a society, really serious about consumer rights and are CHCs capable of securing them?

This report shows that these and many other important issues have been addressed in the past by CHCs themselves, researchers, Government and others but the findings have been fragmented and often ignored. This is the first attempt in the 1980s to bring the pieces together.

When in 1985 it became clear that there would be no early review of CHCs and other elements in health service consumerism by Government, ACHCEW, the national forum for CHCs in England and Wales, commissioned its own study. It was fortunate to get someone of Christine Hogg's calibre and wide experience of CHC work to carry it out.

Her brief was to consult CHCs and the wider health community, to examine their role and structure and to identify problem areas which require attention and reform. She carried out the task with remarkable objectivity, skill and diligence.

A draft report was overwhelmingly approved at ACHCEW's Annual General Meeting in July 1986.

Part V on 'Future Directions for CHCs' makes a number of clear recommendations which command the support of CHCs and deserve an urgent and positive response from Government, the political parties, health authorities and everyone involved in the NHS and the care of the sick and disabled.

The report encourages the CHCs themselves to address issues like standards and quality in their own performance and the NHS interface with other forms of care in the community.

Encouraged by what the report shows about CHC achievement and potential, ACHCEW commissioned a further study on CHC Good Practices for publication in 1987.

The public need and respect the NHS. The NHS needs continuing public support and more public participation. CHCs have increased understanding of health service issues and the responsibilities we all have to promote good health. They have campaigned for adequate resources and for a more sensitive response to the health needs of women, ethnic minorities and other groups whose needs and interests have been neglected in the past. They remain the vital link between the users, the providers and the controllers of the NHS.

Tony Smythe
Director of ACHCEW 1983/86

SUMMARY

Community Health Councils were set up in 1974. Since then, the NHS has changed, but the reasons for creating CHCs are still valid. In fact, with the increased emphasis now given to 'consumerism', the users' and consumer voice can best be developed through the structure provided by CHCs.

In 1974 the functions of public representation and management in the National Health Service were separated. Community Health Councils were seen as a new way of representing the interests of patients and the community to the managers of the health service. From the start, there was no clear idea about how they would work. The interpretation of the role and detailed working relationships was left to each CHC to work out with local and regional health authorities. Successive Governments have given little further guidance.

Not all health authorities have been willing to seek community views through CHCs, to involve them in planning or provide them with information. CHCs have found that their statutory rights have been difficult to enforce when health authorities have not recognised them.

The budgets and staffing of CHCs are at the discretion of each Regional Health Authority and there are variations in the funding of CHCs in different Regions. In all Regions, the resources available to CHCs do not reflect the scope of their duties. RHAs also interpret their relationship with CHCs differently. Some have tried to control CHC activities to the extent of jeopardising their theoretical independence.

Lack of guidance and clear terms of reference have led to diversity in the way CHCs have developed locally. Some have found innovative ways of representing the community's views, introducing good practices and acting as user advocates. Others have become shadow health authorities, giving their views when consulted.

There have been some more serious consequences for the development of community representation in the NHS:

- unnecessary conflict with NHS staff. Debates often focus on the rights and working methods of the CHC, rather than issues concerning the community.
- wide variation in the way CHCs see their role and discrepancies in the standards of service provided by CHCs.

This wide variation has re-inforced CHCs' concern for their own autonomy, which has meant that CHCs have tended to develop in isolation, often not sharing or learning from each other's experiences. Concern with local issues has restricted the development of regional and national structures for CHCs and has limited the impact of CHCs as advocates for users. In recent years, the Government has looked more to the voluntary sector as user representatives rather than building on the structure provided by CHCs.

However, CHCs have had a considerable impact on the NHS. They have put NHS managers more in touch with local people. They have started a process of opening up the NHS to the public and have kept the needs of more vulnerable NHS users, such as mentally ill, handicapped and elderly people and those from ethnic minorities, in the forefront of debates about resource allocation.

If CHCs did not exist, some of the duties undertaken by CHCs could be taken over by health authorities or by voluntary organizations. However, without an independent consumer body to protect local interests, develop new ideas and promote good practices, public participation would be reduced to small interest groups dealing with specific issues. There would be a lack of co-ordination or an overall view of the public interest, particularly for deprived and unorganized communities.

Changes in the NHS mean that the role of the CHC has and will continue to change. If CHCs are to take the opportunities given by the new emphasis on 'consumerism' and 'market forces', they need to consider how they can most effectively represent users and provide a higher standard of representation in the NHS.

The report concludes with suggestions about how CHCs might provide a better framework for representing users in the NHS and for strengthening their voice at national level.

- Clear guidelines are needed to define the relationship of CHCs and the public to Health Authorities and Family Practitioner Committees, including consultation procedures, access to information, representation on committees, dealing with complaints and visiting NHS units.
- Everyone receiving health care has a right to independent representation. The role of CHCs should be extended to cover all patients receiving health care, which is funded by the state.
- CHCs should develop a Code of Practice on the way they relate to the NHS and consult the public they represent. Particular attention should be directed to ways of involving people from ethnic minorities in the work of CHCs.
- CHC staffing and budgets should reflect the amount of work a CHC undertakes and its importance; and ensure the independence of the CHC from NHS management.
- The national and regional structure of CHCs should be strengthened to provide resources and training for CHCs, and a stronger voice for users at national and regional level.

PART 1
BACKGROUND

1 REASONS FOR CREATING CHCS

The NHS Re-organization Act, which was passed in 1973, was supported in principle by all political parties. It was an attempt to integrate personal health services run by local government, NHS and the family practitioner services, and to introduce service planning and more professional management. Community Health Councils (CHCs) were created as a new way of representing the interests of the community to the managers of the NHS.

The reasons for creating CHCs were various:

1. It was decided to separate management and representation of patient and community interests. In the health services run by local government up to 1948, management and representation were united in locally elected councillors. When the NHS was established, hospital management committees became responsible for both management and representation. It was felt this had led to a conflict of interest and there had been scandals about care in some long-stay hospitals.

2. 'Consumerism' was growing. As a near monopoly the NHS, like the nationalised industries, needed representation of consumer views. The model of consumer councils used in nationalised industries was not followed. Community Health Councils were an attempt at a more localised community approach, which might provide a model for representation in other Government-run services (Annex 1).

3. CHCs would ensure the involvement of voluntary groups and lay members in the NHS. Their representation in the new management-oriented health authorities had been reduced.

4. Local authority appointments to CHCs provided additional local authority involvement in the re-organized health service. Area Health Authorities (AHAs — since abolished as a tier of management) covered more local authority areas than hospital management committees. Some AHAs covered so many local authorities that not all of them could have a representative on them. *"So CHCs were invented to fill a political vacuum".*[1]

A number of major changes in the role and structure of CHCs were introduced during parliamentary debates, indicating how little thought had been given to the functions and working methods of CHCs. A Minister involved is quoted as saying, *"We first decided that there should be such a body and then decided what it should do. As we worked on the CHCs, we found more things for them to do".*[1]

In February 1974 there was a change of Government which introduced last minute amendments. These included: the provision for appointing CHC Secretaries from outside the NHS and observer status for CHCs at health authority meetings. These changes had a significant impact on the way CHCs later developed.

2 STATUTORY DUTIES OF CHCS

The statutory duties of a CHC are defined in broad terms. These are to *"keep under review the operation of the health service in its district and make recommendations for the improvement of that service"* and to publish an annual report.[3] No area of the NHS is excluded from their terms of reference, even extending to *"the effectiveness of co-operation between health services and local authority services".*[3]

"Community Health Councils will provide a new means for representing the local communities' interest in the National Health Service to those responsible for managing them. In the re-organized National Health Service management and representation of local opinion will be distinct but complementary functions, entrusted to separate bodies but working in close relationship. Successful administration of the service will depend on a continuing and constructive exchange of ideas between Area Health Authorities and CHCs; the AHA will then be aware of local opinion on needs and deficiencies in the service and the community, through the CHC, will know of the actions and intentions of the AHA and of the problems and constraints with which it is faced."[2]

The Statutory Instruments did not indicate how CHCs should undertake this task or recognize the potential conflict in the relationship between CHCs and health authorities.

3 THE RIGHTS OF CHCS

The rights of CHCs are to:

- Be consulted by the health authority on any substantial development or variation in service
- Information from the NHS, which a CHC may 'reasonably require'
- Receive comments from the health authority on its annual report
- Meet the health authority at least once a year to discuss matters relating to the functions of the Council
- Attendance of an observer at health authority meetings.
- Enter and inspect NHS premises *"at such times and subject to such conditions as may be agreed by the Council and the District Authority".*[3]

From 1985, these rights were extended to family practitioner services, except that CHCs did not have the right to enter the premises of private contractors where NHS services were provided.

The actual powers of CHCs appear to be limited to causing delay and inconvenience, if health authorities choose to ignore their views. However, in disputes over closures, CHCs have the right of appeal to the Secretary of State through the Regional Health Authority (RHA).

4 CHCS AND GOVERNMENT POLICY 1974-1985

In the first few years CHCs were seen as an interesting and successful experiment and received favourable mentions in several Government reports.[4] The Health Advisory Service reported in 1977 that CHCs had been *"one of the very few success stories of the re-organization of the National Health Service. Councils are now becoming well-established, and are acquiring a very realistic and thorough knowledge of the health needs of their district".*[5]

In 1979 the Royal Commission on the NHS[6] concluded that: *". . . since their introduction at re-organization, community health councils have made an important contribution towards ensuring that local public opinion is represented to health service management. They need additional resources to fulfil this task more effectively, and further guidance from the health departments on their role."*

It recommended an extension of CHCs' role in relation to Family Practitioner Committees (FPCs) and complaints.

However, in 1979 there was a further change in Government. The new Government was aware of the hostility to CHCs in many professional circles and was committed to a reduction in non-executive bodies and quangos as well as a further re-organization of the NHS to improve efficiency. In 1979 'Patients First' was published as a Consultative Document.[5] It suggested that if Area Health Authorities were abolished, the *"need for separate consumer representation in these circumstances is less clear; next year the councils will cost over £4 million. The Government will welcome views on whether community health councils should be retained when the new district health authority structure has been implemented".*

There was wide opposition to the abolition of CHCs from all political parties. CHCs were given a reprieve, with a review to follow three years after the 1982 re-organization. *"In the longer term the case for retention will be reconsidered in the light of the experience of the operation of more locally based District Health Authorities".*[8]

In 1983 the NHS Management Inquiry, (Griffiths Report) was published.[9] The central recommendation of the Report was to appoint General Managers with clear decision-making responsibility and accountability to replace District Management Teams (DMTs). The need for consensus among members of the team was seen as a block to efficient management. The Report criticised the lack of 'customer'/consumer orientation in the NHS and gave qualified support to CHCs. *"Underlying all that we recommend is the desire to secure the best possible services for the patient. At present consumers' interests are principally in the hands of lay members of Health Authorities and of the Community Health Councils. We have not made any judgments about the effectiveness with which they perform this function, although we have been impressed with the grass-roots work of some CHCs".*[9]

In March 1985, the Under-Secretary for the DHSS reported to a Committee of the House of Commons that any review of the work of CHCs 'was for the future'. Nevertheless, those involved with CHCs are themselves concerned with improving their effectiveness and extending the service to the public. The aim of this report is to promote discussion of these issues.

PART II
CONFLICTS AND DILEMMAS

1 "INTERWEAVE" OF MANAGEMENT AND REPRESENTATION

From the start there was a lack of definition about the respective roles of health authority and CHC members. The NHS Re-organization circular, which set up CHCs, gave an idealised view of the separate but complementary roles of the CHC and AHA.[2] Only 4 months later, in May 1974, following the change of Government, a DHSS Consultative Document said:

"The Government do not accept that it is possible or desirable to make such a clear-cut distinction between management of public services and representation of consumer interest and views. Our whole national democratic process as it has evolved over the years is a complex interweave of management and representation".[10]

This potential friction in overlapping roles of health authorities and CHCs was worsened because:

1. Many members of both CHCs and health authorities were appointed from the same local authority source. About 2/5ths of CHC members appointed in 1974/5 had been either on a local authority health committee, or a hospital management committee.[1]

2. Local authority councillors were experienced in combining management and representative functions and some felt CHCs were irrelevant. There was also resentment from local authorities that their health functions (i.e. community services) had been transferred to the NHS.

In 1979, in the Consultative Document 'Patients First',[7] the Government suggested that management and representation functions could be combined once again. Because many of the new District Health Authorities (DHAs) covered a smaller geographical area than Area Health Authorities, members would, therefore, be more *"closely in touch with the needs of the community"* and CHCs might be unnecessary. CHCs were retained, but with the number of members reduced. *"Ministers are of the firm view that CHCs would be more effective if they were smaller and do not think it right that they should have a membership larger than that of the District Health Authority to whom they will relate".*[11]

This illustrates the continuing misunderstandings about the role of members of CHCs and DHAs. DHA members are appointed to manage the services, CHCs to represent the community. The number of members necessary for an efficient management body bears no relationship to the number for an efficient representative body.

2 THE ROLE OF CHC MEMBERS

Half the members of each CHC are appointed by the local authority and so these places are often in the political gift of the party whips. One third are elected by voluntary organizations, thus giving representation to specialist groups. The remainder are appointed by the Establishing Authority (i.e. Regional Health Authorities/the Welsh Office) *"after consultation with relevant District Authorities, relevant committees and with such bodies as the establishing authority may consider appropriate".*[3]

There are two theories about how appointed rather than elected representatives can be considered representative.[1]

- Members are selected as individuals, because they reflect the social and economic structure of the community.
- Members are selected because they represent groups in the community and are their 'agents'.

CHCs are a hybrid of individual and group representation and their accountability is far from clear. Some voluntary bodies require their representatives to report back regularly and, occasionally, mandate them on particular issues. Some local authority representatives feel they are obliged to put forward their authorities' views. Others are not expected to report back on CHC activities. Certainly, some clearer accountability would add credibility to CHCs.

Klein and Lewis in 1976 found that CHC members tended to be middle-aged, middle-class and over half of them were members of political parties.[1] A study in the South West Thames Region found little changes in the profile in membership in 1982.[12] In spite of this, Klein and Lewis concluded that the variety of methods whereby members were appointed had managed to *"create a greater diversity among the members — with a wider representation of social experience, occupational background, interest groups and public service know-how — than might otherwise have been the case".* However, there is a lack of representation of some groups, in particular, ethnic minorities on CHCs.

CHC members, unlike DHA and RHA members, do not have the right to be granted statutory relief by employers to undertake their duties. This precludes many people from becoming involved. Much of the work, — such as NHS planning meetings and visits — are normally undertaken during the day. In order to attend these duties, members may have to take unpaid leave from work.

The number of members on each CHC is determined by the RHA and there are no agreed criteria for deciding this. In 1980 most CHCs had between 22 and 33 members.[13] This was reduced in 1982 to an average of 18 to 25 members. This reduction in membership has decreased the direct representation of different sections of the community on the CHC.

Much of the work of a CHC depends on the involvement of voluntary and lay members. Many of the tasks of CHC — representation on committees, talking to local groups and reporting back to the CHC, visiting NHS units and acting as spokesperson — are generally undertaken by members. Active CHCs often are those with the most members. In 1980 a study found a positive relationship between the

number of surveys undertaken and the number of members. In 1980 62% of CHCs had co-opted people to working groups. The more members a CHC had, the more likely it was to have additional co-opted members.[14] CHC members are more often expected to take an active role than other non-managerial statutory committees, such as the nationalised industries consumer councils.

A survey of members in the South West Thames Region in 1982[12] asked members the amount of time they gave to the CHC.

Table 1: Hours per week devoted to CHC work, by appointing body

Hours per week	Voluntary Organization	RHA	Local Authority	Total Sample
	%	%	%	%
2 hours or less	36	53	58	48
3-5 hours	42	35	35	38
6 or more hours	21	12	7	14

Source: University of Surrey[12] **Response rate 63%**

Representatives of voluntary organizations gave more time to the work of the CHC than members appointed by the local authorities or RHA. This is also reflected in attendance at CHC meetings.

Table 2: Attendance at CHC meetings, by appointing body

Attendance	Voluntary Organization	RHA	Local Authority	Total Sample
	%	%	%	%
Less than 70%	8	12	30	19
70-90%	42	53	45	44
More than 90%	50	35	25	37

Source: University of Surrey[12] **Response rate 63%**

3 INDEPENDENCE AND THE ESTABLISHING AUTHORITY

Regional Health Authorities (RHAs) in England, (the Welsh Office in Wales), have delegated authority from the Secretary of State in relation to CHCs. These functions were delegated to RHAs rather than District Health Authorities, so that CHCs could be clearly seen to be independent and to ensure that DHAs were not responsible for allocating resources or involved in staff appointments. As there are no RHAs in Wales, DHAs undertake many of these functions.

The functions that RHAs perform for CHCs, include:

- Arranging voluntary organization elections and appointment of members to CHCs.
- Determining CHC staff levels and employing staff.
- Administering arrangements made for the provision of accommodation and services.
- Determining CHC budgets and monitoring expenditure.
- Considering appeals in disputes between CHCs and DHAs.

There is no authority for either the DHSS or RHA to give directions to CHCs. *". . . pursuant to Section 13 of the National Health Service Act 1977, the Secretary of State can issue Directions to RHAs, and pursuant to Section 14 RHAs can issue Directions to DHAs, but there is no provision for the Secretary of State or the RHA to issue Directions to CHCs other than with regard to financial arrangments."*[15]

However, RHAs have used their position as establishing authorities to influence the activities of CHCs and control the budgets and staffing levels. In such circumstances, the relationship between RHA and CHC chairperson and members is ambiguous.

CHC Activities

There have been many occasions when RHAs have tried to restrict CHC activities. In 1982 Salford CHC held a series of public meetings on issues concerning women and health. The CHC wrote to the RHA asking about legal requirements for running a crèche during meetings. The RHA replied suggesting that the NHS Act 1977 did not empower the CHC to run health courses. They wrote *"health education falls within the scope of health care rather than within the scope of representation of the local community's interests"*. The CHC pointed out that running meetings and courses was often undertaken by CHCs and the Government itself had recently stated that CHCs *"can help to transmit the preventive message to the public"*.[16]

In 1979 the South Western RHA carried out a review of CHCs. They concluded:

"CHCs should be reminded of their functions as laid down in Circular HRC(74)4 and should be discouraged from going beyond these parameters, particularly into executive functions. . . . We are of the opinion that the central function of the CHC is to represent the views of the public to the managers of the Area/District and the views of the managers to the public. Since the main instrument for change is the NHS planning system, it is to this that CHCs should direct most of their attention".[17]

Budgets and Allocation of Resources

The resources at its disposal, affect the way a CHC operates. The disposable income available to a CHC varies enormously. Not all CHCs are able to decide to economise on some expenses, such as rent, in order to employ more staff, undertake research or publicity campaigns. The range of duties or local circumstances in which the CHC works, are not reflected in the budget allocation.

Each RHA determines the budgets, staff establishments and location of premises of CHCs in its region. In 1984/5 budgets varied from £15,000 to over £50,000. The majority had budgets between £25,000 and £35,000. In terms of constant prices, there has been little change in CHC budgets over the years. In 1980 a survey found that just over half of CHCs kept within their budgets, some underspending by up to £2,000. Additional funds were available from RHAs to about a third of CHCs. About a quarter of CHCs had approached their RHAs for additional funds for particular projects and about half of those were granted.[13]

Table 3: RHA spending on CHCs

RHA	Average Expenditure on each CHC £ pa	Pence allocated to CHCs per head of population		
	1983/4	1978/79*	1983/4**	Difference
Northern	28,000	9.1	6.9	−2.2
Yorkshire	27,200	7.5	7.8	+0.3
Trent	34,500	6.4	11.1	+4.7
East Anglian	26,800	6.6	8.8	+2.2
NW Thames	35,600	10.5	6.5	−4.0
NE Thames	33,500	9.3	6.9	−2.4
SE Thames	28,100	7.2	8.5	+1.3
SW Thames	30,000	11.6	7.5	−4.1
Wessex	24,900	5.7	11.1	+5.4
Oxford	32,100	7.3	9.1	+1.8
S Western	28,800	6.8	8.2	+1.4
West Midlands	29,900	7.3	7.8	+0.5
Mersey	28,900	7.7	7.7	–
North Western	26,600	7.4	8.0	+0.6

* CHC News May 1979, No 42.
** Calculated using health region populations, supplied by OPCS.

There is no rationale for the variation in resources related to the size of population of the District, or other factors which might affect a CHCs workload. Some RHAs allocate resources partly according to the size of the population covered by the CHC, but the quality and level of activities are not reflected in the budget allocations. Some CHCs, which cover a large geographical area, may spend £5,000 a year on travel, but no additional allowance is made.

The workload of the CHC is largely self-generating and will depend on the energy and enthusiasm of members and staff. In 1985 CHCs' responsibilities were widened to include statutory working with Family Practitioner Committees (FPCs). An enquiry carried out by the Association of CHCs for England and Wales (ACHCEW) revealed that none of the RHAs responding felt that CHCs required more resources to cope with the considerable extra work, this would involve.[18]

Overall, in England CHCs cost £7.5m in 1983/4 out of the NHS budget for England of £13b. This works out as 0.057% of total NHS expenditure. It has remained largely unchanged over the years. In 1976/7 CHCs cost 0.058% of total NHS expenditure.

CHCs are designated as an RHA administrative function (rather than patient care or services). CHCs are included in the RHA management costs and there has been increasing pressure on the NHS to reduce management costs. Health Education Officers, who like CHCs provide direct services, were designated as administrative staff. This has now been changed. As long as CHCs are categorised with RHA administrative staff, any increase in resources is unlikely, however good the case may be.

CHC Staff

Staff establishment varies between one half-time person and four full-time people. Most CHCs have an establishment of two full-time staff, (discounting volunteers, Manpower Services Community Programmes or Urban Aid schemes).

"Between them, (the staff) have to cover a very wide range of duties — Chief Officer, Deputy Chief Officer, Researcher, Policy Adviser, Official Spokesman, Public Relations Officer, Conference and Exhibitions Organizer, Committee Clerk, Office Manager, Finance Controller, Personal Counsellor, Survey Compiler, Interviewer and Analyst, Receptionist, Secretary, Shorthand Typist, Clerk, Office Junior, Telephonist.. the staff cannot hope to perform all their present tasks effectively and are forced to be selective in the work that they tackle."[19]

Even if they had time, few people could undertake all those tasks equally competently. With so few staff undertaking such a wide range of tasks, there can easily be a mismatch in the skills of staff and the expectations of CHC members, which may lead to conflict. There is also potential conflict always between members, who are voluntary, and the paid staff — because of the different part the CHC plays in each person's life.

In 1980 52% of CHCs said they needed additional staff to help carry out their work properly. Some CHCs (29%) had applied to their RHA for extra funds to employ additional staff. Of these, 62% had been refused. CHCs have used different ways of overcoming the lack of manpower. In 1980 a third of CHCs used volunteers and a third had made use of Manpower Services Schemes, while 13% had students working with them.[13]

In a 1985 study, CHC Secretaries and District General Managers (DGMs) were asked what they considered the most important factors influencing the effectiveness of a CHC. Both General Managers and CHC Secretaries considered that the Secretary was the most important factor.

Table 4: Most important factors influencing CHC effectiveness*

Factor	General Managers	CHC Secretaries
Secretary	84%	80%
CHC members understanding of their roles	71%	72%
Chairman	69%	68%
Co-operation of DHA officers	67%	62%
Co-operation of DHA members	44%	37%
Total Respondents	111	131

*** % allocation to first choice, ranked order.**
At the time of the survey, 156 District General Managers were in post, 71% response rate, CHC Secretaries. 68% response rate.
Source: Dag Saunders, 1985 [20]

Accountability

The CHC staff are employed by the Regional Health Authority, but responsible to CHC members. A Secretary who has come from the NHS or who is aiming for an NHS career, may face disadvantages or conflicts of interest because of this. Where the relationship between Secretary and members breaks down, the Secretary is isolated and not necessarily able to turn for help or conciliation to her/his employer, the RHA.

Traditionally the appointment of the CHC Secretary has been a matter for each CHC, with an RHA observer attending the interviews. In 1986 the South Western RHA announced that the selection panel for a CHC Secretary post would be comprised of of 2 CHC representatives, and 2 RHA representatives, one of whom would take the Chair.[21] The DHSS then pointed out to the RHA that the ultimate decision on the appointment lay with the CHC.

Career Structure

In 1974 it was expected that the post of CHC Secretary would attract retired or ambitious young NHS administrators. When the post was opened to outside competition, appointments came from a wide range of backgrounds with only about one third from the NHS.[22] The situation does not appear to have changed much since then.[23] In some CHCs it was policy to appoint a Secretary with knowledge of the NHS. Others wanted a Secretary who had not previously worked in the NHS. Few RHAs have taken an interest in providing training for CHC staff.

The post of CHC Secretary has not turned out to be a training grade in the NHS (and many CHCs oppose any suggestion that it should be). The lack of a career structure for CHC Secretaries has created difficulties for them in making a career move.

Salaries and Grading

The CHC Secretary is expected to relate to and negotiate with all levels of the NHS: District General Managers, Regional General Managers and occasionally Ministers of State. The status of their grade within the NHS is not consistent with this role. Most CHC Secretaries are paid on NHS Administrative Scale 9, though some in Wales are on Scale 4 and some in Trent on Scale 14. The post of CHC Secretary is quite different from the management or professional functions of other 'Chief Officer' posts in the NHS and so is difficult to grade or value.

Some CHC Secretaries have applied for regrading, but without success. In a survey undertaken by the Association of Community Health Councils for England and Wales (ACHCEW), RHAs maintained that the grades and salaries were determined by the Whitley Council.[18] However, the Secretary of State stated that the grading of CHC Secretaries was a matter for each RHA, *"taking into account local circumstances"*.

In an appeal for re-grading the Secretary of Wandsworth CHC pointed out that the original job description of 1974 did not take into account the range of activities in which the CHC had become involved or the different duties introduced by changes in the regulations. The RHA also did not give recognition to the size or needs of the District's population or its overall budget. The Regional Personnel Officer dismissed the application:

"... the Regional Team of Officers have asked me to ensure that you are aware that the duties and responsibilities of the post are those set out in the job description which should not be changed or developed to any significant extent without the prior approval of the RHA".[24]

This implies that the CHC Secretary should not carry out instructions from the CHC, not covered by the 1974 job description, without RHA approval. The RHA later said that in their 'opinion', the CHC Secretary was not required to advise on policy or planning issues, which were matters for CHC members to decide.

CHC Secretaries belong to different unions, which lessens the possibility of raising the issue of CHC staff grading effectively at a national level. In 1978 the Society of CHC Secretaries was formed to develop 'good practices', enable the exchange of information among members and represent their interests to appropriate bodies. In its constitution it chose not to act as a trade union. From the start membership was not open to all CHC staffs and a number of CHC Secretaries were not willing to join because of this.

4 ACCESS TO INFORMATION

In order to comment on plans and put forward counter-proposals, CHCs need detailed information and have the right to it. Problems arise often not from the outright refusal or the inability to give information by the health authority, but from delay or failure to provide information in a form useful to the CHC and the public.

Information available to the CHC varies according to local DHA and FPC policy. In 1974 the NHS, unlike local authorities, was not used to publicity and feared it. Therefore, information given to CHCs was often sparse and depended on the CHC asking the right question at the right moment. It often caused extra work for NHS staff, because they wanted to 'launder' it first to avoid 'misinterpretation'. NHS managers and CHCs did not necessarily have the same view of the sort of information which should be regarded as confidential. Many CHCs did not accept, for example, that advance warning of proposed closures should be regarded as confidential information.

Another area of dispute concerned clinical judgement. For example, in 1976 the Joint Consultants Committee and the Royal College of Obstetrics and Gynaecology expressed concern that CHCs might be given information about induction of labour. They felt this was inappropriate for CHCs as it was an area of 'clinical judgement', albeit an area where there is considerable variation in 'expert' medical opinion.

In 1984 the National Consumer Council undertook a survey on the information needs of CHCs.[25] CHCs were asked what information they received routinely; what they found impossible to get; and what they would like to know. Though the response rate was low (53%), wide variations in information available to CHCs were found.

"Information offered as of right by some DHAs is treated almost as if it were classified by others... The fact that a small majority were satisfied with the situation as it is, should not lead to complacency. Some CHCs may not yet be sufficiently aware of the volume, scope and relevance of information which could be made available. Or they may lack confidence in their capacity to handle more information, given their small staff and other resources".

Alternative sources of information give CHCs an independent base from which to comment on NHS plans. CHCs have access to information directly from members of the public, community groups, voluntary organizations, individual NHS staff, trade unions and other CHCs. Surveys and research on a wide variety of issues have been undertaken by CHCs, some of which have produced important information highlighting needs and gaps in services.

5 ENFORCING THE RIGHTS OF CHCS

According to Statutory Regulations, the managers and representatives of the community must interact. Managers do not have to act on the views of the CHC. The effectiveness of a CHC in influencing decisions will depend on a number of factors, including: the attitude of NHS management, the professions and trade unions to the CHC and public participation; how well the CHC represents the community; and the quality of the information on which its views are based; as well as the way it uses the media and carries out political lobbying.

A CHC is not a legal entity and cannot take legal action itself to enforce its rights or those of patients, though third parties have taken action on their behalf. In Brent (1977), in Lewisham (1979) and in Islington (1984) legal action was brought by the local authority to enforce the right of the CHCs to be consulted.

In 1979 the Soho and Marylebone CHC threatened an injunction against the AHA in order to prevent the closure of a 45 bed recovery unit. However, because the RHA refused to pay for the legal costs, the CHC dropped their action. The CHC was expected to use the RHA legal department, even though it may not have been in a position to give independent advice. In 1984 the Secretary of State conceded that there might be instances when it would be reasonable for a CHC to receive independent legal advice, and it would be the duty of the RHA to meet the cost.

If a CHC feels that the health authority has contravened the regulations by not consulting about a closure or change of use or by withholding information, it can appeal to the Regional Health Authority (or in Wales, the Secretary of State for Wales). However, the DHSS does not monitor the way in which RHAs fulfil this role. A CHC may oppose a closure or change of use on the grounds that the procedures have not been followed and appeal to the RHA. If the RHA supports the closure, it may not be willing to isolate the procedural issue from its own interest in implementing the closure or change of use.

6 ATTITUDES OF NHS MANAGEMENT

From the start there were reservations among some NHS administrators about how effective CHCs would be as consumer councils. In a survey carried out by a working party of the Association of Chief Administrators of Health Authorities in 1975, Regional, Area and District Administrators were asked if CHCs were working as intended and whether any pattern had begun to develop.

The most common problems identified were:

"i. The principles upon which they were based had not been thought through (Area Administrators)
ii. The Councils were still searching for a role and were anxious about their capabilities (District Administrators)
iii. They tended to see themselves as part of management, exerting power without responsibility (all levels)
iv. There was a tendency for them to be used as political platforms, (Regional Administrators 14.3%, Area Administrators 10.9%, District Administrators 3.4%)
v. Communications were poor (all levels)
vi. There was a fear that they would be manipulated by the District Management Teams (Area Administrators)
vii. There were doubts about how representative they were (all levels)
viii. There were doubts about their willingness to do sufficient background work on problems referred to them (all levels)".[26]

Table 5: Are CHCs yet, or likely to be effective as consumer councils?

	Regional Administrators % (no)	Area Administrators % (no)	District Administraors % (no)
Yes	75 (6)	58.5 (38)	28.9 (34)
No		16.9 (11)	22 (26)
Doubtful	25 (2)	9.2 (6)	15.3 (18)
Too early		15.4 (19)	26.3 (31)

Source: Association of Chief Administrators of Health Authorities, 1975".[26]

"Clearly, the Regional Administrators had more faith in the Councils' ability to represent the consumers than did either their Area or District colleagues who will be preparing the proposals for service change that will be embodied in the planning process".[26]

Six years later, District Administrators (DAs) saw CHCs as having more impact than their Area colleagues. In 1981 a study looked at relationships between NHS managers and CHCs in 24 Districts.[27] CHC Secretaries, District Administrators, Area Health Authority and Family Practitioner Committee Administrators were interviewed in depth.

Table 6: Does the CHC have an impact on decision making of your DMT, AHA, FPC?

	CHC Sec	District	Area	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%)		

Source: Bates[25]

The study concluded that:

"It is clear that CHCs are having a significant and beneficial impact on the administrators with whom they mostly deal — the District Management Teams. 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 outwards to the community and to hitherto neglected groups of patients."

Administrators saw CHCs most valuable roles to be:

- Bringing in new fresh ideas;
- Keeping the management on 'its toes'; and
- Commenting on priorities in service provision.

The researcher concluded:

"Since DAs have had to learn to deal with CHCs, the DAs have become much more adept at re-phrasing 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 Chairmen and DMT members, the CHC is in a very poor position to exert influence. The CHCs' 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 CHCs representations are not taken seriously, MPs take notice if many voters seem to be discontented."[26]

It is too early to assess the effect that the introduction of General Managers in 1984 will have on the ability of CHCs to influence decisions. District Unit and General Managers may see the CHC as a useful ally in battles with medical staff and unions or, at least, a forum for meeting the public. Alternatively, they may see the CHC as an unnecessary impediment to effective management. It may help a CHC to know exactly who makes decisions and apply pressure accordingly.

7 PUBLIC AWARENESS OF CHCS

The Royal Commission on the NHS said:

"The siting of CHC offices is ... important ... and health authorities should encourage them to find 'High Street' or easily accessible premises wherever possible".[6]

CHC premises are important not only for accessibility to the public, but also to establish the CHCs' independence from the NHS, which is difficult for a CHC based in a hospital. One in five CHCs are in shopfront premises. Shops are however expensive to rent and some RHAs are not willing to pay rent for CHC premises. 12% of CHCs are sited in hospital or other NHS buildings [13].

Most CHCs give priority to publicising themselves. Nearly all hold public meetings, produce leaflets, posters, newsletters, talk to local groups, use the media.[13] With limited resources, publicity is time-consuming and expensive. Recent research, not surprisingly, found that the more publicity obtained by a CHC and the more major events in which it was involved, the more members of the public contacted the office.[14]

Surveys of the general public have shown varying levels of awareness about CHCs, ranging from 2%-30%.[28] There have been no recent studies to indicate current knowledge of CHCs among the public.

However good CHC publicity may be, it will be limited in effect if the public are not interested in the idea of CHCs. One researcher asked his sample, who had not heard about CHCs, if they thought the idea of a CHC was a good one:

Table 7: Attitude to CHCs and age

	Age		
	18-34	35-64	65+
	%	%	%
CHC: Good idea	57	51	38
Unnecessary	38	43	55
Other Comment	5	6	7
Sample size	230	368	148

Source: Anderson[2]

"Although the amount of contact with the health service appears to influence the appeal of CHCs very little, the quality of previous experience does seem important;... However, even among those who were dissatisfied or had mixed feelings about their care, one third still thought the CHC was unnecessary. It is likely that younger people and those with more education have higher expectations, as well as finding notions of community participation and consumer involvement more attractive or meaningful".[28]

In Wales in 1977/78 the Welsh office made £6,000 available to Welsh CHCs to make a film about their work. Otherwise, no funds for a national publicity campaign have been made available by the DHSS and the Central Office of Information has given no assistance in publicising CHCs. CHCs are not always mentioned in DHSS official information leaflets from DHAs, FPCs, RHAs, DHSS or the Welsh Office.

8 IDENTIFYING THE 'COMMUNITY'

CHCs 'represent the local community's interests'. There is no guidance how this should be defined. Does a CHC represent the actual or potential users of the NHS? The transient as well as the resident population? Private patients in NHS hospitals as well as NHS patients? There will be differences in priorities for different sections of the community, how does the CHC decide who to represent?

The NHS has changed since 1974. The shift towards care in the community and the running down of the large mental hospitals have moved some particularly vulnerable groups from the care of the NHS to local authorities, voluntary groups and private residential establishments. Most CHCs find the organizational demarcations have little meaning for ordinary people. Whether someone is cared for by the NHS, local authority, voluntary or private establishments paid for from public funds, standards should be safeguarded.

Other groups of patients have no representation. In 1974 post-graduate hospitals were excluded from the new NHS structure and had no formal relationships with their local CHC. Patients in Special Hospitals, such as Broadmoor and Rampton, and prison hospitals are particularly vulnerable and come under the Home Office, not the DHSS. In military hospitals, if there is a medical accident, the patient has virtually no redress as s/he cannot resort to normal legal channels. The CHC has no authority to represent these groups and the Government has indicated that at present it sees no reason to review existing procedures.[29]

PART III
CHCS IN ACTION

1 PARTICIPATION IN PLANNING

NHS Planning System

Planning of services is a management function. Health Care Planning Teams (HCPTs, later District Planning Teams) are set up in each district to cover different service areas and examine the needs and advise the District Management Team (now the General Manager). Their reports form the basis for service planning.

Though the DHSS envisaged that CHCs would be involved in the planning process, arrangements were left to local negotiation. CHCs are not involved in the planning process by right. Consumer participation in planning is important because:

- It is unlikely that major alterations will be made once plans are formed.
- Subsequent disagreements may be avoided if CHCs are involved at an earlier stage of the planning process.

Some CHCs did not want to be represented on planning teams, lest they become too involved with management. If the CHC representative had agreed a proposal in the planning team, this might inhibit the CHC later in opposing these proposals. Other CHCs did not see this as a problem, if the role of the CHC representative was that of observer and not member of the planning team. In this way they can advise the team of the community's view but, having no vote, do not take part in the decisions.

Some CHCs may have lost their consumer identity because of a close relationship with management. In the West Midlands, a DHA involved the CHC in planning teams and a number of other joint activities from the start. The District Administrator attended CHC meetings and dealt with questions as they arose. The result was that *"the Council now has some difficulty in identifying or getting to grips with problems or ideas as the "answer" is readily given at the very first airing. The Council now meets five times a year instead of monthly and has disbanded all of its interest groups and sub-committtees".*[30]

Early surveys found that the role of CHCs in planning teams depended on the good will of the DMT rather than anything else.[31] The antagonism of some NHS managers was due to fears that:

- CHCs would interfere with 'management' and had nothing to contribute to planning discussions among professionals.
- CHCs would not respect the NHS managers views on confidentiality.

CHC representation on Planning Teams has increased over the years, both with voting rights as members or speaking rights only as observers. The number of CHCs which have not wanted representation has decreased, as has the number refused representation by the health authority.

Table 8: CHC representation on Planning Teams 1977 and 1980

	1977 %	1980 %
CHC represented — speak & vote	16%	31%
CHC represented — not speak, not vote		2%
CHC represented — speak not vote	21%	24%
CHC wishes to be represented but not allowed by AHA	19%	15%
CHC does not want representation	15%	6%
Planning team not set up	7%	6%
No information/other	22%	16%
Number of CHCs in survey	180	195

Source: Farrell and Adams[13].

In 1980 just under half of health districts were in favour of CHC membership on planning teams. There was a significant difference between regions in the North and regions in the South of England. In the Northern RHA 21% of districts favoured a CHC presence, while 75% did in South East Thames RHA.[32]

Table 9: District Policy on Planning Teams

In favour of CHC representation	47%	(85)
In favour, CHC Secretary only	4%	(8)
Against CHC representation	31%	(56)
Neutral/no policy	18%	(32)
	100%	181

Source: Murray-Sykes, Kearns and Mullen[32]

Of planning teams with a CHC representative, 84% considered their presence to be beneficial. Teams with CHC representatives were also more likely to be satisfied with their effectiveness.

Table 10: Satisfaction with effectiveness of Planning Team

	Satisfied	Dissatisfied
With CHC Member	84% (137)	16% (27)
Without CHC member	65% (116)	35% (63)

Source: Murray-Sykes, Kearns & Mullen[32]

The study found that CHC representatives had a better than average attendance rate on planning teams. Most CHCs had sub-groups, which shadowed the planning teams in their health district:

"Rather than abolishing CHCs, there might well be scope for extending their role in planning. Used constructively the CHC 'planning' system can form a valuable adjunct to the NHS planning system. By including a representative from the relevant CHC sub-group in their membership, planning teams can obtain consumer views on a regular basis and at an early stage in the discussions. Major benefits could be:

a) a saving in time and money by finding out sufficiently early on an informal level, whether certain planning options are as likely to be acceptable to the local community as others.

b) increased understanding on the part of the consumers of the difficulties faced by the 'professionals' in planning health services.

c) consumers and professionals combining their experience and channelling their energies into providing a better service for patients".[32]

LOCALITY PLANNING IN EXETER

In Exeter planning is based on localities rather than client groups. There are 15 Locality Planning Teams in the District, covering populations ranging from *10,000-40,000. Health service users are involved* through CHC members, local parish councillors and voluntary organizations.

***Health Forums have been set up by the CHC in four* localities and the DHA provided additional funding for them. The Forums have been successful in involving a wide number of lay people, in particular in scattered rural areas.**

Source: Exeter CHC Annual Report 1985

LOCAL ADVISORY GROUPS IN WEST LAMBETH

West Lambeth CHC was involved with the Health Authority in establishing Local Advisory Groups for small scale health service facilities in Lambeth. The aim of the Groups is to give local people and users a say in the way the centres are run and an opportunity to suggest improvements and discuss wider health related issues. The CHC is able to take up and campaign on issues they raise.

The first Group was set up in 1986 at a centre for the elderly. Half of the members are local health and social services staff. These include a social services representative, a district nurse and a local GP and *four members are elected by the staff at the centre.* Half of the group are representatives of the local community. One representative is nominated by Age Concern and six people were elected at a public meeting. The CHC co-ordinated and arranged the elections for community representatives.

Source: West Lambeth CHC

WEST BIRMINGHAM: PANEL OF THE PUBLIC

West Birmingham CHC have established a Panel to assess informed (but disinterested) public opinion. It set out to recruit a group of people, orginally 200 in number but subsequently increased to 350, which reflects the population of the district in terms of geographical area, age, sex and membership of minority groups.

The CHC sends panel members policy papers to be considered at each CHC meeting and also sends out questionnaires on topics on which the CHC wishes to assess public opinion. Members of the public become more aware of health service issues and the CHC can assess public response. 'If one accepts that the panel work will frequently do no more than indicate areas for further and more scientific work, such a panel can be a very cheap way of assessing public opinion and of increasing public awareness of the CHC within the district'.

Source: West Birmingham CHC

Joint NHS and Local Authority Planning

The 1974 Re-organization circular suggested that CHCs might direct their attention to *"Collaboration: the effectiveness of co-operation between the health services and the related local authority services".*[2]

A formal relationship has not been established between CHCs and local authorities.

Improved co-operation between local authorities and the health service was one of the basic objectives of the 1974 re-organization. Joint Consultative Committees (JCCs) were set up to advise health authorities and their matching local authorities on planning and operation of services. Membership is drawn from both health authority members and councillors. In 1985 voluntary organizations were given the right to elect three members to JCCs, and, strangely, no reference was made to CHCs.[33] In January 1986 the DHSS produced a draft circular on collaboration between the NHS, local government and voluntary organizations which made no reference to CHCs and gave no recognition of the role CHCs already played in JCCs.[34]

Joint Care Planning Teams (JCPTs) are made up of NHS and local authority officers and normally match the JCC area. They advise NHS and local authorities on the development of strategic plans and guidelines covering priority services which require a joint approach in planning.

Table 11: CHC Representation on JCCs and JCPTs, 1980

	JCC %	JCPT %
CHC represented, speak and vote	4	6
CHC represented, speak, not vote	23	11
CHC represented, not speak or vote	3	1
CHC wishes to be represented, but refused	30	26
CHC does not want representation	14	13
JCC/JCPT not set up	2	11
Other/No reply	24	32
Number in survey	195	195

Source: Farrell and Adams[13]

In 1984 a survey carried out by the National Council for Voluntary Organisations and ACHCEW showed that 42% of CHCs responding had observer status on JCCs.

A report by NCVO on the role of the voluntary sector in planning pointed out:

"Voluntary sector representatives on JCCs need support in their role from local bodies such as Councils of Voluntary Service and CHCs if they are to be effective. Where Community Health Councils participate in JCCs and JCPTs they have often proved extremely helpful to voluntary sector representatives in analysing the issues under discussion".[35]

Many CHCs see joint planning of finance as central to their work for the local community. They find it difficult to understand why they should not be formally involved, particularly as they are often called upon to inform and advise the voluntary organization representatives, who need some equivalent of the officer support given to DHA and local authority members.

Family Practitioner Services

Family practitioner services account for one quarter of all NHS expenditure. For most NHS consumers they are their only contact with the Health Service. Many Family Practitioner Committees (FPCs) have resisted collaboration with CHCs. By 1980 39% of CHCs had obtained observer status by local arrangement and 40% had been refused representation.[13] In 1985 CHCs were given the same rights and duties in relation to FPCs as to DHAs,[36] including observer status on FPCs, consultation rights and annual meetings between FPC & CHC members.

Family Practitioner Services are fundamental to community care, with which CHCs are particularly concerned. It is important, therefore, that CHCs and FPCs learn to work together. It is early days to assess how collaboration between CHCs and FPCs will develop. In Lancashire, a joint procedure has been negotiated between the CHCs and the FPCs, which attempts to define issues requiring consultation and lay down procedures.[37]

There are difficulties both for CHCs and FPCs in building up a relationship:

1. FPCs cover larger areas than District Health Authorities. One FPC may have to relate to up to seven CHCs.

2. The requirement for FPC members to meet formally with members of each CHC once a year may be unrealistic for FPCs who relate to many CHCs. CHCs may need to combine in relating to FPCs.

3. FPCs and CHCs have not been given any additional resources with which to take on the new activities of planning and consultation. This may cause difficulties for FPCs who may not have enough staff of the calibre to undertake public consultation and strategic planning.

4. FPC members may see their role as administering an existing service and not being involved in policy making and planning. In contrast to DHA membership, FPC membership is largely made up of professionals rather than lay people or managers.

5. The FPC has less authority to plan and develop their services than DHAs. The Family Practitioner Services are provided by doctors, dentists, pharmacists and optical practitioners who are self-employed independent contractors and the local professional committees have strong powers of veto.

2 CONSULTATION ON CLOSURES AND CHANGES OF USE

Regional Health Authorities

There are no nationally agreed procedures for Regional Health Authorities to consult the public. The Capital Programme for new buildings is controlled by the RHA and there is no input from CHCs, though the implications of long-term plans for each district are enormous.

Five broad areas have been identified as ones on which CHCs might wish to be consulted by RHAs:

- Strategic Planning
- The development of 'philosophies of care' likely to be used as guidance for DHAs
- Regional speciality services and their location
- The pattern of consultant appointments in the Region
- Operational services managed directly by the RHA[15]

CHCs do not have the resources or the regional structure to work together to look at the long-term implications for the Region as a whole. RHAs vary in their willingness to involve CHCs in strategic and capital planning. If the CHCs disagree with the RHAs plans there is no procedure for appeal, as in the case of disputes with District Health Authorities. The RHA can therefore proceed with minimum consultation.

District Health Authorities

Procedures for Consultation

"The relevant Area Authority has a duty to consult the CHC on any substantial development of the health service in the Council's district"[2] In 1974 CHCs were given a special role in relation to closures. Until 1974 all closures were referred to the Secretary of State for a decision. After that, where a CHC agreed, this was no longer necessary. If a CHC opposed a closure, it had to make 'detailed and constructive' alternative proposals and the matter would be referred to the Secretary of State for a decision.

The Griffiths Report was not impressed by NHS consultation procedures:

"A very great deal of importance is attached to ensuring that the views of the community at all levels are taken into account in any decision. The reality is, however, that by any business standards the process of consultation is so labyrinthine and the rights of veto so considerable, that the result in many cases is institutionalised stagnation".[9]

In 1985 new regulations stated that the DHA did not have to consult on *"any proposal on which the District Authority or Committee is satisfied that, in the interests of the health service, a decision has to be taken without allowing time for consultation; but, in any such case, the District Authority or Committee shall notify the Council immediately of the decision taken and the reason why no consultation has taken place".*[3]

Difficulties Arising From Consultation Procedures

In spite of the obligation, health authorities have not always consulted CHCs about closures and changes of use.

Table 12: Proportion of CHCs consulted about closures and changes of use, 1980

	Hospital	Hospital ward	Community facilities
	%	%	%
CHC always consulted	55	34	44
CHC never consulted	2	4	5
CHC consulted on some closures but not others	3	2	2
No changes proposed or *no information provided*	40	60	49
Number in sample:	195	195	195

Source: Farrell and Adams[13] **Response rate 85%**

The main difficulties arising from consultation procedures are:

1. Some Health Authorities have evaded consultation by reporting that a closure is 'temporary' and therefore exempt from the procedure. Consultation then proceeds with the unit already closed, so it is difficult to get it re-opened. There is no definition of how long is 'temporary'. DHSS guidance in 1979 to Regional Health Authorities was that:

"A temporary closure could, however, have a considerable effect on district services, for example, if it involved the temporary cessation of the only service of its kind in the district, or the removal of such a service to another centre elsewhere in the area. Such a closure might well constitute a substantial variation of service and so fall within the scope of Regulation 20(1)".[38]

2. Consultation procedures are open to various interpretations. How do you define 'substantial'? 'Substantial' relative to what or whom? This was defined in 1985 by the Minister as *"Broadly speaking I would expect authorities to go along with the CHC's view in most cases".*[39]

3. In 1974 some hospitals were handed over to management outside the district where they were located. Others were managed by one authority while taking patients from many areas. Post-graduate hospitals were excluded altogether from the regulations. In 1974 post-graduate hospitals had no relationship with CHCs. In 1982 they came under the new Special Health Authorities who were encouraged, but not obliged, to relate to local CHCs.

4. The amount of information given by the health authority often is insufficient to be called consultation. In some cases 'consultation' is limited to presenting a list of closures and cuts in services said to be necessary to stay within cash limits.[13] In 1984 a DHSS letter to General Managers stated *"The Consultation document must contain comprehensive and clear information, including the use to which savings will be put, so that it is plainly demonstrated how patients and the community will benefit by the closure".*[40]

5. The time allowed for consultation may be too short for the CHC to undertake a major public consultation.

6. If a CHC opposes the health authority's plans it must put forward detailed counter-proposals, within the same financial constraints. It is difficult for a CHC with limited resources to produce properly costed alternatives, particularly as it may have to rely on the health authority for information to do this. It may involve proposing alternative closures or, at the very least, different priorities for service development. Some CHCs are not willing to choose priorities in allocating resources. Others consider that, in fighting for more resources for the 'cinderella services', they should accept some closures to free funds.

There has been no monitoring by the DHSS of the number of 'temporary' closures, which may last for many months, or how many closures are made on the grounds that, in the interests of the health service, there is not enough time for consultation. The only safeguard to a CHC in ensuring that a DHA does not misuse its power to avoid the delay and inconvenience of consultation, is the right to appeal to the RHA in a dispute whether the variation in service is substantial or not.

A report from West Birmingham CHC concludes:

"Over the years, CHCs have suffered from poorly drafted DHSS guidance in this area and a lack of authoritative interpretation; this has hampered their attempts to promote particular local policies for service provision... It has also often been the case that procedural disputes have understandably occurred at the same time as attempts to debate the substantive issues. This is not the best time, for the presentation of those substantive policy points can all too often be lost as a result.

"The response of the government has typically been to seek to disregard procedural problems. For example, in a letter to Jeff Rooker MP on 5 February 1985, John Patten MP wrote:

> *'We currently have no plans to introduce statutory rights or duties into the consultation process. Generally speaking I believe it is in the best interests of good working relationships between CHCs and DHSS for any difficulties to be worked out at local level rather than providing recourse to formal appeal procedures to sort out every failure of communication.'*

"But procedural rules are most important in those difficult cases where good working relationships have broken down. Therefore they should be drafted to cover precisely those cases. They are rarely important in straightforward cases, and there is no evidence that sensible procedures hamper communication in such cases".[15]

Impact of CHCS in Consultations

CHCs have not used their delaying powers indiscriminately. The 1980 survey found that 44% of CHCs, consulted on closures and change of use, had opposed the proposals, 32% agreed and the remainder opposed some proposals, but agreed others. Of those opposing, one in six had not put forward counter-proposals; half the CHCs had worked out alternative proposals and a third had put forward counter proposals in some cases, but not others.[13] In the six years, between May 1979 and June 1985, fifty proposals which had been opposed by the CHC were sent to the Secretary of State for a decision. In these cases the Secretary of State found against the health authority in only five cases.[41]

There is no hard information about the changes which have happened at local level during negotiations arising from consultations. From anecdotal evidence, it is probable that a CHCs known opposition deters many closures or changes of use from being formally proposed.

Some CHCs have felt that their formal consultation rights have not brought benefits to the community and have weakened the public's voice in the NHS.

"The introduction of the formal consultation procedure has ensured that these battles take place on ground which is familiar to health service managers but alien to most local people — including CHC members.... Critics of CHCs have argued that they are not an antidote to the NHS management but an essential part of it — channell-

ing potentially disruptive dissent into manageable forms".[42]

Consultation on closures and change of use has become a major part of a CHCs work. Resource re-allocations and public expenditure cuts have led to more closures and changes of use of NHS buildings than envisaged when CHCs were set up in 1974. As a statutory responsibility which generally arouses public concern, the CHC may be accused of colluding with management and not protecting local interests if they do not fully consult the public on all closures. However, opposing closures and drawing up alternatives is not rewarding, if it happens regularly, and may leave little time for other activities, where CHCs might have a longer term impact in the community.

CONSULTATION: THE BIRTH OF A COMMUNITY PLAN

In 1978 the Area Health Authority consulted the Paddington and North Kensington CHC on its long-term plan to rebuild the teaching hospital, St Mary's, Praed Street and to close St Mary's, Harrow Road. Following lengthy consultations with the public the CHC rejected the plan and then obtained a three month delay in order to formulate an 'alternative' strategy.

The CHC conducted a random survey based on the electoral register, asking people to consider four alternative plans and say which they preferred. The vote was overwhelmingly for the CHC's own plan to rebuild St Mary's Teaching Hospital in Paddington and replace the general hospital at St Mary's, Harrow Road, with a community hospital on the same site. GPs would admit their own patients to the new community hospital, which would also provide facilities for pre-convalescents, the elderly, mentally handicapped adults, young chronic sick as well as a health centre and minor casualty centre.

In April 1979 the AHA agreed to adopt this plan in principle and to explore with the CHC how it might be implemented. Following this the CHC canvassed local GPs and local community groups and social services to obtain their support and involvement in the idea of a community hospital. In September 1979 a Joint Working Party was set up with membership from the CHC, DMT, GPs, RHA and local authority social services.

The Paddington Community Hospital opened on a trial basis in January 1982, with 25 beds. An Appraisal was undertaken in 1984 which recommended that the hospital become an esablished part of the District.

Source: Naomi Honigsbaum, CHC News, No 69, August/September 1981. The First Inner City Community Hospital: An Appraisal of the first two years of operation, Paddington and North Kensington Health Authority, September 1984

PUBLIC PARTICIPATION IN BOLTON

How does a CHC find out what the public wants? In 1978, Bolton CHC was faced with a sophisticated plan to redevelop and extend an existing district general hospital over a period of 10 years on the site of a poor law hospital on the edge of town. This development could involve the closure of the centrally situated and popular Royal Infirmary. The threatened closure of the Royal Infirmary was vigorously opposed. The Metropolitan Borough Council seemed destined to vote against the plan. Opponents of it dominated the public meetings held by the CHC and the CHC deliberately took no votes. The main grounds for opposition were transport difficulties and sentimental attachment to the Infirmary.

However, the CHC was not so sure. Acute services were split between the two hospitals and this involved frequent transfers of patients from one hospital to another. The central site of the Royal Infirmary was too small for any extension. Maybe this redevelopment was the only chance in the forseeable future of improved services for Bolton.

So the CHC decided to seek the views of the uncommitted public. The CHC printed invitation cards, booked a room in a well appointed medical institute for two evenings in one week and arranged a meal for 100 people on each of the two evenings.

Twenty five CHC members and volunteers went out to invite people to tea and chat. The volunteers travelled a random route in every ward, leaving a personal invitation only where there was a commitment to accept it and then knocking on the 10th door up the street or around the corner. The novelty of the random approach attracted much publicity, all of which contributed to public awareness.

At the first evening more than 100 people turned up and were given fact sheets, programmes and badges. Following the buffet, they split into groups and were asked what they expected of their ideal local hospital service. Each group had a recorder, experienced in participation groups, who reported back of the views of the group to the main meeting. The panel of 'experts' were then asked to explain how the proposed plan would solve or fail to solve the problems presented. Once the 'experts' were persuaded that in this forum they were not the 'experts' any more and to listen to the people, the discussion got going.

The plan went through the AHA, the CHC and the Metropolitan Borough Council without rancour and with the tacit agreement that the same community would now want to be involved in more detailed planning in the future.

Source: June Corner, Bolton CHC

3 MONITORING SERVICES

Monitoring the NHS

The statistical approach

The 1974 DHSS Circular, which set up CHCs, suggested for their attention:

"Standards: assessment of the extent to which district health facilities for patients conform with published Departmental policies in their administration and practices; the extent to which facilities match up to recommended standards (where these exist) or national or regional averages, e.g. numbers of hospital beds in particular specialities per 100 population, average number of patients on family doctor's list; the share of available resources devoted to the care of patients unable to protect their own interests, especially those living in hospital for long periods or indefinitely".[2]

This is a strange task to give a lay body. Surely monitoring standards is the role of each health authority member? Perhaps the DHSS saw CHCs as an internal pressure group to ensure NHS managers followed the DHSS guidelines. Many DHSS policies on quality of care are only recommendations and not mandatory.

However, there are difficulties for CHCs in monitoring services by using NHS statistics:

1. The CHC is dependent on the health authority or FPC for information and enforcing the right to information is not easy.

2. Understanding and interpreting statistics are a specialist skill, especially if the information is presented in such a way as to support a particular viewpoint.

3. Much of the information which CHCs require, for example, on the quality of care, is not available in statistical form.

4. Even if the CHC can point to major discrepancies as outlined in the Circular, the NHS managers, if not health authority members, will be aware of them, but may not give priority to bringing standards up to DHSS norms.

CHCs have taken the statistical data and used it to ask pertinent questions. For example, a CHC in the Midlands noted that the chance of being admitted to an obstetric unit which was a Regional 'centre of excellence', correlated inversely with social class. In view of the fact that people in Registrar General's Social Class V are twice as likely to lose their babies at birth or within a week, it seemed that expert help was not getting to those who were most in need of it. [43]

Surveys of patient satisfaction

The 1974 Circular gave examples of existing services which CHC could monitor: facilities for children and parents in hospital; waiting times in outpatient clinics; visiting hours; amenities for hospital patients; waiting periods for appointments; and quality of catering services.

In this area CHCs have been most successful, because:

1. CHCs can define for themselves a clear role, based on the abilities of lay members, of looking at services from the patients' point of view.

2. The changes required are often in procedures and attitudes and may not always involve extra resources. While attitude change is slow, such suggestions are more likely to be supported by some managers.

3. Because CHC attention is often targeted at specific areas of the service, it may not be challenging major planning or management issues. So, the CHC will probably not arouse much hostility and can co-exist with NHS management without major friction.

CHCs often mount surveys to ask for user's experiences and views on services. According to a study in 1980 75% of CHCs had carried out at least one survey between 1977 and 1980. The average number was 2, but many had done far more. Many CHCs indicated that they would like to do more research but were caught up in responding to consultation documents.[13]

In 1979 the West Midlands Regional Health Authority set up a committee to encourage and support the development of information and library services and survey research. A fund of £15,000 a year was allocated to assist CHCs in information projects. The Committee consisted mainly of CHC representatives and was chaired by an RHA member.

In 1981 a study was undertaken by the committee to look at the surveys and research CHCs were undertaking. In the West Midlands there are 22 CHCs, 18 of which had undertaken some kind of survey research:

- 13 had undertaken public opinion surveys.
- 9 had undertaken surveys of health professionals and 2 of these included surveys of access for the disabled.
- 2 had carried out surveys which involved both public opinion and health service professional opinion.
- 12 were either just completing surveys or had surveys in progress at the time of the report.

Four CHCs had not carried out any survey research, though two of them were planning to undertake surveys in the next few months. Some CHC Secretaries were interested in undertaking surveys, but their members were not as enthusiastic for a number of reasons:

"(a) Surveys are too expensive and time-consuming.
(b) Members represent the public so there is no need to find out public opinion.
(c) Members do not think that this is something with which CHCs should be involved".[45]

Visiting hospital units is conscientiously undertaken by most CHC members and often produces valuable data on services. However, some health authorities are unwilling for CHC members to make informal vists to talk to patients. The formally arranged CHC visit, often involving a retinue of senior NHS officers, are not generally useful and CHC members may not have the opportunity to talk to patients.

HEALTHCARE NEEDS OF CHINESE PEOPLE IN BLOOMSBURY

The area around Soho is well known for its Chinese restaurants, shops and meeting places. In 1984 pressure from the Chinese Community led Bloomsbury CHC with the Bloomsbury Community Services Unit to see how services could be made more appropriate to the Chinese community.

In-depth interviews were conducted with 80 Chinese families. The aim was to find out whether local Chinese people knew about the services available and how to use them; whether they were satisfied with the services they use; and which services they do not use and why not.

The findings revealed that 'the Chinese community knew very little about available health service provision. In every area of health care examined, communication — about treatment, diagnosis, prognosis, prevention and day-to-day care and so on — was the major problem experienced by most people'.

The recommendations included the recruitment of a Chinese health visitor/community nurse, staff training and development of health education material in Chinese. A Chinese health visitor was immediately recruited.

Source:The Health care needs of Chinese people in Bloomsbury Health District, Bloomsbury Community Services Unit/Bloomsbury CHC, 1985.

SERVICES FOR PEOPLE WITH HEARING IMPAIRMENTS

In 1979 South East Cumbria CHC conducted a survey on the problems of people with hearing impairments. The survey highlighted a number issues:

1. The service for the manufacture of hearing aid moulds was inadequate. After local measuring these moulds were made in the South of England. Many were ill-fitting and poorly made, causing delays to patients waiting for an aid.

2. New recipients of hearing aids need counselling at home. Many aids were being discarded because of inadequate advice about how to use them.

3. Communicator devices with 'loop' systems and headphones were needed to enable doctors and others to hold confidential conversations with patients.

4. Hard-of-hearing people complained about the problems of watching TV and called for clearer speech, less background music and more programmes with subtitles.

As a result of the survey:

- **A domicilary counselling service staffed by trained volunteers was established by the audiology department at Beaumont Hospital, Lancaster.**
- **Cumbria Deaf Association organized the gathering of hundreds of signatures on a petition to the broadcasting authorities seeking better provision for the hard-of-hearing.**
- **Plans were drawn up to manufacture ear moulds adjacent to the audiology department.**
- **Kendal Lions Club raised money for a communicator device for hospital clinics.**

Source: Fiona Drake, CHC News, No 62, January 1981

CONSUMER ATTITUDES IN DORSET

East Dorset Health District covers a large area, which includes 5 local authorities covering both urban and rural areas. Since 1975 East Dorset CHC have monitored consumer attitudes to health services. Initially the surveys were small and experimental to determine the best way of eliciting information from the public with limited staff and resources. Methods included interviews, group discussion, interviews with community leaders and professionals and questionnaires to local organizations and individual households.

In 1980 the CHC settled on a system of distributing information packs (containing introductory letters, leaflets and questionnaires) to as many households as possible in representative areas or rural parishes. From 1980 to 1983 5 areas were surveyed, with an average response rate of 35% (2828 completed questionnaires 1980-1983).

The surveys involved local people in identifying existing and potential problem areas. These have provided the CHC with information to advise on improvements and extensions in services, including the establishment of GP branch surgeries and a service to deliver and collect prescriptions.

Source: Mike Gumbley,[46]

Highlighting Bad Practices in the NHS

Complaints are a useful source of information, indicating areas requiring further investigation. Many changes have been brought about through CHC action arising from a single complaint. Some CHCs regularly 'audit' schedules of all complaints made to the health authority. This assists in identifying trends and recurring difficulties and can give the public more confidence in the DHAs impartiality and thoroughness in investigating complaints.

The main sanction of the CHC is to publicise what is happening. Health authorities may be aware that things are wrong, but not prepared to take action. National concern about cervical cytology services in 1985 arose because one CHC draw the issue to the attention of the media. The problems of Normansfield in 1976 and Stanley Royd Hospital, Wakefield, in 1984 only came to public attention following major incidents. In both cases the CHC was commended for speaking out.

CERVICAL CYTOLOGY

2000 women die a year from cervical cancer, which if diagnosed early enough, can be treated and death rates drastically reduced. In 1984 one woman died and two others were seriously ill in Oxford, because they had not been recalled for treatment after their smear tests had proved positive. Oxfordshire CHC publicised this and, in a survey following the publicity, it was found that only 7 out of 201 health authorities had a proper call and recall system; 77 had no scheme at all, and the position was unclear in a further 10.[47]

In a DHSS Circular the Minister of Health asked all RHAs to set up regional computer systems where this had not been done; to introduce a system for telling all women how to get the results of their tests; to improve the effectiveness of the laboratories which process smears; and to develop more ways of offering tests to older women. He refused to make any further funds available.

Oxfordshire CHC highlighted a serious problem, which many CHCs had already taken up locally. The ensuing debate resulted in a nationwide review of recall procedures.

Source: Community Health News, No 4, February/March 1985

NORMANSFIELD

"Late in the evening of 4 May 1976 an informal meeting of certain members of the Confederation of Health Service Employees was held at Normansfield Hospital, Teddington, Middlesex. That night the hospital housed 202 mentally handicapped patients of varying ages, many of them suffering from multiple handicaps to the point of complete helplessness. Those present at the meeting were members of the nursing staff and they were angry that the Health Authorities had apparently failed to take full notice of their grievances against the Consultant Psychiatrist in Mental Subnormality in the hospital. After some hours of discussion they decided to go on strike from seven o'clock next morning with a view to persuading the S W Thames Regional Health Authority to suspend the doctor from duty.

Shortly after daybreak pickets were out at the hospital. Patients were attended by a skeleton nursing staff, helped by a few other staff and relatives. Nursing cover fell below danger level and the health and welfare of patients were endangered.

Later that day, the Consultant was suspended from duty and the nurses returned shrtly after 3.30pm . . . This industrial action was unprecedented in the history of the National Health Service".

The report of the Independent Committee of Inquiry highlighted the failure of all levels of management to deal effectively with problems about which they were well aware. The Area Health Authority sought to improve the situation by non-intervention and persuasion. This policy was soon shown to be ineffectual but it was nevertheless persisted in for too long. *"At Regional level an attitude of 'wait and see' was adopted regardless of the knowledge that the price of waiting was being paid by patients"*

The only NHS body to be commended in the report was the CHC. 'The Kingston, Richmond and Esher Community Health Council is to be congratulated on its tenacity in exposing and reporting on the situation it found at the hospital.'

Source: Report of the Committee of Inquiry into Normansfield Hospital[48]

STANLEY ROYD HOSPITAL, WAKEFIELD: DEATH IN THE HOSPITAL KITCHEN

In August 1984 there was an outbreak of food poisoning at Stanley Royd Hospital, a psychiatric hospital with 830 patients. Nineteen people died and four hundred and sixty patients and staff were taken ill. The subsequent public inquiry into the incident found an apalling situation. The kitchens contained open drainage channels infested with oriental cockroaches. Drains in the pan washing area gave off such an offensive smell that staff could not work there. Kitchen tables and food preparing services were washed down with the same mops and buckets that were used for the floor.

The part played by Wakefield CHC was noted and their 'considerable assistance' put on record.

Source: Report of the Committee of Inquiry[49]

Monitoring Local Authority Services

Because CHCs consider health services from the point of view of users, they are aware of shortcomings in collaboration between local authority and health services, hospital staff and NHS community staff and General Practitioners. When reporting on issues, such as hospital discharge procedures, or rehabilitation of mentally ill or handicapped, the provision of local authority services has to be considered. In considering prevention of ill-health and in determining the level of health care needed, housing and economic circumstances are very important.

PUBLIC TRANSPORT AND ACCESS TO HEALTH SERVICES

In 1984 the Government proposed the de-regulation of bus services and to allow private operators to compete in order to keep down costs and fares. Subsidies would still be given to keep uneconomic services going, with bids being put out to tender. Especially in rural areas, many essential services require heavy subsidies to operate. A number of CHCs investigated how the withdrawal and reduction of such services would effect people visiting doctors and hospitals. In three rural areas, Devon, Hereford and Worcester, the Government had already experimented with removing regulations.

In Plymouth the new expanding general hospital is in Derryford and the present bus service means that about half the population are within a quarter of a mile of the direct bus route to the hospital. The direct bus route was not commercially viable. Plymouth CHC opposed an application for a route which would have resulted in a curtailment of the service to the hospital. It was demonstrated to the Traffic Commissioners, that the current services were needed in the interests of the public and hospital patients.

Source: Community Health News, No 1, November 1984

Monitoring the Environment

Many have commented that the NHS concentrates on sickness rather than preventing ill health. Wider social and public health issues may become lost in the increasing importance given to expensive high technology answers to medical problems. In 1974 the role of the Medical Officer of Health was transferred from local authorities to the NHS, as the District Community Physician, (now District Medical Officer). However, public and environmental health are still mainly the responsibility of local and national Government.

Some CHCs have taken up environmental issues, including pesticides, and the potential hazards for people living near nuclear installations, where there are above the national rates of childhood leukæmia. District Medical Officers and District Health Authorities have generally shown little initiative in investigating reports of abnormal disease rates. CHCs in areas at risk have taken up this issue.

ENVIRONMENTAL HAZARDS

North Devon CHC has drawn attention to problems of families living near the Re-Chem plant at Bonnybridge near Falkirk and a similar plant in Wales. Chemicals processed in the plants included 245T which releases dioxin, traces of which have been found in soil surrounding the industrial plants. Apart from deformed and sick cattle in nearby farms, there have been cases of babies born with severe eye defects or without eyes at all. A similar deformity is found in Vietnamese babies whose parents were exposed to the 245T-based defoliant, Agent Orange.

In other areas there are incidences of doctors' surgeries suddenly filling up with people complaining of rashes, stinging eyes, sore throats and headaches and other minor ailments after intensive crop spraying. Durham CHC took up the incident in June 1984 in Blackhall when 12 people were treated in hospital and people in the area were not able to eat fresh vegetables for 28 days, following aeroplane crop spraying.

District Medical Officers and District Health Authorities have been reluctant to investigate such complaints or accept CHC representations on the grounds that this was an environmental health matter.

Source: Community Health News, 3 January 1985

Monitoring the Private Sector

CHCs have been concerned with patients in private hospitals, nursing homes and 'bed and breakfast' hotels, who are not otherwise represented.

For acute illness, people may choose to go to a private hospital. There is an element of consumer choice and the traditional market forces generally ensure reasonable standards. An increasing number of the more vulnerable groups, elderly, mentally ill and mentally handicapped people, are being admitted to private facililties and paid for at public expense. With the move towards community care, the use of private homes by the NHS and local authorities for their ex-patients/clients is increasing. These patients are in particular need of protection.

Standards in the private sector vary. Statutory control of private establishments ensures the fulfilment of basic requirements. Nursing homes are inspected by the DHA and residential homes by the local authority. However, boarding houses and hotels, which are accommodating an increasing number of ex-psychiatric patients are not inspected.

Some CHCs have negotiated informal visiting arrangements with some private proprietors. There is an increasing awareness of the need to monitor health care in the private sector, which is taking over the care of many for whom CHCs work.

CONSUMER GUIDE TO PRIVATE NURSING HOMES

In 1983 Oxfordshire CHC published a Guide to Nursing and Old People's Homes in Oxfordshire. The Guide, which was updated in 1985, gives information on the amenities and facilities as well as the charges. The purpose of the Guide is to help elderly people and their families and friends to assess the Home before making a choice.

The survey was undertaken by CHC members and staff visiting every private, voluntary and charitable Nursing and old people's home in Oxfordshire.

Source: Oxfordshire CHC, A Guide to Old People's Homes and Nursing Homes in Oxfordshire, 1985.

PRIVATE MENTAL HOSPITAL IN CAMBRIDGE

In 1985 Cambridge Health Authority gave permission for a 55 bed private secure unit, Kneesworth House, near Bassingbourn, for the mentally disturbed patients compulsorily detained under the Mental Health Act. In granting permission the Health Authority said that patients would not normally be admitted from Cambridge since they had strong doubts about the sort of treatments which would be used. Another hospital for the mentally ill, run by the same commercial firm, has been heavily criticised for its co-ercive use of drugs. The only outside committee associated with the hospital is appointed by the hospital owners.

The CHCs request for general visiting rights was refused, though they were given the right to visit patients in contractual beds paid for by the NHS.

Source: Community Health News, No 9 September 1985

4 IDENTIFYING UNMET NEED

CHCs have piloted new ideas and approaches to health care and developed a wider role than that envisaged in 1974. Some CHCs have worked, often with local voluntary groups to identify unmet need and promote the development of self-help groups and community health projects. There is controversy among CHCs about whether this exceeds their remit. Some feel that CHCs should restrict their activities to statutory duties, because of their limited resources.

These new ideas and approaches are important to the health service because, among other reasons, they are a good way of influencing health behaviour. Stephen Hatch has written, *"CHCs are strategically placed at the interface between the health service and the public. Mainly they have sought to represent consumer views, but some have also tried to promote lay involvement in self-care and mutual aid. Their proper role is a dual one, however difficult it may be to balance the two elements of it".*[50]

For CHCs adopting this broad approach, there have been benefits:

1. The CHC establishes its independent identity with the public and the NHS. Separate funding has been obtained for some projects and this gives the CHC more independence in the NHS.

2. The CHC sets its own objectives rather than reacting to NHS management. Going out to the community to identify new areas is creative and more rewarding for CHC staff and members than commentng on DHSS, RHA, DHA and FPC consultations.

3. The CHC acts as a catalyst for innovatory ideas and new services and encourages good practices. The CHC is in a unique position to do this, because it has links with the NHS, local authority and community staff and voluntary organizations.

4. The CHC can promote change by bringing to the attention of NHS staff what can be done with few resources.

5. The CHC chooses to concentrate on activities where it feels it can have the most impact on the health of the community.

INEQUALITIES IN HEALTH IN GREENWICH

The Black Report in 1980 showed the inequalities in health between people from different social classes and the impact of social, economic and environmental factors on health. In 1984 Greenwich CHC looked at the health of local people in Glyndon ward. The aim of the project was to examine the health of people living there and to help them to improve their own health. It was funded by the local authority.

Glyndon is a poor area: 56% of people living there receive housing benefit; there are no dentists in the area; only one chemist; no well-baby clinics; no family planning clinics and only two single handed doctors operating branch surgeries.

The health of respondents and their children was poorer than that of even some inner city areas of London. A number of people said that they had mental health problems and unemployment, poverty and money troubles. Housing came high on the list of factors causing stress. Respondent's occupations had a direct impact on health — a large number said they had suffered illness or injury due to the type of work they did. Lack of money was given as a reason for poor diet.

People from ethnic minorities had particular problems in communication and knowledge of local services available. Their take-up of services was very low. On the whole, in line with the Black Report, community services were found to be inadequate, poorly organized and relied too heavily on hospital services.

The report concluded that environmental and social factors meant that people living in Glyndon were in need of a greater provision of health services which they were not receiving.

Source: Community Health News, No 9, October 1985

EXETER: HEAD INJURY

Survivors of serious head injury face a frightening new life. The survivor may have to face personality changes, loss of memory concentration and motivation. In addition there may be physical problems of impaired mobility, speech and co-ordination.

Exeter CHC looked at what happened once the patient was out of danger and had left the acute ward. The survey found that many had received no follow-up help. There were only very few specialist rehabilitation centres, outside the region, which could help a small proportion of patients. The report was published in June 1984.

The most important conclusion was that there was a *"lack of any defined responsibility, either administrative or medical, for brain-damage patients. The result is that they can find themselves the inappropriate responsibility of one of a number of specialities depending on which of their symptoms is manifest. None of the specialities to which they are referred is equipped to deal with all the needs of the brain-damaged. Thus services for the mentally handicapped, the mentally ill, the young chronic sick, stroke sufferers and others are struggling in isolation to do something for a small numbers of patients who are not really the main concern of the service."*

Source: Exeter CHC Annual Report 1985

CENTRAL MANCHESTER: AIDSLINE

In February 1985 Central Manchester CHC sponsored a meeting with the gay community on AIDS. Following this meeting, a telephone counselling service began operation for 3 evenings a week in October 1985. Aidsline gives information about aids, HTLVIII-testing and advice on ways of reducing risk.

The Steering Group, which is serviced by the CHC, is seeking funding from the RHA for further developments, which include: support and training for district testing; advisory services on multi-district basis; the establishment of local non-medical counselling services; and a co-ordinated health education programme.

Source: Central Manchester CHC

THE WELL WOMEN OF WESTON

Following inquiries from women after an article in a Sunday paper, the CHC held a public meeting where women attending asked why there was no well-woman service in Weston.

The District Management Team informed the CHC that such a service would be uneconomic, there was no money and they would not give it priority. The CHC held a public meeting and were astonished by the response. Speaker after speaker complained of hurried or unsympathetic doctors who had told them to 'buck up' or take tranquillisers. What they wanted was the opportunity of having unhurried consultations with a woman doctor in Weston.

When Weston Health District was merged with Bristol, it was agreed to change an existing clinic to cytology, breast screening, blood, urine and weight tests. Meanwhile the CHC organized a series of educational meetings, with professionals answering questions on topics such as pre-menstrual tension, depression and self-examination of the breast.

Developing from this basis, the screening clinic became the Weston Well-Woman Clinic, with the Family Planning Association running a counselling clinic and the Marriage Guidance Council offered skilled leaders for therapy groups.

Source: Martha Perriam, CHC News, No 49, December 1979.

COALITION FOR COMMUNITY CARE: KENSINGTON, CHELSEA AND WESTMINSTER

The Kensington and Chelsea and Westminster AHA planned to merge two large Victorian psychiatric hospitals — Banstead and Horton in Surrey — and use the money released from the early closure of Banstead to develop locally based services. Following the 1982 re-organization, the AHA was divided *into three District Health Authorities, two Regional* Health Authorities and two local authorities. The CHCs considered that this would increase fragmentation and make joint planning an even more remote possibility, unless a fresh approach to collaboration could be achieved.

The Coalition for Community Care was set up in 1982 by the three CHCs, Paddington & North Kensington, Victoria and Bloomsbury, and two local mental health associations covering Kensington & Chelsea and Westminster. The Coalition's primary aim is to promote the development of community care for people with local mental health problems. *In 1984 it obtained independent funding for two* staff to develop further the programme of seminars, information dissemination and promoting innovative approaches to the development of community care.

Source: Coalition for Community Care, Annual Report 1985

5 ADVOCACY AND INFORMATION AND ADVICE TO THE PUBLIC

People need information in order to participate in the NHS and their own health care. Providing information and advice to the public assists in the development of 'informed consumers' who are more able to be partners with professionals in their health care. It can also assists those groups of people who are at a disadvantage in obtaining the health care they need — people from ethnic minorities, mentally handicapped and mentally ill people and people with a disability.

Information and Advice

Providing an information and advice service is also a practical way of helping people and gives the CHC a public identity.

Some CHCs have shop front premises accessible to members of the public to call in for information and advice. This involves additional work and many 'High Street' CHCs close their offices to the public for parts of the week in order to get other work done. North Gwent CHC, when it moved to new shop front offices estimated that their workload trebled.

In Manchester the three CHCs share office premises and employ an information officer. Most CHCs are less fortunate, though some share accommodation with advice agencies, which helps in making referrals for non-NHS enquiries. Most CHCs help individuals to sort out problems with the NHS. For example, concerning discharge from hospital or loss of pathology reports or identifying hospitals where a particular type of treatment is available.

Many CHCs have produced leaflets and handbooks about services and how to use them, covering local authority and voluntary organizations as well as NHS services. They have produced leaflets and handbooks on patients rights, including in a variety of languages for ethnic minorities.

In addition, they have available DHSS and health education leaflets. Some CHCs have also undertaken seminars and training programmes both for members of the public and health service staff.

INFORMATION FOR PATIENTS ABOUT GPS

Exeter CHC in 1985 worked with the Local Medical Committee to produce a 'model' leaflet for GPs to give information to their patients about the services they provide and how best to use them.

The 'model' has been circulated to all GPs in the hope of encouraging them to produce (or in some cases modify) their own leaflets.

Source: Exeter CHC Annual Report 1985

LEEDS: IDEAS IN GENERAL PRACTICE

In 1984 Leeds West and Leeds East CHCs circulated all local GPs to identify examples of new and innovative developments in primary care.

The resulting report covers good practices of local GPs including a 'Well-Person Clinic', an anti-obesity clinic and preventive brief counselling.

Source: Ideas in Practice, Leeds West and Leeds East CHCs, 1985

GOOD PRACTICES IN MENTAL HEALTH

The Good Practices in Mental Health project was set up by the International Hospital Federation in 1977 to discover and publicise details of noteworthy small scale schemes for aiding mentally ill people and their families.

Each local study gathers information on a number of projects for people at risk due to stress or mental ill-health. The identification of good local services raises the morale of staff involved and publicises little known resources. The studies also have an educational role and have been used as the basis for local conferences and training programmes for staff in hospitals and the community.

About 65 projects have been or are at present in progress, over half of which have been co-ordinated wholly or in part by CHCs. CHCs have found that the 'non-threatening' approach of the project can help to break down the barriers between the organizations involved and clear the way for the closer co-operation and planning of future services.

Source: Good Practices in Mental Health

MANCHESTER: DIFFICULT PATIENTS OR DIFFICULT PROBLEMS?

In 1983 the three Manchester CHCs were approached by the FPC about patients who found it difficult to establish and maintain a good relationship with their GP, and consequently kept changing GPs. A 6 month pilot scheme was set up, and renewed subsequently. Under the scheme the FPC refers to the CHCs 'problem' patients who can then be 'counselled' on their attitude, approach and expectations of their GP.

Manchester Medicine, March 1986

THE ERALDIN CAMPAIGN

In 1977 a young mother with 3 children wrote to Merthyr and Cynon Valley CHC asking for help. She had suffered side effects from the heart drug Eraldin, including deteriorating eye sight and hearing, skin rashes, body pains. The CHC launched a campaign calling on all health councils in England, Scotland and Wales to help.

It emerged that Eraldin had been prescribed more in some parts of the country than others and that some people were having difficulties in establishing whether or not they had been prescribed Eraldin, as some GPs were unwilling to give them details of treatment.

Until this campaign Eraldin sufferers were isolated and many let the case fall rather than go through the bother of an expensive legal battle with a transnational drug company. However, forming themselves into groups bolstered their determination and they gave each other new hope.

Source: Bryn Williams, CHC News, No 32, June 1978.

ADVOCACY

Advocacy services represent people who find it difficult to express their own needs and to obtain access to the services they need. This may be because they are mentally handicapped, have language difficulties or are socially or culturally disadvantaged.

The advocate works in partnership with the person, to help to ensure s/he receives necessary services and to give practical help. Where the advocacy scheme is for people with a mental handicap or mental illness, it can provide an important support in the community, particularly for those discharged from long-stay hospitals.

An advocate must be independent of the service provider and CHCs have provided an excellent base for the development of advocacy schemes, often in association with voluntary organizations.

CITIZEN ADVOCACY IN HEREFORD AND WORCESTER

In the USA all mentally handicapped people have the right to an advocate to represent their interests on the basis of trust and partnership. In the UK there is no such right to an advocate and advocates have no right of access to a hospital resident.

In 1986 a citizen advocacy scheme was set up in Worcester and Hereford with funding for three years from the DHSS Opportunities for Volunteering Scheme. The Kidderminster and District CHC worked jointly with Project DIS-CO (a resettlement project for patients from two mental handicap hospitals in the district). The initial idea was to provide this service for people leaving hospital through Project DIS-CO, but they intend to extend the service to include people already living in the community and those still in hospital.

Volunteer advocates are recruited and given training and support. Volunteers are matched with each mentally handicapped person. They develop long-term relationships, both befriending them and representing their interests, for example, in helping them claim appropriate benefits. Mental handicap services are undergoing dramatic changes and resettlement exposes people to new situations and stresses. The advocacy service will assist in the actual process of resettlement.

Source: Kidderminster & District CHC

HEALTH ADVOCACY FOR NON-ENGLISH SPEAKING WOMEN

In 1979 City and Hackney CHC were concerned about the way antenatal care was being delivered, in particular to non-English speaking women. Their inability to present their problems and their lack of knowledge of the system made them particularly vulnerable to bad care.

The CHC obtained funding from the Inner City Partnership to employ health workers to work as patients advocates. The project aimed:
• to improve access to health services,
• to help women understand the choices open to them so that they can make informed decisions
• To advise the Health Authori ty on policy and practice with regard to the needs of non-English speaking women
• to help and encourage NHS staff to provide a service to this high risk group.

The project employs 6 workers, who between them are native speakers of Turkish, Gujerati, Bengali and Punjabi. They do not only translate but speak on behalf of the patient to make sure her needs and problems are presented to staff. Many of the staff wanted someone to interpret hospital policy for the patient. Instead the workers queried the services on behalf of the patients. From these individual requests came suggestions for policy changes. Issues tackled have included: food in hospital; access to women doctors; racist behaviour; conveying bad news; keeping ethnic records.

A study compared a random sample of non-English speaking women who attended the hospital before the project commenced in 1979 and a group attending in 1984. There are improvements in take-up of antenatal care, nutritional status of the mothers and birth weights, which can be attributed to the project. No trends were found in the control group of English speaking women, except an increase in incidents of default in antenatal attendance.

This model has been followed in other areas. A further scheme is being developed by the project for black English speaking women at Queen Elizabeth Children's Hospital and the model can be extended to anyone who is particularly vulnerable. It is a logical extension of a CHCs role as a 'patient's friend'. Advocacy schemes such as this need to be based outside the health service, either in a CHC or a voluntary group, so that the worker is not a part of the hierarchy being questioned and can be given support in pursuing issues on behalf of the patients.

Source: An Experiment in Advocacy, The Hackney Multi Ethnic Women's Health Projects, Ed. Jocelyn Cornwell & Pat Gordon, Kings Fund Centre, December 1984.

SELF-ADVOCACY FOR PEOPLE WITH LEARNING DISABILITIES

West Lambeth CHC has been involved in setting up a small scale scheme for self-advocacy for people with learning disabilities.

This involves a 2 hour assertiveness training session on a weekly basis. It is funded by the National Bureau for Handicapped Students.

Source: W Lambeth CHC

6 COMPLAINTS AND ACTING AS A PATIENT'S FRIEND

People make formal complaints when they do not feel that they can communicate their experiences in any other way. Most complaints are an attempt to improve the system rather than cause trouble. There are three major criticisms of the way some complaints are presently handled:

- Complainants can meet with hostility and they fear adverse consequences
- Complaints are not generally investigated independently
- Complaints procedures are not always known or understood by patients or health care staff

The 1974 Re-organization Circular suggested that CHCs should direct their attention to:

"Complaints: the volume and type of complaints received about a service or institution. The investigation of individual complaints will be a matter for the health authority and its staff or (where appropriate) for the Health Service Commissioner or Service Committee but Community Health Councils will be able, without prejudging the merits of an individual complaint or seeking out the facts, to give advice, on request, on how and where to lodge a complaint and to act as a 'patient's friend' when needed. A CHC will also wish to bring any potential general causes of local complaint to the notice of the AHA."[2]

CHCs are in a good position to help people with complaints and, if possible, mediate with the health service to secure a resolution. The Royal Commission on the NHS recognised the importance of CHCs in assisting complainants and recommended that CHCs be given more resources to extend their role.

However, in the Consultative Document on the role and membership of CHCs in 1981, the Government suggested that:

"Other sources of help are available to people who wish to pursue a complaint — personal friends, the complainant's Member of Parliament or local councillor, Citizens' Advice Bureaux. Ministers do not therefore propose that CHCs should extend their role formally to providing an individual service to complainants, for instance, by writing to health authorities on their behalf or acting as 'patient's friend' at an inquiry."[1]

CHCs have taken different approaches and given different priority to helping complainants. In a 1982 survey 10% of members saw assisting patients with complaints as the most important CHC activity, 16 % seeing it as the second most important activity.[12] Dealing with complaints is time-consuming and can be emotionally distressing. Complaints may create conflict with professional staff, who often do not understand the CHC's role. The role of 'patient's friend' is open to different interpretations and has been seen by FPC and health staff as an advocacy role, which, they consider, may destroy the possibility of an 'understanding' between the complainant and those about whom the complaint is being made.

Family Practitioner Committees have a more standardised and formal procedure than District Health Authorities. FPCs do not investigate complaints, but let both 'sides' state their views before Service Committees, which have a lay chairman and are made up half of lay people and half of professionals (generally working in the same locality as the practitioner against whom the complaint has been

made). In 1980 62% of CHCs had assisted a complainant at a Service Committee hearing[13]. CHC Members can present the case for the complainant at a formal hearing, but CHC Secretaries are sometimes deemed 'paid advocates' by the Chairman of the Service Committee. In North Tyneside, the FPC has given the CHC the opportunity to send an observer to Service Committee Hearings, in addition to the entitlement of the complainant to bring along a 'friend', who may be the CHC Secretary.

While in England there has been difficulty in accepting the CHC Secretary in the role of 'patient's friend'. The situation is different in Wales. In England, complaints about clinical judgement are referred to the Regional Medical Officer. In Wales they are referred to an independent Medical Officer for Complaints. The Medical Officer for Complaints considers that the presence of a CHC Secretary is helpful in the Reviews. If the complainant is subsequently dissatisfied, s/he may claim that the Review was not conducted properly or impartially. If a CHC Secretary is present, s/he may be able to testify that the Review was satisfactory, even though it may not have supported the complainant.

BEING A PATIENTS FRIEND

In February 1983 a woman in her late 60's was admitted to hospital with bed sores which were so deep and infected that her general health had deteriorated and her life was in danger. She had to visit the operating theatre five times to clean the sores and have skin grafts. She remained in hospital for 10 months.

Her husband, Mr X, came to the CHC to complain about the GP and district nurse who had let this happen. He said that his wife had been treated in hospital for arthritis of the hip in 1982 and when she was discharged had small bed sores. Since her discharge she had been receiving physiotherapy and occupational therapy at home. This was stopped then the pain from the sores was so great that she could not stand. Mr X said he had repeatedly told the nurse and the GP that his wife's bedsores and general health were deteriorating and asked if she could be returned to hospital if nothing else could be done at home. He also said the doctor did not look at the bedsores or examine her physically. He just repeatedly gave her pain killers. The GP referred her to hospital only after a relief nurse, apalled by her condition, had insisted that he did something.

Mr X was in his 70's and frail with a heart condition. The CHC explained the complaints procedures — how long it would take, the kind of problems which could arise and the fact that the GP might strike him off. He decided to proceed in order to prevent the same experiences happening to other people.

The CHC supported Mr X in all correspondence with the FPC, who, at the start, maintained that the complaint was 'out of time'. They also informed him that he had been removed from the GP's list and the CHC were involved in finding him a new GP. The GP, in his response suggested that Mr X had been neglected his wife and had prevented her from going to hospital outpatients. The CHC assisted Mr X to get letters from the neighbours who had helped him look after his wife. They also obtained letters from the physiotherpist and occupational therapist who said that they had stopped his wife going to outpatients because of her condition.

At the Service Committee hearing held by the Family Practitioner Committee in November 1983, the CHC Chairman presented the case for him as he was so distressed. The District Nurse gave evidence as a witness for the GP, saying that she considered the treatment she was giving was quite adequate.

The GP was found to have failed to comply with his terms of service and recommended to comply more closely in future.

The CHC also took up the complaint with the District Nursing Officer, who refused to inform Mr X or the CHC of any disciplinary action taken against the nurse.

Source:ACHCEW

7 HEALTH EDUCATION AND HEALTH PROMOTION

A CHC can be involved in health education and promotion in five ways:

1. By undertaking health education activities
2. By giving information on health issues to the public
3. By carrying our surveys and studies
4. By monitoring health education activities
5. By acting as a pressure group both inside and outside the NHS for health education.

A survey undertaken in 1985 looked at the contribution of CHCs to health education for school age children. The results showed that 73% of CHCs were concerned with child health education; 24 % had themselves carried out health education activities for 5-16 year olds; 11 % were not, or only passively, interested in child health education. [51]

Table 13: CHC views on the importance for a CHC to undertake health education

CHC Response		
Unqualified No	39%	(72)
Qualified No	10%	(19)
Qualified Yes	15%	(28)
Unqualified Yes	29%	(54)
No response	7%	(13)
Total	100%	(186)

Table 14: Reasons given for not undertaking health education

CHC Response		
Institutional: not CHC role	27%	(50)
not CHC skill	13%	(25)
Contextual: not priority (now)	19%	(35)
already done by other	7%	(13)
Financial: lack of funding	24%	(45)

N = 186, More than one answer possible. Source: Piette[51]

The study concluded that the first priority of CHCs in child health education was to press for the implementation of an operational Health Education Unit in their District rather than to become involved with health education themselves.

1. *"Within the limits given by the DHSS, (CHCs) are unable to perform anything [other] than an occasional non-professional health education activity."*

Health education projects where CHCs sponsored a project or raised separate funding were considered exceptions.

2. *"It was unrealistic to expect all CHCs to undertake health education as long as no... substantial improvements are achieved in areas with more urgent needs".*

3. There is a lack of *"guidelines for a health education policy. All the time CHCs can possibly give for child health education should be better devoted to pressing for and monitoring such a policy".*

The report argued that CHCs should stick to activities where their expertise as community representatives is most appropriate (i.e. monitoring and pressing for services) and leave service provision (i.e. giving information and undertaking health education activities) to the professionals. It stresses the importance of the CHC's role, in particular in an area where the lack of general policy had led to child health education suffering from *"a lack of continuity, integration, comprehensiveness, scientific approach, education towards participation and did not concern all children".*

CHILDREN'S HEALTH CLUB

Two boys living near St Thomas' CHC in Lambeth began calling in after school asking if they could do anything in the CHC shop. This made the CHC think about how they might make contact with local children and so a weekly Health Club developed. The aims of the project were to increase awareness of the factors affecting health; identify the health care issues that most concerned children and their parents living near the office and encourage a positive attitude to health.

During the Easter Holiday in 1977, the CHC ran a health event for children aged between 5 and 12 years. It was planned around the subject of nutrition and health with particular emphasis on the importance of fibre in the diet. Over 4 days, 30 children considered nutrition and digestion, including a visit to the local baker to see him make his weekly batch of brown bread. As the project developed it adopted a non-directive peer group teaching approach.

In 1979 a grant was obtained to employ a full-time worker to run and evaluate the club. The report concluded that the project was an innovative approach to child health education.

Source: Sally Weston, Sue Thorne, CHC News, No 22, August 1977 and Danielle Piette in (49)

DEWSBURY; CHILDREN'S MULTI-COLOURED HEALTH WEEK

For five days in July and August 1979, Dewsbury CHC ran a 'Children's Multi-Coloured Health Week' to promote health education and to associate health information and activities with having fun.

The event was held in the town hall with two sessions daily. Children were kept busy all the time, working around the activities at their own pace. These included: a Hospital Corner, to help familiarise children with hospital, basic First Aid Training, run by St John's Ambulance Brigade; cookery, painting and games, with a health message. There was also a Teeth Corner, a Food Table and a Home Safety Quiz, run by the area Health Education Department.

About 500 children from 3 to 13 years attended the sessions.

Source: Joy Gunter, CHC News, No 50, January 1980

SCREENING FOR CERVICAL CANCER; NEWCASTLE'S CAMPAIGN

In 1985 Newcastle CHC held an open meeting to promote discussion about take-up of cervical screening. Following this, the CHC obtained a grant from the County Council to co-ordinate a campaign using the Women's National Cancer Control Campaign Mobile Unit for 10 days in November 1985.

Sites were identified in conjunction with local groups and leaflets circulated to houses in those areas.

Women attending were asked a few questions about themselves and their response to the cmapaign. The review of the campaign highlighted requirements for future campaigns.

Source: Screening for Cervical Cancer: Report of a Campaign on Tyneside in 1985, Newcastle CHC.

8 CHCS AND REGIONAL AND NATIONAL POLICY

While CHCs are essentially local bodies, most want to comment on national policies which affect the health of the communities they represent. CHCs can comment on national issues in a number of ways: directly to Ministers; to the DHSS; MPs; and through the Association of Community Health Councils for England and Wales (ACHCEW) or regional networks of CHCs.

However, each CHC has its own style and many have been ambivalent about involvement on a regional, let alone national level. The lack of strong regional or national structure has reduced cohesion among CHCs.

CHC Regional Organizations

Most CHCs within regions meet on a regular basis to discuss general issues. Wales has its own national association. In England the organization of CHCs in the regions is generally loose and rarely a basis for concerted action. Each Region has a different structure and membership. All the work involved is generally done by CHC staff and members. In the North West Thames Region CHCs employ a part-time worker to service the committee, paid for by the RHA.

Regional Health Authority boundaries include urban and rural areas. Resource allocation may lead to a conflict of interests between urban and rural districts in the same Region. In London, CHCs are divided between the 4 Thames Regions. In 1983 the Greater London Association for CHCs (GLACHC) was set up with GLC funding to undertake London wide research and deal with common problems. In 1985 the post of development officer was established. GLACHC has started training workshops for staff and provides a forum for discussion.

A regional CHC structure with staff and funding would mean that:

1. CHCs would have the resources to monitor and comment systematically on long-term planning and activities of the Regional Health Authority.

2. There would be a properly resourced forum for sharing information and collaborating on issues of common concern.

3. There would be a basis of researched information about issues to assist in resolving disagreements between CHCs and enable the development of coherent policy directions.

4. CHCs could more easily work together and enable a national association to build up and maintain links with members.

Association for England and Wales

In February 1975 David Owen, Minister of Health, announced to a conference of CHCs that he intended to form a steering committee to establish a national council for CHCs. He hoped that, by the end of 1975, the national council would present a strong independent 'patient's voice' at national level. *"He said that the relationships with family practitioner committees was one example of where the unfortunate experiences of independent CHCs could be fed into the national council. He gave the impression that this centrally collected information could become a powerful aid to a minister in attempting to put to rights some of the unfortunate administrative features of the re-organized National Health Service".*[22]

The Government assumed that CHCs would welcome a national voice and the strength it would give them. However, many CHCs resented the imposition and mistrusted the Government's motives. Following consultation the *"concept of a much looser confederation of councils having a small unit working directly for them rather than being seen as a permanent secretariat looking to the DHSS, had a considerable attraction to the steering group and the majority of councils it had consulted".*[22]

In May 1975 the first issue of CHC News, a house magazine for CHCs with aspirations to a wider audience, was produced with DHSS funding.

Twenty months later, in November 1976, a national conference of CHCs decided in favour of forming an association. One hundred and twelve CHCs voted in favour, ninety-one against and twenty-six did not attend the conference. The aims of the new Association of Community Health Councils for England and Wales (ACHCEW) were to provide a forum for CHCs, to act as their national voice, to provide information and advisory services and to encourage, promote and protect the independence of individual CHCs. The DHSS provided a grant to cover CHC News and an information service. The remaining funding was to come from membership subscriptions.

In 1981 the DHSS announced that the funding would be withdrawn over two years. This resulted in a financial crisis in 1983 and the DHSS provided deficit funding for the following 2 years. CHC News and the information service ceased and 3 staff were made redundant, leaving three staff in position at ACHCEW.

In 1984, at a Special AGM, CHCs agreed to continue to support ACHCEW and fund it from subscriptions, varying from £250 to £750 a year according to their budget allocations. In 1983/4, 205 out of 217 CHCS were in membership, compared to 175 out of 216 CHCs in 1985/86. In 1985/6 the DHSS restored the grant to ACHCEW and gave £20,000 for an information officer and administration.

The Annual General Meeting determines ACHCEW policy. In the past it has focused on debating motions on policy. The trend is towards member CHCs sharing and learning from each other. The Standing Committee, made up of Regional representatives and Secretary Observers, resolves matters of policy and makes representations and comments on behalf of CHCs between AGMs. The main activities have been to consider issues of a 'national' nature, thus enabling CHCs to concentrate on local issues. ACHCEW has acted as a test bed of ideas and a source of information on what is happening in different CHCs. It also developed the role of advocate for CHCs at national level. In 1986 a Patient's Charter was launched to

promote a better understanding with patients and health staff.

ACHCEW did not become the 'Patient's Voice' envisaged by the DHSS in 1975. It did not develop training programmes, encourage research at academic level or self-evaluation. Some of the problems of ACHCEW up to 1983 were internal, caused by resource difficulties and disputes about the purpose of CHC News and the Association. However, the basic cause goes back again to the nature of CHCs and the way they were set up in 1974:

1. ACHCEW was set up without the whole-hearted support from CHCs, who were suspicious that they would lose their independence and be associated with views they did not share. ACHCEW had to tread carefully to keep consensus among CHCs with opposing views. The antagonism between London and other CHCs has been a consistent theme of ACHCEW meetings.

2. CHCs do not have a clear overall philosophy, compared to voluntary organizations. People are involved with voluntary organizations because of their personal commitment to the aims of the organization. The underlying philosophy of CHCs is a belief in the NHS and a role for its users. However, the NHS represents many diverse and conflicting interests and ways of providing health care.

3. The ratio of paid staff to voluntary members restricts the activities in which a CHC can be involved. CHCs have given priority to their own districts. Work undertaken on a national and regional level may detract from what members and staff can achieve locally.

4. The lack of strong regional structures makes it difficult for ACHCEW to build up and maintain strong links with the membership. It tends to relate to members individually which lessens the possibilities for learning and sharing from each other's experiences.

FIGURE 1
SUMMARY OF DIFFERENT APPROACHES OF CHCS

Relationship with the NHS	
← CHC sees itself as part of the NHS	sees itself as independent of the NHS →
CHC relates mainly to NHS management	relates mainly to community groups
CHC interests reflect the sickness-orientation of the NHS	sees health in the context of well-being of the community
Relationship with the community	
The community is represented through CHC members only	CHC encourages community participation
Terms of Reference	
CHC concerned with local issues	sees local issues in terms of national context
CHC sees itself as outside 'politics'	sees the CHC as part of the wider 'political' debate.
CHC activities closely tied to monitoring NHS	defines remit in broad terms, including the environment
Working Methods	
CHC advises the NHS management and reacts to NHS proposals and actions	undertakes health related projects in the community, raises separate funding, initiates discussion & promotes new ideas from the community
CHC does not involve local people in forming views	consults widely using surveys, public meetings, etc. before forming a view.
CHC staff service the members, not initiating activities themselves.	Staff initiate new activities

9 THE IMPACT OF CHCS ON THE NHS

Evaluating Effectiveness

It is difficult to evaluate the work of CHCs, because there are no agreed criteria for assessing their effectiveness, nor is there agreement about what are or are not appropriate activities for CHCs. Some CHCs see themselves primarily as a part of the NHS, reflecting the priorities of the NHS of caring for sickness. Others see health in a wider context of the well-being of the community and the people in it.

"CHC News induces a sense of inferiority in many CHC members and Secretaries when they read of the many and varied activities of their colleagues up and down the country.... It is only when the projects are analysed that the doubts appear. It is not the function of a CHC to run a health education department or a citizen's advice bureau.... There is scarcely anything in everyday life which does not have a bearing on health. That a CHC should therefore be prepared to concern itself with every aspect of everyday life does not necessarily follow. There are two important areas, of social services and environmental health, into which many CHCs have strayed and thus exceeded their terms of reference".[52]

The public, the NHS management and the Government have different expectations about what a CHC should do and these are not necessarily compatible.

Different Approaches of CHCs

The lack of guidelines has given CHCs scope to develop in different and innovative ways. It has also given rise to misunderstandings and conflicts with NHS management and variable standards.

1. Service Promotion or Service Provision?

The line between promoting good practice and service provision is thin. Some CHCs have become involved, often with voluntary groups, in providing a patient's advocacy service, information, training and health promotion. Others consider that CHCs should press for the NHS to provide such services, if they are needed, rather than directly facilitate provision themselves. However, an independent body such as the CHC is in a better position to provide independent advice and advocacy services — the NHS cannot provide advocacy against itself.

2. NHS or the Wider Community?

Some CHCs have restricted their comments to services provided by the health authority. Others have taken a broad view of their remit to include public health and care for vulnerable groups of patients, such as those in private residential care.

3. Choosing Priorities for the Community?

Some CHCs put forward the views of the community, without choosing priorities, which they consider the task of management. Other CHCs feel that, by assisting management in choosing priorities (which may include agreeing closures and changes in use), they are actively helping to put more resources into services for priority groups, such as mentally ill, handicapped and elderly people.

4. Reacting to the NHS or Setting the Agenda?

It is easy for a CHC to find that all their time is taken up responding to tasks given to them by the NHS manage-

ment. Some CHCs have decided to concentrate their energies in areas where they feel they may have more impact and have given priority to identifying unmet need and working with the community to promote good practices.

5. Central Activities of the CHC

CHCs have concentrated on different activities. Some, generally those with High Street premises, give priority to dealing with individual problems. Others affected by cuts give priority to responding to consultation documents on closures and changes of use.

Looking at CHCs from the view of their relationship with the user, Fedelma Winkler has identified four 'groups' of CHCs:

Group 1
The 'Bureaucratic' CHC, which concentrates on the formal functions and spends much of its time responding to consultation documents, and commenting on the planning process of the DHA.

Group 2
The Health Educators: who put the main emphasis on health education and health promotion. This can give a high profile and acceptable face, generally concentrating on issues that promote a change in behaviour of the individual.

Group 3
User Advocates, who produce independent information for users, do considerable work with complaints and campaign for policy changes, acting as user advocates.

Group 4
Community Health Pressure Groups, who concentrate on community campaigning, extending their brief to include public health issues, such as housing and unemployment.

"Features of each may be found in all CHCs and in particular there may be considerable overlaps between Group 1 and 2, and between Group 2 & 3, and between Group 3 & 4, and inside each group are those who do the central task well and some who do very little of anything".[53]

Standards of Good Practice

Each CHC has defined success in its own terms, and CHCs need to consider their most appropriate role and how they can be most effective. However, an effective CHC must be one which conscientiously represents its community and health service users. There are basic principles for all CHCs:

1. The NHS is service to local people. Everyone has the right to be involved in all aspects of their health care.

CHCs look at health services as users, not staff or management. The CHC has a distinct consumer view on health authority proposals. If a CHC is doing this, conflict may be inevitable, however 'reasonable' the CHC or the NHS management may wish to be.

2. Decisions about health care must be held in public and open to public debate and influence.

Planning services and choosing priorities for allocating resources are decisions which affect the whole community. Only if the discussions are held in public can users influence decisions about local NHS services.

3. CHCs, as public representatives, must actively seek local views and encourage participation.

CHC members are appointed or elected from a narrow base. In order to represent the community in all its different facets, the CHC must be open to participation and views from the wider community and involve non-CHC members in its activities.

With the best of intentions, it is not easy to attract interest and involvement in the CHC's activities. It is, however, up to the CHC to make its activities of interest and relevance to local people.

4. In the past the interests of some people have not been adequately represented in the NHS. The CHC must ensure that their voice is heard.

The balance of power in the NHS has always favoured acute hospital services. In spite of Government policy to develop the 'cinderella' services, the shift in resources has been slow. Services also need to be sensitive and relevant to the needs of women and ethnic minorities.

Some groups in the community do not have equal access to the health services or the capacity to articulate their needs. CHCs must give priority to representing them and helping them to represent themselves.

5. In relating to large organizations, the individual is at a disadvantage. Patients need a 'Friend'.

The individual is at a serious disadvantage in dealing with any large organizations, such as the NHS. On one level, they may not know how to make the best use of the services available. On another level, if things go wrong or an individual is dissatisfied, the isolation and vulnerability of the patient's position is severe.

Patients are dependent for information about their health and the most appropriate treatment from health staff. If this trust breaks down, the individual may need advice and support from a 'Friend' who understands the 'system'.

CHCs are the only part of the NHS which can give independent and informed advice to individuals. All

CHCs must be willing to act as a 'patient's friend', without making judgement about the rights or wrongs of the case.

The Contribution of CHCs to the NHS

CHCs have had considerable impact on the NHS since 1974.

1. CHCs have started a process of opening up the NHS to the public and voluntary organizations and raising public awareness of health issues. Some CHCs have undertaken original and innovative work, demonstrating good practices to the NHS by example rather than exhortation.

2. CHCs have brought health service managers more in touch with the local community. Dag Saunders in 1985 asked CHC Secretaries and District General Managers if they considered that CHCs had played a useful role in making the NHS more aware of patients' needs. 71% of District General Managers considered that they had.

Table 16: Have CHCs played a useful role in making the NHS more aware of patients' needs?

	General Managers		CHC Secretaries	
Yes	**71%**	**(79)**	**96%**	**(129)**
No	**11%**	**(12)**	**0%**	**(0)**
Uncertain	**19%**	**(21)**	**4%**	**(6)**
Total	**100%**	**(112)**	**100%**	**(135)**

Source: Dag Saunders 1985 [20]

3. CHCs have had a unique impact on the professions. They have helped to give lay people the confidence to challenge and question the people providing the services.

4. CHCs have kept the needs of women, mentally ill, handicapped, elderly people and those from ethnic minorities in the attention of NHS. They have helped to shift the traditional power balance in the NHS from acute specialities to community care and priority services.

In a survey in 1980 CHCs were asked to name five major issues with which they had been involved.[13] The most frequently mentioned issues were:

- Promoting better, more equitable health service (83%)
- Improving services for mentally and physically handicapped people (54%)
- Opposing cuts and closures (half of all CHCs)
- Maternity services (one third of all CHCs)
- Services for the elderly (one third of all CHCs).

5. CHC members often move on to serve on management bodies such as DHAs, RHAs and FPCs. CHCs have provided training and experience for CHC members in looking at the NHS from the user viewpoint.

CHC members have a distinct consumer viewpoint. In 1984 a study[54] showed CHCs more often took the side of the patient on policy issues than organizations representing doctors, nurses and NHS staff, who also promoted professional and staff interests. Eighteen of "the most important and influencial organizations in the field of health policy" were surveyed. There was more than 60% agreement amongst CHCs on over two thirds of the issues. 90% of CHCs were in agreement about many issues central to individual patient care. These included:

- The dignity of the patient
- The need to ensure that plans were adhered to
- The development of a team approach to health care with more co-operation between doctors and other professionals
- The prevalence of overprescribing and the need for Government control over the pharmaceuticals industry
- The need for more joint planning and joint finance
- The need for more screening and health promotion
- Maintaining the ideals of the NHS founders — health care for all
- The need for more expenditure on health

PART IV
THE PUBLIC IN THE NHS

People can be involved in the running of the NHS in many different ways. CHCs are one channel of involving users in the NHS, but they were never intended as democratic control or accountability. Debates on policy since 1974 have confused issues of democracy and accountability with representation and participation. This has contributed to the difficulties for CHCs in finding their role.

In assessing a future role for CHCs, it is necessary to consider the alternative ways of looking after the public interest in the NHS.

1 PUBLIC ACCOUNTABILITY AND DEMOCRATIC CONTROL

Under the present system, democratic control comes through the accountability of the Secretary of State to Parliament, and through health authority members. There is no direct accountability at local level.

Parliament

The Secretary of State is responsible to Parliament, where control is exercised through MPs' questions, debates and NHS issues raised in committees. The DHSS exercises control over the NHS in three ways[55].

1. Financial control over allocations to RHAs: there is little central control of how resources are distributed by RHAs between districts and between services. However, Management Review introduced following the Griffiths Report may increase this.

2. Policy advice: the planning system is an attempt to secure greater conformity at local level with national policy guidelines. But there are still very great inequalities in services in different parts of the country.

3. The Secretary of State appoints members and chairmen of RHAs and chairmen of DHAs. He also has the power to suspend health authorities and replace them with Boards of Commissioners.

Health Authority Members

The Secretary of State appoints RHA members. One quarter of District Health Authority members are nominated by local authorities and three quarters appointed by the RHA itself.

DHA Chairmen are appointed directly by the Secretary of State and paid part-time salaries. They are often political appointments and can become more closely identified with the officers and the DHSS than the DHA members.

"Three conclusions suggest themselves: first, that while the formal accountability to Parliament of the Secretary of State for Social Services offers some degree of control, health authorities enjoy a large measure of autonomy and detailed ministerial accountability does not exist; second, the role of health authority members is confused and unrewarding, and the present arrangements are a poor way of securing public representation in the running of the NHS at the local level; and third, that CHCs have proved an important means of increasing the accountability of local health service managers and of providing a channel of public representation, although their own lack of representativeness and formal powers has limited their impact."[55]

The introduction of direct elections for health authority members is supported by the Labour Party and some trade unions. When the NHS was created, hospitals were transferred from elected local authorities to appointed health authorities. At that time Aneurin Bevin hoped that, when local authorities were restructured, health services could be transferred back to their control. The opportunity to do this in 1974 was not taken and further health functions were transferred from local authorities to the NHS. However, a transfer of health services back to local government is not likely in the near future.

Managerial Accountability

Accountability literally means to give a reckoning of how money has been spent. More broadly, it can defined as taking responsibility for one's decisions, and being able to explain or measure in some way the results. There must be openness to scrutiny, agreed criteria to measure performance and the possibility of action if the performance does not meet these criteria.

In 1982, following the Griffiths Report, managerial accountability at local level was strengthened by the replacement of Management Teams by a General Manager who could be held responsible for health services in that District. The Health Services Supervisory Board was set up *"to strengthen existing arrangements for the oversight of the NHS"*. Under its direction an NHS Management Board was set up *"to plan implementation of the policies approved by the Supervisory Board; to give leadership to the management of the NHS; to control performance; and to achieve consistency and drive over the long term"*.[9]

2 CHANNELS FOR PUBLIC INVOLVEMENT

CHCs, as community and user representatives, have provided the main channel for communication between the public and the NHS and provided a framework for public participation. There are alternative and additional ways for the public to be involved in the NHS.

Direct Involvement with the Public by the NHS

Health authority members, whether they are directly elected or not, could have more direct contact with the public and develop their representation role. However, this would still leave the problems which have arisen in the past when management and representation are combined in the same body.

1. Local elections do not bring automatic participation and representation. Local authority councillors manage the services and represent their constituents. Some local authorities recognise the need for voluntary groups to monitor independently what they do. Some local authorities are setting up local neighbourhood offices, which will not only make their services more accessible, but also will set up forums for local participation in planning and operation of services.

2. Some health authorities are now beginning to relate more directly to the public, holding public meetings and producing their own newspapers, which are delivered to all local residents. Some are also producing leaflets and health service guides. These are ideas developed by CHCs.

However, CHCs are the main source of independent information and advice. Relating directly to the public and giving information on health service issues could easily be seen by the health authority and others as public relations rather than a means of identifying and solving problems.

3. Health authority members could, and should, be more representative of the public. They could develop a role in investigating complaints. However, as a role in complaints would involve extra time and work, it would inevitably distract from the members' role in managing the services and determining policy.

4. Health authorities might consult directly with the public. If CHCs did not exist, the main response to consultations on closures would come from more politically-oriented groups, such as the health emergency committees and locally organized NHS staff. There would be no disinterested community body to take an overall view of the implications of closures. CHCs have not necessarily opposed closures, but often used them as a basis for negotiation to ensure that community interests are protected in the event of a closure.

If the community groups had the same powers of delay as CHCs in opposing closures, there would probably be more overt conflict and health authorities would have a harder time in negotiating on closures. If community groups did not have these same powers, consultation about closures would be a mere formality.

5. CHCs are independent bodies of members serviced by independent officers. If a health authority were to undertake this work itself it might appoint special officers for the task, but these officers would have no independent members to back them up, other than those responsible for the services themselves. Equally, authority members would have no independent source of information apart from those actually running the services.

The Patient as Consumer

'Consumerism' is about the increased involvement of the actual consumer/user in the nature and quality of the services provided. 'Consumerism' and representation overlap. The essential difference is that the credibility of 'consumers' comes from their own experiences not from appointment by some other group or body. The model of consumer power assumes the consumer has choice to use or not use a service or product. Organizations such as the National Consumer Council and the Consumers Association educate consumers to make the 'best buy' and to assist them to use their power to their own benefit and raise standards for all.

The Griffiths Report indicated that consumer feedback and market research had an important part to play. Good managers will be concerned about customer satisfaction and try to provide appropriate services accordingly. However, there are many differences between the provision of health services and other services:

- There is little choice in service provider. Apart from the option for some people to go privately, many people do not have choice of GP or hospital.
- Medicine is an inexact and highly specialised science. Users can be helped to make informed choices between different treatments. Ultimately they rely on the advice of professional staff.

Consumers are generally under-informed and unorganized and the traditional patient/doctor relationship encourages this. The impact of the consumer as an individual is limited and addresses itself mainly to existing service provision. It is not normally concerned with preventive and public health issues or developing community participation.

Patient Participation Groups

Some GPs have helped to set up Patient Participation Groups in order to involve patients in the assessment of the quality of the service they are providing and the communities' needs. Some Groups have also been involved in health promotion and volunteer schemes attached to the practice. Patient Participation Groups have been encouraged by the Royal College of General Practitioners, which has established its own Patients Liaison Committee.

However, a recent review has indicated that they have very limited impact and are unlikely to develop as a 'movement'.[57] Patient Participation Groups are most likely to work where communications are already good between patients and doctors and will not develop in the areas where they are most needed. They are generally initiated by doctors and are almost always centred on one general practice. In some instances there may be a danger that participation disguises a manipulative concern which makes people feel more involved, but actually takes away power from them.

Voluntary and Community Groups

Some of the main activities of CHCs could be undertaken by other existing groups or the NHS itself. However, for voluntary groups, unless set up specifically for the purpose, participation in the NHS would be a peripheral activity. Understanding the complexities of the NHS, as any CHC members knows, takes time and commitment.

CHCs have played an important part over the last 10 years in bridging the gap between voluntary groups and staff in statutory services. They have assisted in setting up advocacy schemes and self-help groups and, with more resources, they could develop this role further.

Voluntary groups, such as MIND, the Patients Association, the National Association for the Welfare of Children in Hospital and AIMS (Association for Improvements in Maternity Services), are involved in developing the 'discerning consumer' and helping local groups to get together and promote change. Some groups are involved in providing alternative services in the community. Their role is clearly different from the CHC's role in representing the whole community.

Local representation in planning and service development for particular client groups could be undertaken by voluntary organizations. This may have been the Governments' intention in allocating seats on Joint Consultative Committees to voluntary organizations, while excluding CHCs. However, only a few voluntary groups representing specialist interests, such as mental health or the elderly, will be represented. Without the CHC many groups of patients and communities might have no representation.

If CHCs did not exist, complaints and acting as a 'patient's friend' could be handled by Citizen's Advice Bureaux or other local advice agencies. In 1984 only 3.2% of enquiries dealt with by CABx all over the country concerned health.[58] This suggests that CABx are not associated in the public mind with the NHS and that staff would require extra training and resources to cope adequately with the complexities of the NHS and acting as a 'patient's friend'. In many cases the intervention of the CHC may help to resolve misunderstandings when communication between staff and patient has broken down.

3 INDEPENDENT MONITORING AND CONSUMER FEEDBACK

Monitoring in the NHS

In 1974, CHCs were created as independent 'watchdogs' to monitor local health services. In spite of the emphasis on self-monitoring in the NHS since the 1974 Reorganization, there has not been a great improvement.

The Griffiths Report found:

"The NHS . . . still lacks any real continuous evaluation of its performance . . . Rarely are precise management objectives set; there is little measurement of health output; clinical evaluation of particular practices is by no means common and economic evaluation of those practices extremely rare. Nor can the NHS display a ready assessment of the effectiveness with which it is meeting the needs and expectations of the people it serves. Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question".[9]

There are good reasons why the NHS finds it difficult to monitor itself:

1. The resistance of large organizations to change

Large bureaucratic organizations are notoriously resistant to change introduced from within and the NHS is no exception. For example, implementing the policy to transfer care of mentally ill people from the large mental hospitals to smaller community units was largely achieved by outside pressure. By 1961 it was realized that these hospitals were inappropriate and Enoch Powell, then Minister of Health, set his sights on replacing them all in 15 years. Nothing much happened. There were no closures and few community-based alternatives. There was only a slow decline in the hospital population and an increase in mental illness in prisons and more stress on caring families. Things only began to change when dissident professionals, voluntary organizations and patients intervened. They used media publicity and national and international legal processes to draw attention to the rights of mentally ill patients. They were resisted by staff on all levels — medical, nursing and manual.

2. The difficulty of assessing quality

Quality of care is hard to define and to assess. It is relatively easy to use statistics from different districts and regions to compare performance on bed turnover, length of stay, cost per case of treating patients, etc. Performance indicators such as these were introduced in 1983. They do not directly address the quality of care or what happens to people following treatment, which is much harder to measure. So far only indicators of cost efficiency can be used as the basis for introducing changes in activities.

3. Ensuring follow up action

Once problems are identified, there is no follow-up action guaranteed. For example, deficient long-stay mental illness and handicap hospitals are not necessarily given extra resources to improve standards.

A literature review of consumer feedback in the NHS, undertaken at Edinburgh University, covering the ten years to 1985 concluded:

"It is our impression that those exercises carried out collaboratively between CHC's and Health Authorities probably yielded more practical action than those carried out by the separate parties. The involvement of the HA carries some sort of commitment to take note of the results, and the presence of the CHC makes it difficult to shelve and forget any unwelcome recommendations; moreover, each has access to some of the necessary resources".[59]

Consumer Research in the NHS

The Griffiths Report saw market/consumer research as a basis for planning and monitoring the quality of services. This approach is relatively new to the NHS, though familiar to CHCs. The review of consumer feedback in the NHS concluded:

"It is clear from our review that the consumer movement has not passed the Health Service by. The level of activity is significant, and appears to be growing. It is, however, very fragmented, and is mostly carried out by individual health councils or health authorities who know little of similar work which may have been done elsewhere.... Of the survey, the great majority have been carried out by Community Health Councils. The number initiated by Health Authorities appears to be very much lower"[59].

Following the Griffiths Report, consumer and market research will be increasingly undertaken by health authorities. Consumer research undertaken or commissioned by the health service is likely to be useful, but may be uncontentious:

1. It is unlikely to look at unmet need, except where meeting this need is already DHA policy.

2. Topics for surveys are likely to be uncontroversial and selected for this reason. They are unlikely to take a radical look at issues.

3. If the DHA does not wish to act on the results of a survey it has commissioned, it may be able to suppress it or play it down. If the CHC undertook or commissioned the same survey, the CHC could publicise it and insist that the DHA took action.

4. Measuring health care by what patients think may be more useful than other indicators of quality yet developed. CHCs might assist in the development of Performance Indicators for patient satisfaction.

In a study in 1985 90% of District General Managers considered greater emphasis should be placed on consumer research, a view shared by CHC Secretaries. However, only 30% of District General Managers considered that the DHA or another NHS body was best able to do consumer research. CHC Secretaries were not enthusiastic about the idea of this being undertaken by the DHA.

Table 16: Which Organization is best able to measure consumer opinion?

	General Managers		CHC Secretaries	
Consumer Research Organization	**49%**	**(50½)**	**26%**	**(33)**
DHA	**30%**	**(31½)**	**2%**	**(2½)**
CHC	**13%**	**(13½)**	**67%**	**(84)**
University	**8%**	**(8)**	**4%**	**(4½)**
Other NHS	**0%**	**(½)**	**1%**	**(1)**
Total	**100%**	**(104)**	**100%**	**(125)**

Source: Dag Saunders, 1985[28]

DHA surveys are no substitute for the independent research projects which an organization with strong local community and patient links can undertake. CHCs, with technical resources, would be very well placed to tackle issues which may be a priority to the community but not health service staff, to look at new developments and also to undertake qualitative research.

4 THE ROLE OF CHCS

The reasons for creating CHCs in 1974 remain valid. However, the NHS has changed. There is a trend toward more involvement by the voluntary sector and a more consumer orientation by health authorities. People are increasingly involved in their own health. As a result, the activities of CHCs must change and develop.

In 1985 when asked if they would establish CHCs, if they did not exist, 36% of District General Managers said yes, 49% said no. As there was no follow up question, it is not clear whether those Managers who would not establish a CHC in their district, felt that an independent public representative body was redundant, or that such a body should have a different role and structure to that CHCs have at the moment.[20]

Table 17: If CHCs did not exist, would you establish one in your District?

	District General Managers	
Yes	**36%**	**(40)**
No	**49%**	**(55)**
Uncertain	**15%**	**(17)**
Total	**100%**	**(112)**

Source: Dag Saunders, 1985[28] 156 DGMs in post, response rate 72%

Even if a further NHS re-organization improved accountability and democratic control, there would still be a strong case for some independent body, like Community Health Councils, to represent the public and encourage participation.

Without a body to promote local interests, develop new ideas and promote good practices, public representation might be reduced to small interest groups on special issues. There would be a lack of co-ordination and overall view of community interests, particularly for deprived and unorganized communities. The quality of representation would vary greatly from district to district, depending on the energy and interest of the voluntary groups and the willingness of the health authority to involve them.

PART V
FUTURE DIRECTIONS FOR CHCS

Community Health Councils can provide a framework for public participation and representation in the future. However, changes in their role and the ways they operate are required. If this happens the interaction of the users and those providing the service can become a constructive contribution to the development of the NHS as a service responsive to users and local communities.

Based on the experiences of CHCs over the last 10 years, possible changes in the role and structure of CHCs are proposed for discussion among CHCs, users and health service providers. Some will make it easier for CHCs to play a constructive part in the NHS, without additional resources. Others can only be implemented with additional resources.

Some of the more controversial suggestions involve an extension of the CHCs' formal role to the wider health of the community.

This is proposed for two reasons:

1. Patients in private state-funded care, in prisons or who are transferring from the NHS to establishments run by local authorities or charities are relatively unprotected under present arrangements. They have a right to independent representation.

2. The NHS has concentrated on sickness and high technology medical intervention and rarely on the wider issues of community care, public health and health promotion. This has prevented the development of an integrated health service which fosters a healthy community by promoting a safe environment, encouraging self-help and participation by people in their own healthcare. Our vision is of a comprehensive service where local authority and NHS services work together. CHCs can play an important part in achieving this, provided that they are given the resources to take on further relevant responsibilities.

1. Clear guidelines are needed to define the relationship of CHCs and the public to Health Authorities and Family Practitioner Committees

Representation on Committees

- CHCs should have the right to a place on all general planning teams, including JCCs, JCPTs and project groups for the development of new services. Terms of reference should be agreed between the NHS managers and the CHC for CHC representatives, covering their duties, procedures for reporting back and specifying the capacity in which they represent users' views on the committee.

Consultation on Closures and Changes of Use

- CHCs should be consulted officially before any formal proposals are drawn up for major closures and changes of use.
- Terms, such as what is a 'substantial' or a 'temporary' emergency closure or a closure in the 'interests of the health service', should be defined to ensure consistent adherence to consultation procedures throughout England and Wales.
- Procedures for monitoring temporary closures should be introduced by the DHSS.
- CHCs or user representatives should be consulted and involved in all health services provided by the DHSS. The rights of consultation, access to information and participation in planning, which CHCs have in relation to District Health Authorities and Family Practitioner Committees, should be extended to Regional Health Authorities and Special Health Authorities.

Access to Buildings

- CHCs should have the right to visit NHS premises to talk to patients without making formal arrangements for each visit. A code of conduct should be developed to ensure that CHC visits do not interfere with the running of the service.
- CHCs should have the right to visit, by arrangement, GP surgeries and other premises where NHS services are provided.

Access to Information

- A minimum information base on local health services should be routinely available to CHCs. One method of achieving this is for health authorities to enable CHCs to be linked into their computer-based information systems, where a CHC requests this. Other appropriate information should be readily available on request within a specified time period.

Complaints and Role of Patient's Friend

- Health authorities and FPCs should automatically refer all complainants, if they so wish, to the CHC. Information about the assistance that CHC can give, should be included in all literature given to patients and be available in NHS premises, including the premises of GPs, dentists and other contractors providing NHS services.
- The role of CHC staff as 'patient's friend' should be clarified to ensure that it is not confused with that of paid advocate.
- CHC staff should have the right to accompany and speak on behalf of a complainant at all health service committee hearings and inquiries, including FPC hearings, hospital complaints procedures and in the clinical complaints procedure at all stages.

Joint Projects Between the CHC, Health Authorities and FPCs

- DHAs, RHAs and FFCs should be encouraged to assist CHCs in setting up advocacy services and in promoting good practice.
- CHCs should extend their role in consumer research and users views on services in collaboration with the DHAs, FPCs and RHAs, who should make available resources where appropriate.

Publicising the CHC

- As CHCs are statutory bodies, the DHSS, the Welsh Office and the Central Office of Information should help to promote them and undertake nation-wide publicity.

• Health authorities and FPCs should publicise CHCs in all their information leaflets and other publicity materials they produce. CHC posters and leaflets should be displayed routinely in all areas where NHS users go.

Enforcement of Rights

• Where a health authority or FPC does not follow procedures, CHCs should have the right to appeal directly to the DHSS or an independent body, such as the Health Service Commissioner.

• CHCs should have access to independent legal advice through the Association of Community Health Councils for England and Wales.

2. Everyone receiving health care should have the right to independent representation.

• The role of CHCs should be extended to include patients in health care, funded in full or in part by the State whoever provides it, not just those in NHS care. Local authorities and others providing services in the community are inextricably bound up with health care issues.

• Formal links and visiting rights, by prior arrangement, should be established with the relevant authorities to cover people in:
— local authority care
— private or charitable residential homes and hospitals
— prison hospitals
— armed services hospitals

• CHCs should monitor public and environmental health issues as far as they affect the health of the local community they represent.

3. CHCs should develop a code of practice on the way they relate to the NHS and consult the public

Public Consultation and Participation in the CHC

• CHCs should consult the public directly on all major developments or closures affecting the district where there are different views to be represented.

• CHCs should act as a focus and enabler for community groups and individuals to relate directly to the NHS. The public are only beginning to be aware of the possibilities of participation in the NHS, both for self-help and introducing change at local level. CHCs have an important contribution to make in encouraging and demonstrating the possibilities of increasing levels of public participation.

• Formal links should be established with relevant community groups, in particular Community Relations Councils.

• DHAs and CHCs should work together to set up local advisory groups to enable locality planning for all parts of the health district.

• CHC offices should be accessible to the public, and staffed appropriately to provide a direct service to public enquiries.

Making CHCs More Representative

• The number of CHC members should be restored to the level in 1982.

• The method of selection of members should be reviewed in order to get wider community representation, possibly by increasing the proportion of members elected by voluntary groups and the number of representatives of ethnic communities.

• Clear guidelines for CHC members should be developed to clarify their role in relation to the NHS and CHC staff.

• CHC members should have the right to be granted statutory relief by employers so that they can carry out their duties, where necessary, during normal working hours.

• CHCs should establish a procedure for reporting back to local groups and local people and giving account to the community.

• CHCs should develop ways of involving interested individuals and local groups who wish to be kept informed and participate in the work of the CHC and the health service. Co-options, particularly in specific areas is an important way of increasing the expertise available to the CHC.

Promoting Good Practices Among CHCs

• The national association should be strengthened so that it can provide a proper resource service and training for CHCs.

• Research studies are required to look at the different ways CHCs operate and consider what ways are effective and what ways are not.

4. CHC staffing and budgets should reflect the amount of work a CHC undertakes and its importance; and ensure the independence of the CHC from NHS management

Budgets and funding

• CHCs should be funded from central Government funds and resources allocated accordingly to planned and budgeted activities undertaken by each CHC. Arrangements for payment can still be made through RHAs.

• CHCs should be re-categorised as a patient service for budgeting purposes, rather than as an administrative function as at present.

• CHCs should be able to decide how they spend their money, whether on premises, staff, publicity or research — within normal financial checks and accountability.

Staffing

• CHC staff should be employed by a body which does not have a conflict of interest with the activities of the CHC, such as the DHSS or another independent body, such as a regional CHC structure.

• CHC staff establishments should reflect the workload of the CHC. The minimum staff to carry out the duties given to a CHC are:
— Secretary to the Council (Chief Officer)
— Information and Advice Worker, dealing also with complaints
— Research/Information Officer
— Administrative Officer

• CHC staff grading should reflect their responsibilities, and be comparable to other NHS posts. 'Efficiency' allowances should be introduced to encourage good staff to stay and progress within the CHC.

• The appointment and job description of CHC staff should be a matter for each CHC in arrangement with the employing body.

• Ways of establishing a career structure for CHCs should be considered and staff, who so want, encouraged to move into the mainstream NHS.

• NHS trainee administrators should be seconded to CHCs to work on specific projects to gain a better understanding of the NHS from the community's point of view.

• CHC staff and members should be seconded to serve on the Health Advisory Service and other monitoring bodies.

5. The national and regional structure of CHCs should be strengthened to provide resources and training for CHCs and provide a stronger voice for users.

Regional Associations of CHCs

• A regional CHC structure, with separate staff and budgets, should be developed to provide support and services to CHCs and to monitor the activities of the Regional Health Authorities. It is noted that problems arise in London and other Metropolitan areas as regional boundaries do not reflect natural communities or patient flow.

Activities might include:

— Technical support; to advise on survey/research methods, fund-raising, use of MSC workers, legal advice, press and media.

— Administrative support; to advise on estimates and costing and, possibly also paying salaries and managing accounts.

— Research; to monitor RHA plans and strategies on a region-wide basis.

— Training and staff development; to enable staff development and specialisation.

The Association of CHCs for England and Wales

• The Association should be strengthened so that it can provide a proper resource service to CHCs and a stronger voice for the public at national level. A regional structure would provide a channel to keep ACHCEW informed of events at local level and develop an information base.

Activities might include:

— An information and publication service to CHCs, such as the National Association of Citizen's Advice Bureaux is able to give its members,
— Training courses for staff and members
— Initiating and commissioning independent research about new consumer issues and public participation in the NHS.
— Promoting good practices and high standards among CHCs
— Establishing an All-Party Parliamentary presence
— Developing the production and use of health promotion/consumer advice materials, including audio-visual aids.

• The DHSS should provide core funding for ACHCEW.

Figure 2: Summary of Possible Ways of Strengthening CHCs

CHCs offer variable standards of service to the public

• Clearer guidelines should be introduced for health authorities and FPCs on how they should relate to CHCs on consultation, access to information, representation on committees and visiting.

• CHCs should develop codes of good practice and raise standards amongst themselves.

• ACHCEW & CHCs should establish regional training courses and support systems to provide technical advice.

• More staff and resources should be allocated.

• Research should be initiated to assess the effectiveness of approaches which CHCs have adopted.

CHCs are fragmented & do not collaborate on strategic issues

• More staff for CHCs to reflect their workload.

• Regional structures, with staff, to provide support and research on regional level and supra-regional level.

• A national association with core funding to provide information and support to CHCs and provide an effective national consumer voice.

CHCs are not representative

• Review the number of CHC members, and how they are chosen, in particular to ensure representation of ethnic minorities.

• Set up procedures for involving interested groups and individuals and co-opting members to widen participation outside the membership.

• Set up local mechanism for reporting back to the community.

No one knows about CHCs

• Promote national publicity, through ACHCEW, supported by DHSS and the Central Office of Information.

• Information about CHCs should be included in all DHSS, health authority and FPC publicity and information leaflets. CHC posters displayed in post offices and all NHS facilities.

• Make CHC offices accessible to the public.

CHCs are not independent of local NHS managers

• CHC funds allocated by the DHSS, with CHC control over how they spend the allocation according to their work programme.

• Obtain funds for CHC projects from non-NHS sources.

• CHCs to employ their own research staff to provide an independent source of information (locally, regionally and nationally)

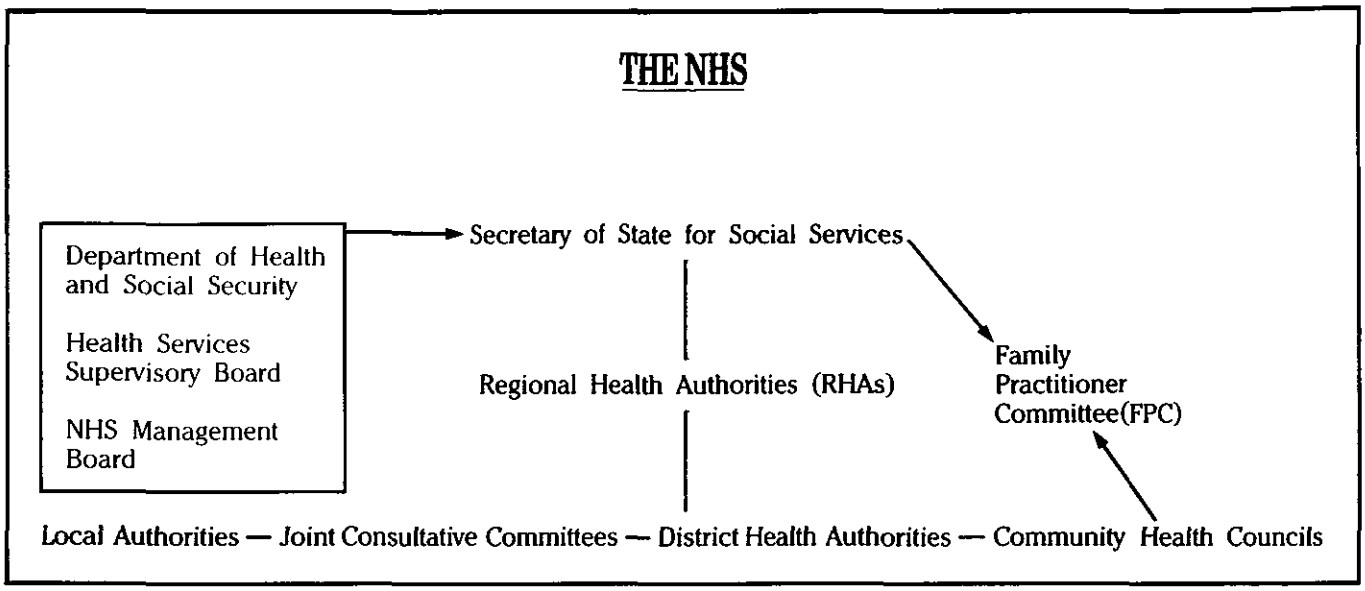
CHCs try to do too much outside their remit

• Undertake research to assess the impact of different approaches.

• More staff and access to specialist resources.

• Develop codes of practice to provide guidelines based on an independent review.

ANNEX 1
NHS STRUCTURE AND ABBREVIATIONS



ABBREVIATIONS USED

ACHCEW Association of Community Health Councils for England and Wales

AHA Area Health Authorities, abolished in 1982 and replaced by DHAs which generally cover a smaller area.

DHSS Department of Health and Social Security, responsible for the NHS, allocating resources, making policy and issuing advice. The Secretary of State is responsible to Parliament for the operation of the DHSS.

DHA District Health Authorities, responsible for managing the health services. Members are appointed by the Regional Health Authority.

DGM District General Managers, responsible to the DHA for the operation of district services. They took over responsibility from the DMT following the Griffiths Report in 1983.

DMT District Management Team managed district health services until 1984 when General Managers were introduced. Teams comprised a District Administrator (DA), Nursing Officer, Medical Officer, General Practitioner, Consultant and Finance Officer. Decisions were made on the basis of consensus.

DPTs District Planning Teams, examine district needs and advise DGM.

FPC Family Practitioner Committees administer services provided by general practitioners, dentists, pharmacists and opticians. They are directly accountable to the Secretary of State. Members are appointed by DHAs, local authorities and local professionals. Most FPCs administer areas including more than one DHA.

GLACHC Greater London Association of CHCs

HCPTs Health Care Planning Teams, later replaced by District Planning Teams.

Health Services Supervisory Board, set up following the Griffiths Report to determine the purpose, objectives and direction for the NHS, appraise overall budget and resource allocation, and receive reports on performance and other evaluations from within the NHS. The Secretary of State takes the Chair.

Health Advisory Service visits and report on services for the mentally ill, elderly and children receiving long-term hospital care. It advises the Secretary of State.

JCCs Joint Consultative Committee, made up of local authority and DHA members, and 3 members elected by voluntary organizations to assist in collaboration of DHA and local authority services, especially on joint financing and joint planning.

JCPT Joint Care Plannning Team, made up of DHA and local authority officers and support the JCC.

NHS Management Board, set up following the Griffiths Report works under the direction of the Minister and is responsible for planning the implementation of policy, giving leadership in management and controlling performance.

RHA Regional Health Authorities. There are fourteen RHAs in England. They plan the development of health services and allocate resources to District Health Authorities. Each RHA has 20 members appointed by the Secretary of State.

Social Services Committee of the House of Commons, made up of Members of Parliament and investigates aspects of the work of the DHSS.

Special Health Authorities, set up in 1982 to manage post-graduate specialist hospitals, which are not considered to provide a local service (i.e. Moorfields, Brompton and Royal Marsden Hospitals). They have no formal relationship with CHCs.

Special Hospitals Services,run by the DHSS for the Home Office as high security units for people with mental disorders. (Broadmoor, Rampton, Moss Side etc)

ANNEX 2
CONSUMERS AND NATIONALISED INDUSTRIES

CHCs have one main thing in common with nationalised industries consumer councils (NICCS): they were all created because of the feeling that user interests in monopolies needed protection, but with no clear idea of what this protection should be or how it might be achieved.

"NICCs were intended essentially to meet concern that in the new state monopolies the interests of management and employees might overide those of consumers".[1]

Reviews of NICCs have criticised the way they operate:[1]

"a) the NICCs are not well enough known to consumers;
b) they are not cost effective in dealing with customer complaints;
c) they are, or appear, insufficiently independent of the industries;
d) they are ineffective when raising policy matters, being too often ignored by the industries and Government."

The picture varies from industry to industry. However, there are certain general patterns which are different from CHCs.

1. Local/grass root involvement

Some NICCs are only national bodies, relating directly to the Board and the Government. Gas and Electricity have a regional structure, perhaps mainly because historically they were taken over, like health services, from the local authority. However in 1976 the National Consumer Council argued that, since the issues of policy were in practice national not local issues, *"the regional councils for gas and electricity should cease to exist, but a regional presence remain"*, mainly for advice and complaints.[2]

This was controversial and not implemented.

2. Activities

Terms of reference vary and are open to interpretation by councils. Some only respond to the Board and take up complaints. A few do initiate research on consumer views. None are considered effective in the area most important to consumers: price control. As many complaints are taken up through CABx, local consumer groups and local councillors as through the appropriate NICC.

In a Consultative Document in 1981 Sally Oppenheimer, Minister of Consumer Affairs wrote:

"I am convinced that... they should spend more of their available time and resources on pursuing concrete problems of customers and less on broad policy issues".[1]

The National Consumer Council in a survey in 1976 undertaken for the Secretary of State for Prices and Consumer Protection had a different vision.

"We recommend that national councils should be the king-pins of each structure.... They should deal with all monitoring and policy questions which are not solely regional in character"[2].

3. Representation

All members are appointed by the Department of Trade and Industry (DTI). Any individual can nominate themselves. The DTI circulates organizations asking for nominations. Only the gas and electricity councils have seats reserved for local authority appointments. (2/5ths–3/5ths in the Electricity Council).

The aim is to make the consumer council as 'representative' as possible by covering various interests: industry, client groups such as the elderly, agriculture, commerce etc. Appointments are reviewed and members are reappointed with regard to merit, (as defined by the DTI and the Chair). Until recently some members had been on the council for 30 years. Now the DTI is trying to ensure a better 'turnover'.

"The NICCs are paid for by the tax payer. They must be fully accountable, therefore, for the effective, economical and efficient use of the public money allocated to them. To this end the Government will continue to exercise the necessary financial and other controls over the NICCs." 'Accountability' is to the Department of Trade and Industry.

4. Independence

All NICCs are independent of both Government and the Board. *"The NICCs must command the confidence of consumers. The whole structure must appear more accessible and be seen to be wholly independent."*

They are given their own budget allocation and manage their own accounts according to public accounting rules.

Some Councils may identify with 'their' industries needs rather than the consumer or public.[2]

5. Staffing and Resources

Staffing of Councils varies according to the work load. The Electricity Consultative Council covering a regional board area would have a staff establishment of about 5. Gas Councils have more as they deal with a larger number of complaints.[2]

The Secretaries of most Councils come from within the industry. All Chairmen are appointed by the DTI and are paid on a part-time basis.

6. Funding

It is also interesting to compare Government funding for *national* consumer bodies for state controlled services:

Table 18: Government funding to consumer bodies in nationalised/state controlled services

	1982/83
Nationalised Industries Consumer Councils	**£3,729,000**
Domestic Coal Consumer Council	**£50,000**
Electricity Consumer Council	**£1,300,000**
Post Office Users Council	**£305,000**
Transport Users Consultative Committees	**£499,000**
National Consumer Council	**£1,267,000**
National Association of Citizens Advice Bureaux	**£5,757,000**
ACHCEW	**£25,000**

Source: ACHCEW Standing Committee News, No 36, Feb. 1984

(1) Department of Trade, *Consumers' Interests and the Nationalised Industries — A Consultative Document*, 1981.
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ANNEX 3
SUMMARY OF PROPOSALS FOR STRENGTHENING DEMOCRACY IN THE NHS

INCREASE PARLIAMENTARY CONTROL AND ACCOUNTABILITY

Set up a separate Parliamentary Select Committee on the NHS. (At present covered by by Social Services Committee).

Advantages:

It would enable Parliament to influence health policy and keep in touch with the NHS in a more systematic way. It would introduce more openness and accountability into NHS management.

Disadvantages:

It would be more difficult to look at aspects of care where social services, community care and health services overlap.

HEALTH SERVICES TO BE RE-INTEGRATED INTO LOCAL AUTHORITY SERVICES

This was the Government's intention in 1948. It would require central funding.

Advantages:

It would enable planning and operation of comprehensive health and social services at local level. With elected members, there would be more democratic control.

Disadvantages:

It would be politically difficult, with strong opposition among NHS administrators and other NHS staff. A further re-organization of local authority structure, with a Regional tier would be required. There would still be a need for a consumer body.

DIRECT ELECTION OF HEALTH AUTHORITY MEMBERS

This would provide for separate elections for members of health authorities.

Advantages:

It would improve democratic control, without the upheaval required by a re-integration with local authorities.

Disadvantages:

It would not necessarily lead to closer co-operation with local authority services. Voting rates might not be high.

Members would have local accountability, without control over the allocation of finances.

DISTRICT HEALTH AUTHORITY MEMBERS AS CONSUMER REPRESENTATIVES

Strengthen Members' role and give them responsibility for both management and representation. Members to elect the Authority Chairman.

Advantages:

As long as there were regulations about public participation and consultation, it would increase direct contact of management and community.

Disadvantages:

Combining management and representation has worked in the past to the detriment of users. DHA members are appointed not elected. There would still be a need for consumer representation and democratic control.

PRESENT SYSTEM, WITH INCREASED RESOURCES FOR CHCS

Advantages:

The present system of public representation by CHCs could be strengthened and made more effective, without major disruption.

Disadvantages:

It does not confront the basic issues of democratic control in the NHS.

A PATIENT'S 'TUC'

The formation of a strong umbrella orgnaization, involving voluntary organizations concerned with health care and CHCs.

Advantages:

It would strengthen the voice of the patient at national level.

Disadvantages:

Its power would be limited, as any voluntary pressure group. It does not confront basic issue of democracy in the NHS.

ESTABLISHMENT OF CONSUMER PROTECTION COUNCILS[2]

This proposal would set up consumer protection councils for all consumer related services, including local authority services, trade and commerce, nationalised industries. Responsibility for public participation in policy formation would become the responsibility of the health authority[2].

Advantages:

It would cover a wide range of services not at present catered for. It would be able to appoint a wide range of staff, including a legal department. It would provide an integrated approach to consumer problems, many of which include more than one service. It could provide a career structure for CHC staff.

Disadvantages:

If public participation in policy formation was carried out by the health authority, it might become a public relations exercise. The Council would be a professional service and lay commitment and involvement of CHC lost. It does not address the basic problem of democratic control in the NHS.

ESTABLISHMENT OF NEIGHBOURHOOD COUNCILS

Small neighbourhood planning units would be set up, covering up to 10,000 people. They would negotiate changes in resource allocation with the health authority, similar to the role CHCs now have over closures. The CHC, or equivalent body, would act as a co-ordinating body for the neghbourhood councils[3].

Advantage:

Covering such a small area, it would be easy to identify and public involvement would be increased. Health authorities would be forced to be more outgoing.

Disadvantages:

Except for some parts of primary care, it is too small a unit for planning and development. It would involve great input of resources.

(1) In 'Power, Patients and Pluralism', Chris J Ham in 'Conflicts in the National Health Service', Croom Helm, 1977.
(2) In Emrys Roberts, 'Consumer satisfaction in the health services: the role of the community health council', Royal Society of Health Jounral, Vol 98, No 4 , August 1978.
(3) In R K Griffiths, 'Community participation and the professional role — a new partnership ?' Royal Society of Health Journal, Vol 98 No 4 , pp 177 — 180, August 1978.

ANNEX 4
NATIONAL ASSOCIATIONS OF HEALTH COUNCILS AND STAFF GROUPS

NATIONAL ASSOCIATIONS OF HEALTH COUNCILS

Association of Community Health Councils for England and Wales,

As we go to press a change of address and phone is imminent. For up-to-date information, please contact a CHC office.

Association of District Committees for the Health & Personal Social Services Northern Ireland,
27 Adelaide Street,
Belfast BT2 8FH

Secretary: Linda Leonard
Tel: Belfast 224431

Association of Welsh CHCs
c/o Ceredigion CHC,
5 Chalybeate Street,
Aberystwyth,
Dyfed

Secretary: John Evans
Tel: Aberystwyth 4760

Association of Scottish Local Health Councils,
21 Torpichen Street,
Edinburgh,
EH3 8HX

Secretary: Linda Headland,
Tel: 031 229 2344

NATIONAL GROUPS OF HEALTH COUNCIL SECRETARIES

Society of CHC Secretaries,
c/o Rugby CHC
18 Warwick Street,
Rugby,
Warwickshire,
CV21 3DH

Secretary: Tony Pitt
Tel: 0788 72409

Society of Secretaries of Welsh CHCs
c/o Cardiff CHC,
15 St David's House,
Wood Street,
Cardiff,

Secretary: H Mansell Davey
Tel: Cardiff 34407

Society of LHC Secretaries
c/o West Lothian LHC,
Bangour General Hospital,
Broxborn EH52 6LR

Secretary: Miss S Windsor
Tel: Dechmont 620

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Community Health Councils were set up in 1974 as a new way of representing the users in the National Health Service. Since then there has been no review of their impact on the NHS or consideration of how they might provide a more effective framework for the public's voice in the NHS.

Users and service providers will always have different views about priorities and the ways services should be run. The NHS is more and more conscious of the need to listen to NHS users. However, consumer satisfaction surveys and market studies by management are not a substitute for community participation and involvement in the NHS. The public needs an independent channel to participate in the NHS. Community Health Councils can provide this framework.

However, CHCs were set up without a clear view of their role or how they would relate to management. This has often made it difficult for CHCs to make a constructive contribution to decision-making in the NHS. Changes are required at all levels — the Government, NHS management and CHCs themselves — to enable a stronger voice for the public in the NHS.

Christine Hogg worked as a Secretary to a Community Health Council in Central London from 1974 to 1980. She is now self-employed, specialising in health and development issues.

The Association of Community Health Councils for England and Wales acts as a clearing house for information among member CHCs and promotes the interests of users and patients at national level.

Association of Community Health Councils for England and Wales
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