'To CHCs who argue against an association I say: Watch and see what we do'

Next week the Association of CHCs of England and Wales holds its annual general meeting. In this interview the association's secretary, Mike Gerrard, looks at some issues which will be concerning delegates and gives his own opinions and philosophy.

Q. Can you tell us something about your background?
A. Before I was involved with CHCs, I worked in industry. I was also a member of the Essex county council's health committee and became closely involved with the birth of the Chronically Sick and Disabled Act. So I had some sort of health background and knowledge. I was then appointed to the CHC in West Essex in 1974 and very shortly afterwards, when they were appointing staff for CHCs, I became secretary of Haringey and ultimately got this job.

Q. What attracted you to this post?
A. Partly it was something I knew I was going to enjoy doing. I also had been working for 15 years in industry and commerce and I thought I would like a change in my way of life.

Q. Do you see yourself as an administrator?
A. No, I don't really. Clearly there is administration in so far as I have got to make sure that things happen when they are supposed to happen. But I would see myself rather more as a facilitator to bounce ideas off — someone who tries to draw out the things that members of CHCs and members of the standing committee have got to offer and make use of them.

Q. What is the history of the association?
A. Almost at the word go, Barbara Castle asked Lady Marr and Ken Cullis, who was the Lord Mayor of Manchester at the time, to inquire among CHCs how they were getting on, what they wanted to do and if they wanted some sort of national organisation to back them. She then set up a steering committee for the formation of a national organisation.

I think the intention was that it was going to be something rather formal with an established appointed chairman and community health councils appointing their own people to it. But it emerged that CHCs didn't want that type of statutory thing between them and the government. They wanted a free association and not even everybody wanted even that. This was partly because of expense and partly because they felt it would infringe on them concentrating upon their own domestic scene.

When the question was finally put to CHCs towards the end of 1976 they agreed by a small majority — roughly 112 to 90 — to a free association with a voluntary membership. Gradually it has grown to a membership of 185.

Q. Did you have any initial fears about the 112 vote and could you have carried on if membership had stuck at that?
A. No we couldn't. We had a provisional standing committee which took over to establish a constitution. Within that constitution it was decided that if less than 55 per cent of the CHCs wanted to be members of the association at any one time then we would fold up.

Q. What plans have you for the future?
A. The constitution sets up the association as a forum for CHCs to exchange views and to take a common view on things of general concern. It also presents the association with the opportunity of making representations on behalf of CHCs if that's what they want. This is the facility to act as a national advocate for CHCs and to do research which can help CHCs to do their own local jobs better.

I would say that the aims of the association for this year and for further on are firstly to promote the status of CHCs in the sense that they get the proper recognition that is due to them and to provide the back-up such as our information service to help them do their work.

Q. On research, do you have any specific projects?
A. We have a project which is looking at casualty services in which we are studying the whole business of minor casualty services. We are looking at the complications which arise from

concentrating accident/emergency services into a limited number of places in terms of minor casualties taking up these services and major accident services having to wait a very long time.

We are also doing a study into health service dentistry. What we want to look at is the relationship between the dentist and the patient; the question of whether or not dentist remuneration is right and the pressures on a dentist which limits the sort of NHS service he can give.

Q. How far do you see the association helping an individual CHC when it has problems?
A. I think one wouldn't want to get involved in a local situation too closely. Every local situation is different just as every CHC and AHA are different. When it comes to resolving a difficult problem locally its really much the best thing for the CHC involved to look for its own solution. Maybe if the CHC wanted to try some ideas out on us, we would certainly be available. For instance if they wanted to find out if other CHCs had had the same problem and how they had solved it, we would be only too happy to help out.

Q. Can you tell us something about your publication, CHC News?
A. It has a staff of three. In the main they write the paper, do the research work and put it together. It comes out monthly and I think on the whole it is a very satisfactory journal. It certainly gets read. I can never go to any CHC in the country without people bringing up items or issues in CHC News.

Q. What do you say to critics of the association who argue that its very existence is a contradiction to the grass root functioning of a CHC?
A. I think the best kind of answer you can give to that sort of criticism is in the proof of the pudding. If a CHC says to me that they think an association is unnecessary and that money could be spent better elsewhere, all I can say to them with some confidence is to watch and see what we do. I am aware from my own experience that it didn't take long for CHCs to start contacting each other in their own areas when they had a joint interest. I think its clear that there are a lot of areas of common interest and a lot of matters which are of deep concern to CHCs which have a national significance, and don't end at the frontiers of one CHC or even for that matter at the frontier of England and Scotland or Wales.

'It may sound silly to you but the last thing I can do is say things on a CHC's behalf without proper authority'

There are a lot of things people will be wanting to say in concert to the DHSS and the association provides a facility for doing this. Another facility we have begun to provide, although at this stage it is in its infancy and controversial, is being a means by which CHCs get an opportunity to comment on things they otherwise wouldn't have known about. For example the DHSS comes to the association and asks what we think about, let's say, the admission of mentally handicapped children to hospital. We say to them, surely this is something you should be asking CHCs about. Out of that comes some sort of opportunity for CHCs to say what they think about these issues.

Q. Because of your association's terms of reference and its make-up it must be difficult for you to have a collective view.
A. We very seldom express a collective view. What happens is that when we are looking at an issue it will come to the standing committee from some CHC and people debate it and decide to send out a consultation paper or a questionnaire to CHCs. Depending on the answer, we set up a small working party which tries to hammer something out of that.

Q. But what about issues which needed a swift reaction, for instance something which threatened the existence of CHCs? Surely in such a case the method you have described is a bit cumbersome.
A. If the Press phones and asks me for an instant opinion on something, then I have just got to consider it. If it's something totally new to us, I either have to relate it to something similar on which the CHCs have a position or to be careful about it and, if possible, reserve judgement. It may sound silly to you but the last thing I can do is to usurp the functions of CHCs and to say things on their behalf without proper authority.

Q. In your association do you have any code of conduct regarding the behaviour of individual members?
A. Not at all. That would be be wrong. In the short period of time we have been going, obviously CHCs have taken different positions and have acted differently. It wouldn't be right for me or for anyone else to question their tactics.

Q. What is your relationship with the DHSS from a statutory point of view and your working relationship?
A. Let me take the working relationship first. By and large it's quite cordial. In many instances they have been helpful in trying to ease the way of the association. On the other hand, the statutory relationship is a little difficult. The principal problem that exists is the problem of consultation. One can understand why a big organisation like the DHSS would want to consult on policy matters with a number of small national organisations. But we are not representative in the sense that we have not accorded ourselves the right to speak for individual CHCs.

Q. Do they treat you as if you have that right?
A. Well, we quite frequently get letters from them asking for the association's comments and I think it is more appropriate in a lot of instances that the CHCs themselves should be allowed to comment. What I think we have to do is to remind the DHSS that this is the case and prevail upon them that it is much more effective in such cases as the Court Report, that a local CHC should comment on what the report means for its own health district rather than to talk in broad terms.

Q. Do they ever ask you to canvass CHCs for them?
A. We've done that. But in other instances we have said no and the sort of information the DHSS are looking for would have to come directly from CHCs. Now this is a question which is not yet sorted out between us and the DHSS although we tried clearly at the outset to establish that we weren't an intermediary between the DHSS and CHCs. Apart from every CHC having

the statutory right of direct contact with the DHSS, it must also be said that if the Department used us as their link they would automatically disenfranchise those CHCs which do not belong to the association.

Q. Do you have contact with the CHCs which don't belong to the association?
A. Oh yes. I would think there are less than a handful of CHCs which don't have any contact with us. I personally welcome the fact that although they are not members, they are, nevertheless, in touch.

Q. Do you think your membership has reached its ultimate number?
A. I think we're fairly close to it. I think that every year there are going to be some new CHCs joining and some leaving. Sooner or later we must one way or another upset some CHCs by a statement we make and that is one of the reasons CHCs pull out. It could also be caused by expenditure priorities or a change of philosophy because of new membership in a CHC.

I would see a small number of CHCs constantly being outside the association. I believe that to some degree that is beneficial to the association and the CHCs. It means we have to think and take care to try as far as possible to be the kind of association that CHCs want.

Q. How is the association financed?
A. CHC News is funded directly by the DHSS and that amounts to something in the area of £48,000. The rest of the money to run the secretariat comes from the £150 per year subscriptions from the CHCs.

Q. But does this mean that CHC News is independent from the DHSS as far as editorial policy is concerned?
A. Yes, completely.

Q. Turning to CHCs themselves, what would be your ideal of a model CHC?
A. I think it would be one that looked very carefully at all the circumstances in its own district. It would look at the proposals and the philosophy underlying the proposals of the AHA. It would be looking at the kind of relationships that AHAs have with local authorities and other important organisations such as the DOE and I would be asking them in all this that the central focus of their activity be the needs of their patients. They should be looking at things objectively and trying

'Sometimes, if it is used as a tactic, a little explosion in the Press can provoke what you have spent months trying to achieve'

to get a whole picture as opposed to a partial one. But I do accept within that kind of framework that you have got to stick your neck out. Sometimes, because of circumstances, you are forced into short consultations and into making a statement almost off the top of your head. I would say to CHCs that when they have to do that they should put the patient at the centre of their considerations.

Q. When it comes to making instant statements do you not think that some CHCs tend to become easy meat for the more sensational newspapers?
A. Don't forget local newspapers like to have sensational news and if they can get an instant quote from a CHC then it pleases them. Sometimes, if it is used as a tactic, a little explosion in the Press can provoke what you were working several months to try and achieve — so I wouldn't be opposed to it automatically. But I think that one ought to be quite cautious when dealing with the Press because they do have the power to present things in the way that suits them best and that may not be in your interests. But it is vital that CHCs have the closest and friendliest relationships with the Press. That way you can work together to get the maximum impact.

Q. When CHCs were first formed many administrators were quite suspicious of them. Is this still the case?
A. Quite honestly I don't see much change. I would almost say that I see a reintensification of those feelings. It has now reached the point in a number of districts where CHCs who might have been regarded as being easy marks for the administrator, are now making an issue of certain matters and are demanding to be consulted properly. As a result they are making life difficult for some of these administrators who are suddenly finding what they thought was a reasonable outfit to get along with has turned into quite an awkward and questioning body.

Q. What about CHCs' relationships with clinicians?
A. I can think of many instances where clinicians have been very keen to invoke the support of the CHCs and, of course, there are numerous cases in which clinicians in hospitals or in the community have been bitterly upset by what CHCs have said or done.

Q. On the question of invoking CHCs' support, do you not think there are instances when they can be manipulated?
A. Part of the technique of public or political action or pressure group activity is manipulation in the sense of getting people to support your position. As far as that goes CHCs are open to such pressures. But then any organisation which is prepared to listen to argument is in the same position. At the end of the day it's down to judgement.

Q. Where would you draw the line between a CHC being too abrasive and a CHC being too passive?
A. Clearly one can be aggressive to the point where it becomes counter-productive and equally one can be complacent to the point where it is definitely unproductive. I wouldn't want to set any hard and fast rules.

Q. Do you think CHCs get sufficient funds and back-up facilities?
A. The funding of CHCs was originally established on a very low basis on the assumption that CHCs would have quite a small staff and their activities would be quite constrained. The increase of funding over the last few years has also been quite small because of the economic situation. I think lots of CHCs would say at this stage that they would want to have more funding than they have got.

Q. If you had a brief message for the conference next week what would it be?
A. I think the message we will give to CHCs will be to tell them to carry on, and to battle as hard as they can for their patients for I am convinced that CHCs have had some influence on the way the health service has developed since reorganisation. The concrete achievements seem very slight as you look at them from day to day, but the accumulative effect is worth something and worth striving for.