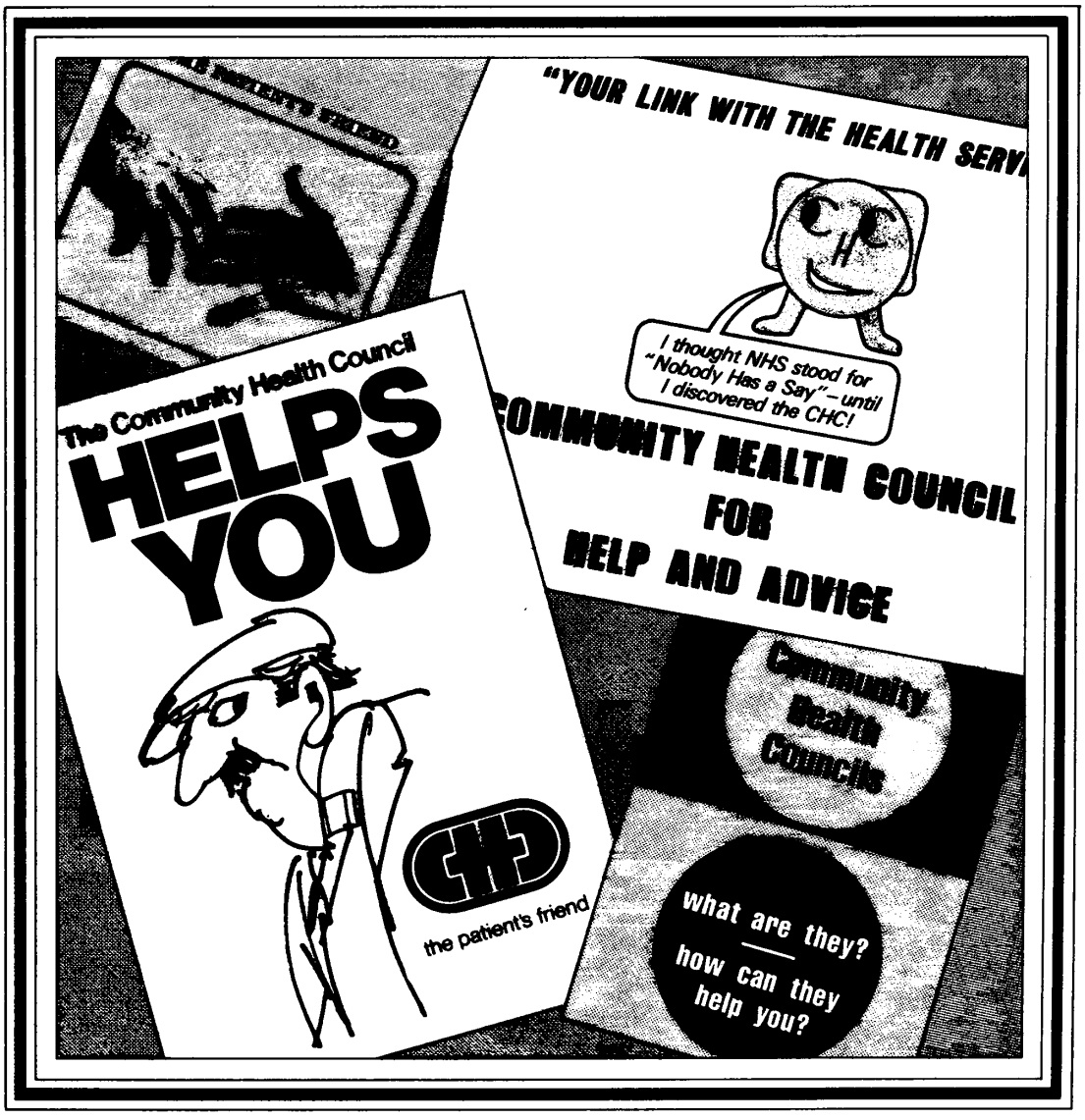
The People's Voice in the NHS

by Ruth Levitt



King Edward's Hospital Fund for London

The People's Voice in the NHS

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The People's Voice in the NHS

community health councils after five years

by Ruth Levitt

King Edward's Hospital Fund for London

Printed by Green, Wade & Wilson Ltd in England

Illustrations by kind permission of the Association of Community Health Councils for England and Wales on behalf of member-CHCs

ISBN 0 900889 80 2

Distributed for the King's Fund by
Pitman Medical Limited

King's Fund Publishing Office
126 Albert Street
London NW1 7NF

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Introduction

This short book has been prepared to mark the first five years of community health councils' existence. They came into being in 1974 when the National Health Service underwent a major administrative reorganisation. Nothing quite like them had ever existed before in the form of a special statutory body with the unique responsibility of representing the public's interests to the health authorities.

In this first period up to 1979, the growth and development of community health councils have been important and interesting to observe. The King's Fund asked me to set down some observations and comments about community health councils in the belief that there would be interest from both health service workers and the wider public in a documentation of that period. As this book went to press, the government's proposals for changes in the NHS were published in a consultative paper, *Patients First.*[17] The paper contains a small paragraph on CHCs which states the government's recognition of 'the time and energy that many CHC members have devoted to their role', but which ends with a request for 'views on whether community health councils should be retained' in the new organisational structure which the government proposes. It is hoped that this story of the first five years of CHCs will help inform the debate on their future. The comments in this book are personal observations and cannot be said to represent an official or objective account of the events of the last five years. However, I have done my best to keep the bias to a minimum and to set down as useful and accurate a record as I can. Any errors are entirely my responsibility.

I am grateful for the opportunity to write about community health councils and I would also like to express my thanks to all the many CHC members and staff with whom I have come into contact in the last few years. Their opinions and ideas have been a vital source of information for this book.

RL
1980

How were community health councils created?

It is difficult to be absolutely sure why community health councils appeared on the scene when the National Health Service was being reorganised. Certainly lay people had been involved in the various management committees of the NHS before 1974, either as members of hospital management committees or regional hospital boards running the hospital service, or as elected councillors or co-opted members of the health committees of local authorities which ran a number of community-based services.

Representing the public

But there has never been a completely separate statutory body to represent the public's view and in the early debate on the reorganisation during the 1960s no such body was mentioned. The first indication that there would be a special consumer body was made in the consultative document produced by the Conservative Secretary of State for Social Services, Sir Keith Joseph, in 1971.[14] This document was not formally published but circulated privately to particular interested parties (mainly within the health service). In it for the first time bodies called 'community health councils' were identified – these would be set up to represent the public's interest in the health service and thereby create a separate channel for the expression of consumers' views distinct from the health authorities. In the subsequent debates leading to the National Health Service Reorganisation Act 1973[23], community health councils attracted further attention as a part of the new structure. But they were never a prominent part and they were not – at that time – made much fuss of.

The principle concern of the legislators was to establish efficient, reliable, and managerially skilled health authorities that could cope with the tremendous problems of running the health service. The councils were seen to be necessary in order to give the service a 'human face', but they were not a particularly controversial part of the system and did not appear to be a significant preoccupation at that point.

So after the passage of the Act, but in advance of the appointed day for introduction of the new service (1 April 1974), a series of circulars was issued by the DHSS indicating what preparations were to be made for introducing new bodies and administrative arrangements. There were 87 circulars in all, and one of them was HRC(74)4, entitled *Community Health Councils*.[9] It was issued in England to the new authorities (the regional and area health authorities) and to the old authorities (the regional hospital boards, the boards of governors, hospital management committees, and the various local authority boroughs and councils) outlining what community health councils were meant to do and why they were being set up.

It referred to Section 9 of the 1973 Act which gives community health councils their statutory existence. Section 9 states that the Secretary of State is obliged to set up community health councils to cover areas, or parts of areas, and that the duty of each of these councils should be to represent the interests in the health service of the public in its district. The Secretary of State is given the power to make regulations covering the membership of community health councils, their proceedings, their staff, premises and expenses; also consultation and provision of information to councils by area health authorities, the right of CHC people to enter and inspect premises, the consideration by councils of matters relating to the operation of the health service within their districts, and the preparation and publication of reports. In addition, the Secretary of State is allowed to authorise payment of travelling and other expenses to CHC members; and lastly, the Secretary of State is given the power to

'(a) provide for the establishment of a body –
  (i) to advise Councils with respect to the performance of their functions and to assist Councils in the performance of their functions, and
  (ii) to perform such other functions as may be prescribed; and
(b) make provision as to the membership, proceedings, staff, premises and expenses of the said body.'[23]

This rather mysterious power relates to the national body for community health councils which is discussed in Chapter 3.

Setting up

The circular was really published to put a bit more flesh on the bones of Section 9, and it was the first detailed and official attempt to describe what community health councils should do. It also explained the vital steps that had to be gone through actually to establish a community health council in each place. The following stages were necessary.

First, the regional health authorities had to consult their appropriate local authorities about the number and the district boundaries of the community health councils that would be set up, and on the size and composition of each council.

Then, regional health authorities had to compile lists of voluntary bodies with an interest in the National Health Service in each district and publish advertisements inviting applications for inclusion on the list. After looking at the replies, and further consultation, they had to determine which voluntary bodies were to be invited to take part in appointing members. These selected voluntary organisations would be invited to confer in order to determine which of them should make the appointments. Then the regional health authority would invite those voluntary organisations to appoint the appropriate number of members to each community health council.

The rule is that half the CHC members should be nominated by

the local authority, one-third by the relevant voluntary organisations and the remaining one-sixth by the regional health authority. So the RHA, having been notified by the local authorities and by the voluntary organisations of their respective choices, could formally appoint these people and choose its own remaining appointees.

In theory, this process should have been complete in time for 1 April 1974, but of course it was unlikely that regions would move sufficiently fast, particularly in the light of their other more pressing concerns, to ensure that the services falling within their responsibilities would actually be functioning and managed by appointed staff by that date. So although a few community health councils were in existence in April 1974, it took the whole of that first year until April 1975 before all of them were set up in England. The West Midlands region, the largest region in England, was the slowest of all.

Having appointed all the CHC members, the regional health authority had to ensure that there was some mechanism for them to meet and start to conduct their business. The authority convened the first meeting of each of its community health councils, usually in the board room of a hospital or convenient committee room of the town hall, and invited the members to consider how they would appoint their own chairman and vice-chairman and set about the business of recruiting staff.

In Wales, the procedure was much the same, although not every community health council had been convened by April 1975 – it took a little longer. In Scotland, the equivalent bodies, called 'local health councils' took a great deal longer to get going, and first local health council meetings were not held until well into 1975.

Legislative changes

Further details of the membership, staff, other resources, and working methods are described in the next chapter. In this chapter it is simply the intention to outline the chronology of

events which led to the creation of community health councils, and to run through the legislative changes in relation to them after April 1974.

A most significant change, not only for the councils but for the whole of the health service, came in February 1974 when a general election returned a Labour Government which took office just before the appointed day for instituting the reorganisation of the NHS, and therefore had to oversee the subsequent stages of the reorganisation of which it was not itself the architect.* The new Secretary of State for Social Services, Mrs Barbara Castle, very quickly promised to publish proposals to make the reorganisation more 'democratic'. This promise was fulfilled in May 1974 when a pamphlet entitled *Democracy in the National Health Service*[11] appeared and was widely circulated for comment. This was followed in September 1975 by a circular with the same title[10] which announced the final decisions on the proposals contained in the pamphlet. In relation to community health councils these were, firstly, that henceforth each council would be entitled to send one of its members to meetings of the area health authority to act as an observer. These observers would have the same rights as members of the authority to speak during meetings, but would not be allowed to vote; nor would the observers be automatically excluded from those parts of the meetings which were not open to the press or public. In addition, the councils would in future be allowed to appoint their own staff through open competition. It had been originally proposed that CHC secretary posts should be filled by staff on secondment from the NHS and that there should be preferential advertising within the NHS first of all. Also, the councils would be able to require a representative of the district management team to attend their meetings to answer questions in public.

Some other new rules later affected community health councils. First, in May 1976, circular HC(76)25[12] was issued giving

*The Labour Party in opposition had been against the idea of appointed health authorities and the separation of management and representation.

further details about eligibility for CHC membership and the methods of appointing members. This relaxed some of the rules, enabling employees of the health service to become eligible, although it reiterated that people could not simultaneously be members of a community health council and of an area health authority or a regional health authority, or of a family practitioner committee. The circular urged nominating bodies not to appoint people over the age of 70 unless there was a special reason, to pick people normally living or working in the district concerned, and to give prospective CHC members a clear idea of the considerable amount of time and energy needed to be an effective CHC member. In addition, the circular told regional health authorities that they should include a trades council representative and a disabled person amongst their nominees to each council. Regional health authorities were also reminded that they had the duty to review periodically the number, size and composition of CHCs. Finally, the term of office of members who were due to retire on 30 June 1976 was extended to 31 December 1976, to enable people appointed in 1974 for a period of two years to serve for two years at least.

Rules of procedure

Section 9 of the 1973 NHS Reorganisation Act gave the Secretary of State the duty of establishing community health councils and empowered him to make regulations about various aspects of their functioning. The first set of regulations was circulated in January 1974.[22] In them, the Secretary of State delegates certain of his powers in relation to the councils to the regional health authorities, and forbids the latter to delegate these powers in turn to area health authorities – although they are allowed to require the area health authorities to help them do certain parts of the work. In Wales, the comparable powers rest with the Secretary of State for Wales, but he may direct the area health authorities to assist him.

The regulations then go on to discuss the number, size and

composition of the councils and lay down that at least one member of each council must be appointed by the local authority which covers the health area concerned, and that at least half the members shall be appointed by the local authorities. Local authority members do not all have to be elected councillors, but if a councillor is appointed and later ceases to be a councillor because of a local election, or for any other reason, he automatically ceases to be a member of the community health council. One-third of the members must be appointed by voluntary organisations and the remainder must be appointed after consultation with the local authorities (and such other bodies as the regional health authority may consider appropriate). The term of office of members is specified as four years, but initially one half of the original members should be appointed for only two years. The aim of this rule was to ensure that half the members of each council retire every two years. Subsequently all members would be appointed for a full four-year term.

All CHC members are eligible for a further term of office after their original term, but somebody who has been appointed for two consecutive terms is not eligible until a period of at least four years has elapsed.

The regulations lay down how CHC meetings should be conducted and require that no business may be transacted at a meeting unless one-third of the membership is present. It is required that minutes and proceedings of each meeting should be prepared and signed at the next meeting by the person presiding.

The next part of the regulations instructs the regional health authorities to appoint a person 'acceptable to the council' to act as secretary of that council, and also to appoint any other staff that the council may wish and that the regional health authority is satisfied may be necessary. In other words, CHC staff are chosen by the council and have to be acceptable to it, but the staff are formally employed by the regional health authority and not

by the council. The regulations oblige the regional health authorities to provide each council with office accommodation and other facilities for the conduct of its business, and to meet the expenses reasonably incurred by the council in performing its function. In practice, each council is allocated a sum of money to cover its necessary duties – and these include paying the staff, paying the rent and rates and other office costs, the travelling and other expenses of members, and any additional sums that may be agreed between the council and the regional health authority.

The regulations further require community health councils to provide an annual report to the regional health authority, to give copies to each relevant area health authority and to ensure that the report 'is made known to the public in its district' (regulation 18(1)). The area health authority must comment to the council on any recommendations or proposals made in the report, and ensure that these comments are also made known to the public.

Later in the regulations, in the part dealing with the performance of CHC functions, the key sentence is: 'It shall be the duty of each council to keep under review the operation of the health service in its district and make recommendations for the improvement of such service or otherwise advise any relevant area health authority relating to the operation of the health service within its district as the council thinks fit' (regulation 19).

Subsequent sections require area health authorities to consult the councils about any proposals that they have under consideration for substantial development, or for variation in provision. The authorities are also obliged to provide councils 'with such information about the planning and operation of health services in the area of that Authority as the Council may reasonably require in order to carry out its duties' (regulation 21(1)). There are provisos concerning confidential information and the right of appeal that a council has if information is refused.

The regulations give community health councils the right to enter and inspect any premises controlled by an area health authority, within reason, although for residential accommodation and any premises used by general practitioners, dentists, opticians or pharmacists, it is first necessary to obtain the consent of the users.

Lastly, the regulations require each area health authority to arrange, not less than once a year, a meeting between itself and the community health council to discuss in public such matters relating to the function of the council as may be raised by it or by the area health authority.

Suggested activities

That then is the first, and so far only, detailed set of statutory regulations describing rules, rights and responsibilities of community health councils.* Circular HRC(74)4 takes it a little further, partly by expressing many of the same points in less formal language but also by listing as an appendix matters to which councils might like to direct their attention.[9] The distinction here is between the passage in the regulations which simply instructs councils to take note of the operation of the health service in their districts and make recommendations, and the circular which specifies the mechanisms and subjects through which this shall be achieved.

The appendix says, first, that area health authorities must consult community health councils but the latter should not expect to wait until they are consulted, they can take their own initiatives. Second, the councils can be concerned not only with general provision and effectiveness of services but with the planning of new services, and, third, may criticise and comment on changes in the services. Fourth, it is suggested that the councils might want to look at the effectiveness of collaboration between the health services and local authority services. Fifth,

*The statutory instrument of 1973[22] was amended by SI 1976, No. 791[20], and by SI 1978, No. 21.[21]

standards are mentioned: it is suggested that the councils can monitor how the health district's provision of services relates to DHSS policies and norms. Item 6 says the councils may look at facilities for patients; for example, hospital visiting arrangements, waiting times, amenities, rehabilitation. Waiting periods for inpatient and outpatient treatment and for domiciliary services, plus the quality of catering in health service institutions, make up items 7 and 8.

Item 9 deals with complaints. It says, '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 individual complaints 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.'

The next chapter returns to this passage on complaints because, although it may appear fairly straightforward, the language is extremely ambiguous and has given rise to a number of interesting different interpretations of the rights that CHCs have in relation to complaints.

Items 10 and 11 in this list of suggested activities say that the councils may wish to divide their members into special interest groups, either looking at particular parts of a district, particular institutions, or particular health care groups such as the mentally handicapped or the elderly. And lastly, item 12 indicates that the councils must publish annual reports on their activities and will want to make these widely available.

So there we have the available guidance to community health councils who came into being for the very first time in 1974. The

members had to set about getting to know each other, getting to know how the local health services worked, and how they could perform the functions described in the regulations and circulars.

The health service itself, the area health authorities and regional health authorities, had no other guidance. They too had to get to grips with these new councils and understand what the descriptions and rules would mean in practice. It is not an exaggeration to say that there was a great deal of apprehension on both sides about quite what would result from this statutory establishment of a consumers' voice in the health service. A community health council, coming together for the first time, usually found that a member of the regional health authority's administrative staff had been seconded to it (and perhaps to several other councils) to keep its activities ticking over while the business of appointing the permanent staff was undertaken. This done, which usually took several months, the next priority was to find some permanent premises. So, it was not until well into their first year of life that the councils began to take a look at how the health services were working, and were able to start getting to know who and what was involved in the local health services.

What do they do?

We have studied the structural and administrative arrangements that were made to get community health councils started and working in their districts. This chapter describes what they do. The easiest way to go about this is to describe the rights they have and then to go on and look at the responsibilities they have to fulfil.

Rights

First of all the rights. The most important of these is the right to obtain information. The councils are allowed, and are expected, to question the health authorities on matters ranging from broad strategy to minute detail, depending on the issues that they have under scrutiny. It is written into the regulations that health authorities cannot refuse reasonable requests for information from community health councils. In practice, most requests have to do with local matters, with the detail of how particular services operate, in order to obtain an accurate picture of the intentions of health service managers about organising services. The information can come in a variety of forms and styles: it can be impersonal, objective, numerical, or it can be conversational, impressionistic, and personal.

In each case, the council has got to see what is available and choose the most fruitful source. The word 'reasonable', in relation to requests for information, indicates that councils should not expect to receive facts and figures that will take a great deal of trouble for the health authorities to collect and present, particularly if this information is not of much use to the health authority itself and of apparently doubtful use to the council. Also, if health authorities are particularly busy and collecting the information will take a lot of time or divert the staff from more important activities, the councils should be prepared to wait, or to forgo the request. Furthermore, if there are

alternative ways to get the information, the councils should not necessarily assume that it is the health authorities they have to go to. Nevertheless, a great deal, perhaps most, of the information that community health councils need about the operation of services will probably have to come from health authorities; so the right to ask for it is important and is one that most councils take very seriously indeed.

Another right is to visit health service premises; usually this means hospitals, acute or long-stay, both the inpatients' and the outpatients' sections. Many councils have formed panels of visitors and have regular programmes so that they get to know the staff and some of the patients and can understand in detail the way the place works. Often the visits are followed up by a report to the hospital authorities, and perhaps to the district or area authority concerned with the hospital, and there may be discussion of the report in open meetings. CHC visitors are not allowed free entry to doctors' or dentists' surgeries or to any other premises of which a health authority is not the owner or manager. To gain access to these sorts of places, councils have first to obtain agreement of the manager or practitioners concerned.

Community health councils have a number of specific rights, particularly in relation to the area health authority that covers their district. (In single-district areas, there is no district management team and the council deals directly with the area management team and area health authority). All the councils have the right to send an observer to meetings of the area health authority. This means that, certainly for the public part of the area health authority's regular monthly or bi-monthly meetings, a representative from each council is allowed to sit in and participate in the discussions, but cannot take part in any voting. It is recommended that CHC observers be allowed to stay, even if the health authority decides that it wants to go into private session to discuss matters without the presence of the press or the general public.[10] In many cases, the health authorities do not find it necessary to go into private session at all, but when they do

they are meant to allow community health council observers to remain unless a matter relating directly to an individual patient or member of staff is being discussed, in which case the community health council would not necessarily have an interest and would certainly not expect to be represented as of right.

The result is that the CHC members are allowed to participate quite fully at area health authority meetings, asking questions, making comments, although they do not in any way take the same part as a health authority member. Their job is to listen, to offer comment and information when appropriate, but basically to act as the 'eyes and ears' of their council, keeping track of what the area health authority is doing and how its plans are shaping.

Many councils send their chairman to the health authority meetings as the observer, some designate another member; but whoever it is needs to be prepared to attend the meetings regularly, to do some reading of papers before the meeting, and to be able to report back accurately to the council. This is an important right that community health councils have. It was not included in the original design but was announced after the publication of the pamphlet *Democracy in the National Health Service.*[11]

They have no similar right to send an observer to meetings of the other major committees or management bodies of the health service, such as family practitioner committees, joint consultative committees, regional health authorities, district management teams, or any of the planning teams. In many cases, however, as a result of negotiations between the council and the committee or authority concerned, agreements have been reached and CHC members attend these meetings as observers. But they have no automatic right and, so far, Ministers of State have resisted giving such rights, although they have recommended arrangements be made for CHC observers to attend meetings of family practitioner committees.

All those bodies of the health service that are governed by the

Public Bodies (Admission to Meetings) Act 1960[24], have to admit members of the general public to their regular meetings, but if they resolve themselves into private session the CHC observer has no special right to stay. District management teams, planning teams and similar groups are not obliged to open their meetings to the public anyway, so CHC members cannot necessarily get in by that route.

Reciprocally, community health councils are obliged to open their meetings to the general public and to the press, so any health service official or health authority member who wants to could attend a CHC meeting as a member of the public. There is no automatic right for any health service person, staff or member of authority, to observe CHC meetings. It is entirely up to the individual council whether it extends an invitation to any other organisation, within or outside the health service, regularly to send an observer to its meetings: there is no obligation. But community health councils can ask for a representative of the district management team (or area management team) to attend their public meetings to answer questions. This again was not included in the original specifications, but has subsequently given community health councils the power to question health service officials about matters of policy and about the operation of services, in the full view of the public and the press.

Community health councils are obliged to produce an annual report describing their activities, which has to be presented to the regional health authority, the establishing body. Although the regional health authority is not required to give any formal reply, the area health authority is required to comment on the report and to publish its response. There is a rule that each year the community health council shall have a meeting with its area health authority and this is usually where the annual report is discussed. The meeting is usually attended by the chairman, certain members and certain senior officers of the health authority, and most if not all of the CHC members and the staff.[22] The occasion can be quite formal, with discussion based

on an agenda that has been agreed in private before the meeting. It is rare for public attendance to be very considerable unless publicity has been given in advance to some issues of special interest.

Consultation

A further right of community health councils is to be consulted by the health authorities on their plans. The operational and strategic plans produced by the districts, areas and regions, have to be submitted to community health councils for comment and for suggestion. The timetable for doing this is roughly set out in the NHS planning guide[15], but there are no particular firm rules about the length of time that the councils should be given to comment, or about the detail in which their comments should be set out. Nor is there any obligation on the health authorities to accept the comments of the councils. But it is taken as implicit that, if such consultation is to be of any use, a health authority should acknowledge any comments made by a council and do its best to accommodate them in revisions of the plans, or to give good reasons why the suggestions are unacceptable. The only formal rule in this context is that the health authority shall consult the councils.[22] The detail of how it happens, when it happens and how effective it is, is left wide open.

A special case of consultation on plans occurs when a health authority intends to close a hospital or change its use. A DHSS circular sets out in considerable detail the steps that a health authority must take if it wants to close, permanently or temporarily, a health building or change its use.[8] This gives community health councils a specific role, in commenting initially on a proposal, in consulting the public about their views on the proposal, and in following through the range of comments that the health authority receives. The health authority is obliged to consult more widely than just the community health council or the staff; various other community organisations and other interests have to be consulted too, as do members of parliament and the local council.

After the initial round of consultations, on the basis of the document that the health authority has prepared, community health councils come into the process again to give their own views on the comments submitted by other groups. If the council is in agreement with the proposal, the health authority is fairly free to go ahead. If, however, the community health council opposes the proposal, and is able to put up a detailed counter proposal, the health authority may not proceed independently. It has either to change its own mind, or to persuade the higher authority (usually the regional health authority, which must then obtain the Secretary of State's approval) that the proposal is a valid plan and that the community health council's objections should be overruled. But it is, in the last resort, up to the Secretary of State to overrule the community health council's continued objection. If this happens, the health authority may proceed with the closure or change of use of the building.

In short, community health councils have the right to be consulted about closures and substantial changes of use of health service buildings, and if they object they cannot automatically be overruled. This is a crucial right, and again is one that was given some time after community health councils were first established.* It is a right and – it could be said – a responsibility given to them at a time when hospital closures are becoming increasingly frequent. Health authorities are in many cases forced to look to the big move – the closure of a whole hospital or a whole wing of a hospital – as a more practical way to save resources than to make a number of piecemeal changes. But such closures can alter very substantially the provision of health services to the community and it is vital for the public's voice to be heard. Community health councils have to have a go at fulfilling this role. More will be said in the next chapter about the practicalities of doing this.

These, then are the main rights of community health councils.

to demand and receive information

*One year and nine months after the first guidance circulars were issued.

to visit premises

to send observers to area health authority meetings

to have an annual public meeting with their area health authority

to be consulted on plans

to play a key role in proposed closures and changes of use of hospitals.

Responsibilites

Let us move on now to consider responsibilities. Some have already been mentioned, such as the responsibility to open meetings to the public and press, and to produce an annual report. Another major role here is to help individuals who want information and advice about services and, in particular, who wish to make a complaint. The original circular gave rather confusing advice on this[9], and it appears to have been interpreted in a variety of ways. Some community health councils have chosen shop front premises in the high street and offer 'advice bureau' type information to the public. Others, in less accessible premises, hold their regular meetings in different parts of the district, or have evening and weekend 'surgery' sessions in the style of local MPs or councillors. Some have agreed with local bodies, such as citizens advice bureaux or councils of voluntary service, to share their resources and collaborate in helping the public. Others have collected and disseminated information in the form of leaflets and booklets describing different aspects of local services.

On the specific question of complaints, the main problem for the public is to know what official procedures are, what rights they have, and how to best go about making a complaint. The community health council's role, as 'patient's friend', is to explain the procedures, to assist with making contact and writing letters (if required), and to ensure that the complainant's case is

adequately dealt with. For complaints about hospitals, the approach usually has to be made to the administrator of the hospital. For complaints about family practitioners there are informal and formal procedures, the latter involving the family practitioner committee. And if a matter has not been adequately dealt with by the authorities, it may be appropriate to ask the Health Service Commissioner to undertake an investigation. The various procedures are complicated and have all sorts of attached rules and exemptions which influence the best approach to be made. Community health councils can, therefore, be of considerable help in assisting people to find their way through this maze, although their job is not to assess or judge the complainant's case. By their activity, community health councils can not only assist individuals confidentially, but can also gather useful information on problems arising in their districts, and pass these general observations on to the managers.

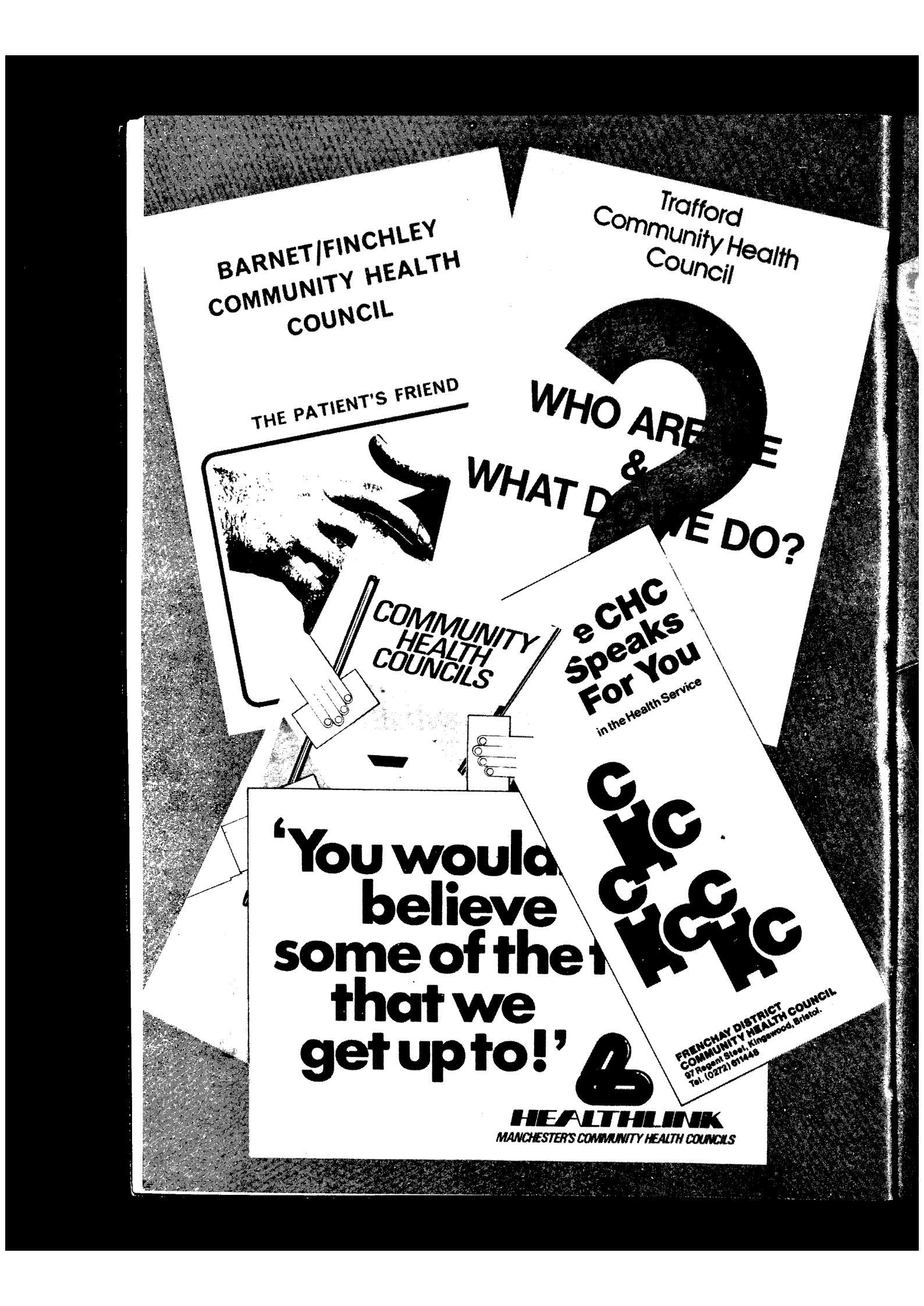
Beyond that, it is difficult to be categoric because little else is spelt out in any of the guidance or legislation. It is expected that community health councils will make themselves available to give the public help and advice, will listen to what the public has to say, and will invite the public to make comments, indicate areas of need and suggest lines of work which the councils should undertake. But all this is variable, and difficult to pin down in any official sources.

It is, nevertheless, apparent that most councils are active on three broad fronts.

> They play a part in giving individual members of the public help and advice about how to improve their own access to services, about how to make complaints or suggestions when problems arise.
>
> Most councils are active in commenting on plans and in dealing with proposals to close or change the use of buildings.

Most councils play a part in improving public knowledge about ways to avoid illness, and ways to make better use of facilities for treatment.

In practice, most councils regard it as an obligation to do something in all these areas; perhaps not equally and perhaps not simultaneously (some have specialised in one area rather than another) but the generalisation broadly holds.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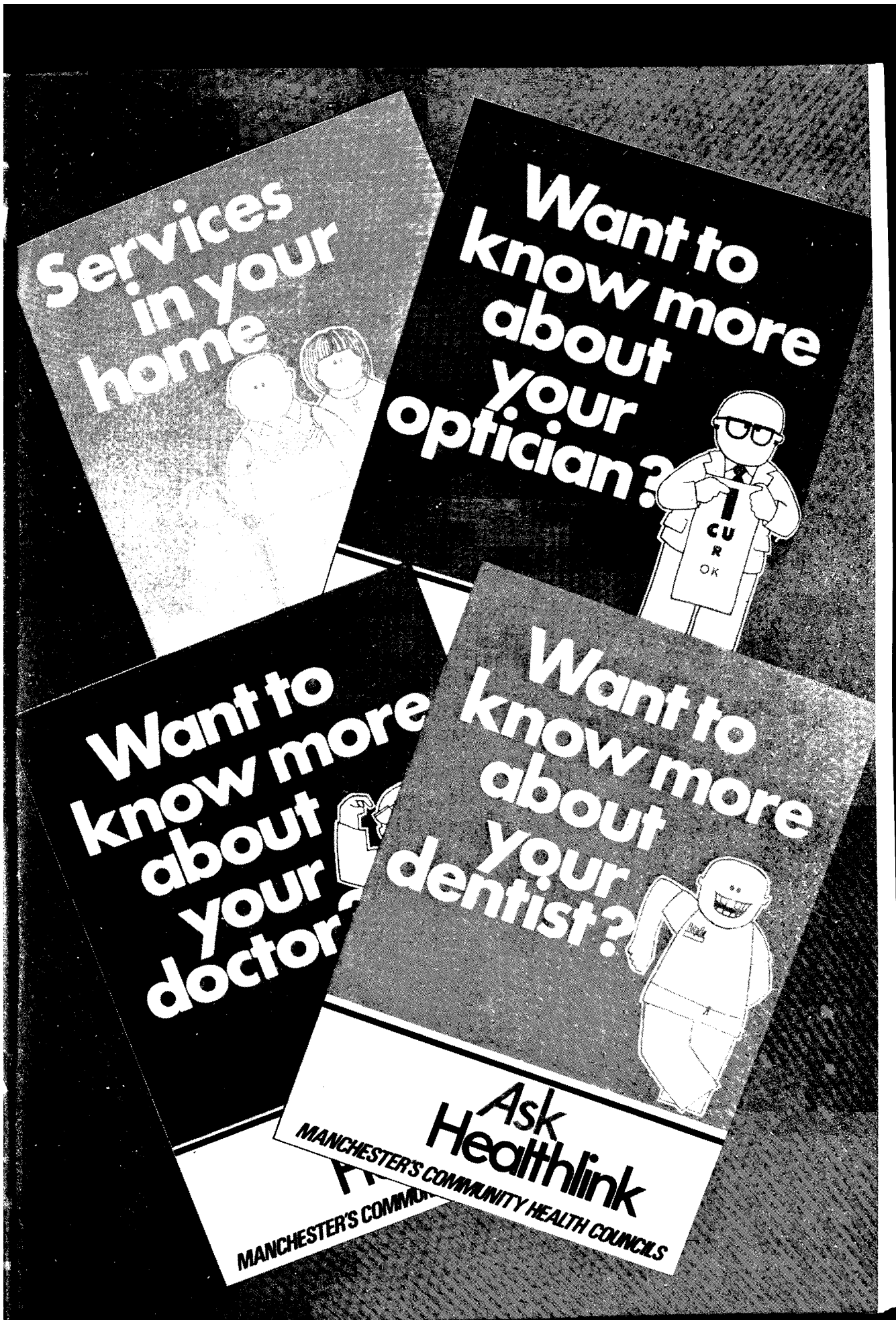
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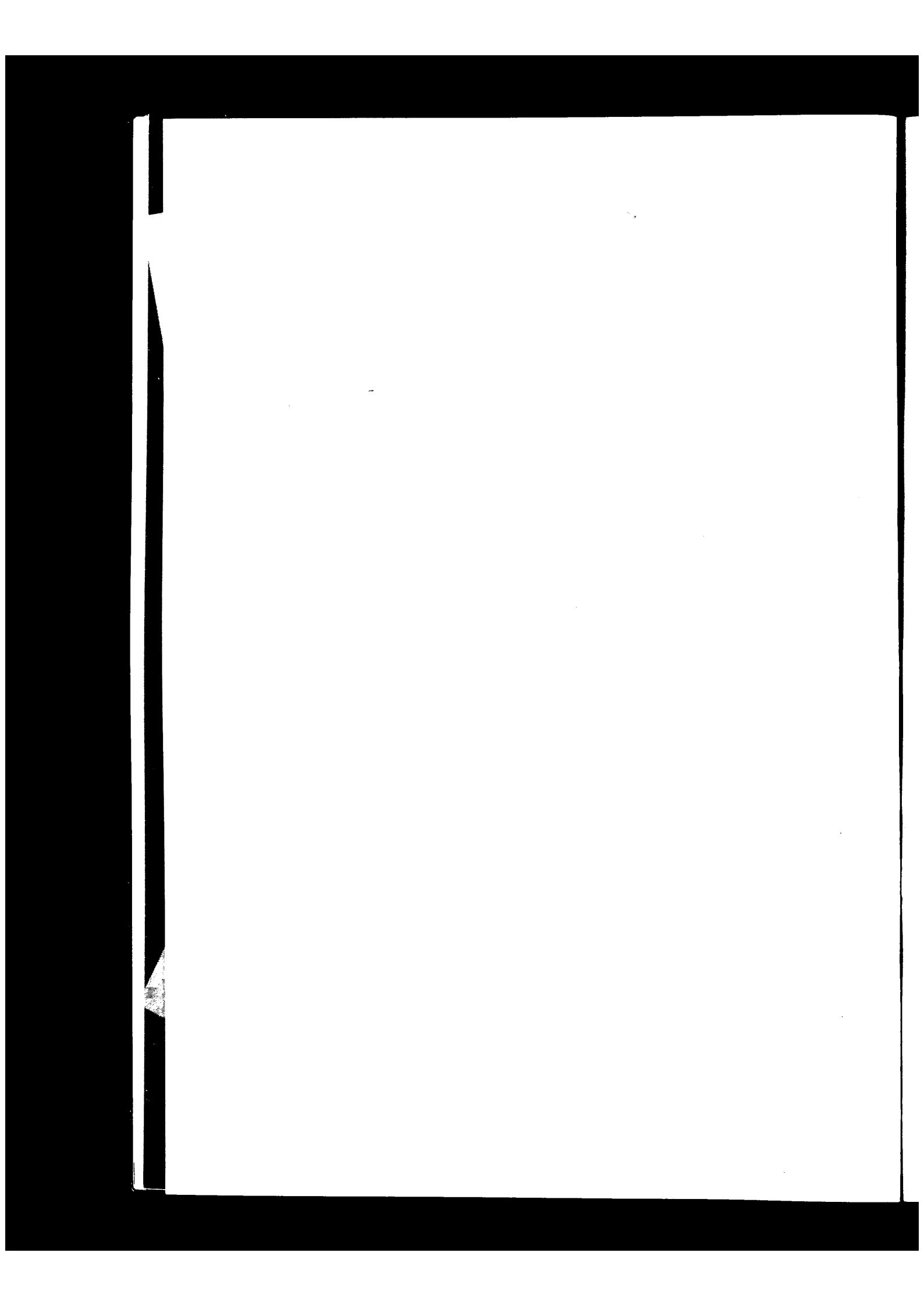


Working with others

Most of the day-to-day contact of a community health council is with the staff of the health services working in its district, or single-district area. But the councils also come into contact with a large variety of other individuals and organisations, both locally and from outside their own patch. The examples that follow should give some idea of this variety, and show how determined the councils are in extending their contacts in the community to make themselves more widely known both amongst the people they serve and the people who can influence the health services of the community.

Contact with the district management team

The district management team is likely to be the most common contact point and, by and large, community health councils have extremely good working relations with their district management team. This is not to say that they see eye to eye all the time. An interesting case of a difference of opinion arose in Islington, in north London, where a small band of protesters consisting of CHC people and members of the public picketed the Whittington Hospital to further their protest that women's services were being unduly curtailed as a result of the district's plan to cut spending. The CHC secretary, Marcia Saunders, was interviewed and said that although her council enjoyed a good relationship with the district management team, the team was failing to preserve the hospital services and that the council's protests about cuts, made at regular meetings with the team, had gone unanswered. The team reacted to the picket by calling a press conference at which one of the members denied all the community health council's claims. Indeed, the district administrator pointed out that there were regular meetings between the council and the team and that the former was closely involved on all the planning teams, so its form of action was

unnecessary (and the district management team was clearly hurt by it). But Marcia Saunders indicated that the pressure would continue and that it was in no way inconsistent with their otherwise good relationship with the team that the council should apply this kind of pressure.[29]

Another example of local relationships with the health service comes from Central Birmingham district where, in 1978, a new health centre was being planned for Balsall Heath. The community health council, in close communication with a range of community groups, was particularly concerned to see that a number of services would be offered from the health centre, in addition to the normal medical services. It managed to persuade the project team planning the health centre to include a representative from the CHC in its membership and it was also pressing for continuing resident involvement in the management of the centre once it had opened.[35]

Relations with the area health authority

In their relations with area health authorities, the experience amongst community health councils varies, and although many get on very well and work productively together, others have found it difficult to establish the sort of contacts they desire.

One very positive example comes from Kensington and Chelsea and Westminster AHA, in London, where one of the famous teaching hospitals, St Mary's in Paddington, has for many years been the subject of substantial redevelopment plans. In putting forward its ideas for redevelopment, the area health authority was obliged to consult the community health council covering the North-West Health District in which Paddington falls. The council said it could not accept the plan because it felt the community did not consider that the most suitable changes for the district's hospital services were being proposed. But, having rejected the area health authority's scheme, the community health council was obliged to provide alternative, constructive,

proposals, so it decided to take a large random sample of local opinion, asking health service users about their attitude to the health care being provided and about their wishes concerning hospital and primary care facilities.

The survey included four alternative schemes and asked respondents to pick the one they preferred. There was overwhelming support for one particular development. The community health council was careful to ensure that the survey was correctly conducted and for this it obtained the services of a medical sociologist and a market research agency. The respondents replied through a postal questionnaire and some were also interviewed. The area health authority was duly impressed by this attempt to develop a counter proposal. It announced that it would accept the council's suggestion for redevelopment and it involved the council closely in discussions about how the development could proceed.[2,4]

A further case of working together comes from Aberdeen, where the local health council had been particularly worried about continuing staff shortages at a psychiatric hospital and, instead of leaving this question to the Grampian Health Board, it decided to make some positive suggestions so that patients at the hospital need not suffer. It made the suggestion that a staff crèche should be set up in a nearby disused primary school, with equipment and a playgroup organiser provided by the city council, and nursery nurses employed by the health board. The local health council was convinced that trained nurses with children would return to work if a crèche were available, and that there were many unemployed nurses in the area who could staff the crèche. The health board was unresponsive, so the local health council set about gathering hard evidence from trained nurses who were not at work currently, in order to persuade the board that this would be a positive solution.[36]

Dealings with family practitioner committees

Reference has already been made to the difficulties that

community health councils can face in trying to have an impact on family practitioner services. Dealings with family practitioner committees can be awkward, and many general practitioners are suspicious of the council's interest in them. An interesting example of how to overcome this came from Crewe Community Health Council. The council embarked upon a large survey of people living in the district, asking them not only about the services provided by general practitioners, dentists, and pharmacists but also about the community and hospital services and preventive medicine. The responses concentrated on ways of making GPs' appointment systems less of a barrier, overcoming the problem of receptionists' hostility and getting access to primary care services.

The result of publishing the report of this survey, *'I like my doctor but . . .'*[6], was that the family practitioner committee and the area health authority set up a joint working party with Crewe Community Health Council to discuss the report and try to find out where improvements could be made.[33]

Other developing relationships

It is interesting to see how relationships with the Health Advisory Service have been developing. Usually, when the HAS visits a service or a hospital, it tries to make contact with the whole range of people concerned, and that can include a community health council, but many councils have found it difficult to make much of an impression on the HAS or subsequently to press for any changes that the HAS has made in its report – so the experience of Sefton Northern Community Health Council is worth recording.

When the HAS team visited Rainhill Hospital (which is not in Sefton Northern Health District) the council was invited to a meeting because people from its community use the hospital – a psychiatric hospital. The council made a strong claim to the HAS about the lack of its own district-based psychiatric services,

and this resulted in the HAS's report containing a special annexe on the problem. After pressure from the council, Sefton Area Health Authority agreed to try to get another HAS team to visit Sefton Northern Health District. This shows how a community health council's understanding of organisations outside the local district or area, such as a national service like the HAS, can help it to spread awareness of the need for improvements in its locality.[37]

Another national visiting service is the National Development Team. In 1978 it reported on its visit to Tatchbury Mount Hospital in Southampton and South West Hampshire Health District. The report describing a worrying situation in which custodial care, inefficient management, poor communications and lack of coordinated programmes of training were mentioned as deficiences in the service being provided for the mentally handicapped patients. The community health council welcomed the report and felt it confirmed impressions that the Council's members gained in contact with the hospital. When the National Development Team visited Tatchbury Mount Hospital they met the community health council, but one of the CHC members commented subsequently '. . . there is no mention in the report of the Team's meeting with the CHC, which raised many of the fundamental issues covered. This poses questions as to the importance the Team attached to the role of the CHC in the overall situation. Bearing in mind that CHCs are constituted by statute, the Secretary of State needs to be approached in order to ensure that the Team has a responsibility to take CHC views seriously in future enquiries.'[41]

Helping patients

Another way in which some community health councils are particularly active is in assisting patients who want to make suggestions and complaints. This is a delicate area where tact and care are important. The official complaints procedures are complicated, and, in some cases, the councils' attempts to assist

would-be complainants have met with considerable opposition from professionals. This has been particularly evident where CHC secretaries have represented patients at service committee hearings of family practitioner committees. In her account of this experience, one CHC secretary gave a vivid impression of the difficulties and concluded that new regulations were needed to ensure that complaints '...are not left to the vagaries of local committee rulings'.[32, 44]

Complaints and suggestions about all aspects of the NHS have been usefully analysed by Liverpool Central and Southern District Community Health Council in the report, *A Profile of Patients' Problems*.[31] This gives a constructive impression of the sorts of things that go wrong and worry patients. The Health Service Commisioner too, in his periodic reports, gives good examples of the vulnerable parts of the service.[3]

In considering other ways in which community health councils work to improve the health service for their communities, the role of ethical committees is worth mentioning. Area health authorities set up ethical committees to screen proposals to undertake research that will involve their NHS patients.[16] Warwickshire Area Health Authority asked each of the three community health councils to nominate a member to serve on the ethical committee which it had set up specially to oversee the computerisation of birth and immunisation records. The authority also nominated three other lay members to the 14-person committee.[34]

The needs of patients who have suffered from the side effects of taking certain prescribed medicines have also been vigorously pursued by a number of community health councils. In particular, Merthyr Tydfil Community Health Council sponsored a national campaign to help sufferers of the side effects of the heart drug, Eraldin. They enlisted the help of several other community health councils in England and Wales, both in bringing the problems of the sufferers to the attention of the

manufacturers, ICI, and also in putting pressure on the DHSS to improve the screening procedures whereby new drugs are allowed to come onto the market. The campaign is an outstanding example of cooperation between community health councils and also of cooperation between the councils, the press and various other community groups. The active pursuance of the issue by community health councils shows a constructive attempt to improve prevention of further disabilities of this kind.[30]

The councils help their communities in a less dramatic but equally effective way by offering their offices and meeting facilities to small groups which want to start up. For example, parents of children with a particularly rare disease may want to come together to share their own difficulties and experiences, and with no money or place it can be hard to make this happen. But community health councils can readily offer to facilitate these meetings. It makes no great demand on their resources and helps the community to increase its ability to develop self-help and a more confident attitude in tackling problems related to the health services.[28]

Helping the community

In the field of mental health, the International Hospital Federation has been sponsoring a number of initiatives to develop good practice more widely, and has realised that community health councils can be a particularly helpful source of information and a vehicle for dissemination, given their penetration into the local communities. A considerable number of CHCs have been discovering local projects for children and adults who are suffering or recovering from mental illness, and in passing on this information have helped the International Hospital Federation to spread the word internationally. In particular, Newcastle and Coventry community health councils have published reports describing their investigations.[39]

For some of their activities, community health councils need

additional staff or other help to make a real impact. An outstanding example is Worthing Community Health Council which has conducted an extensive survey of elderly people living in its district in order to present the health service with incontravertible evidence of their needs, and to base its suggestions for improvements on reliable data. The survey, conducted in 1976, was achieved with the help of nine people who were made available to the community health council through the Job Creation Scheme.[48,49]

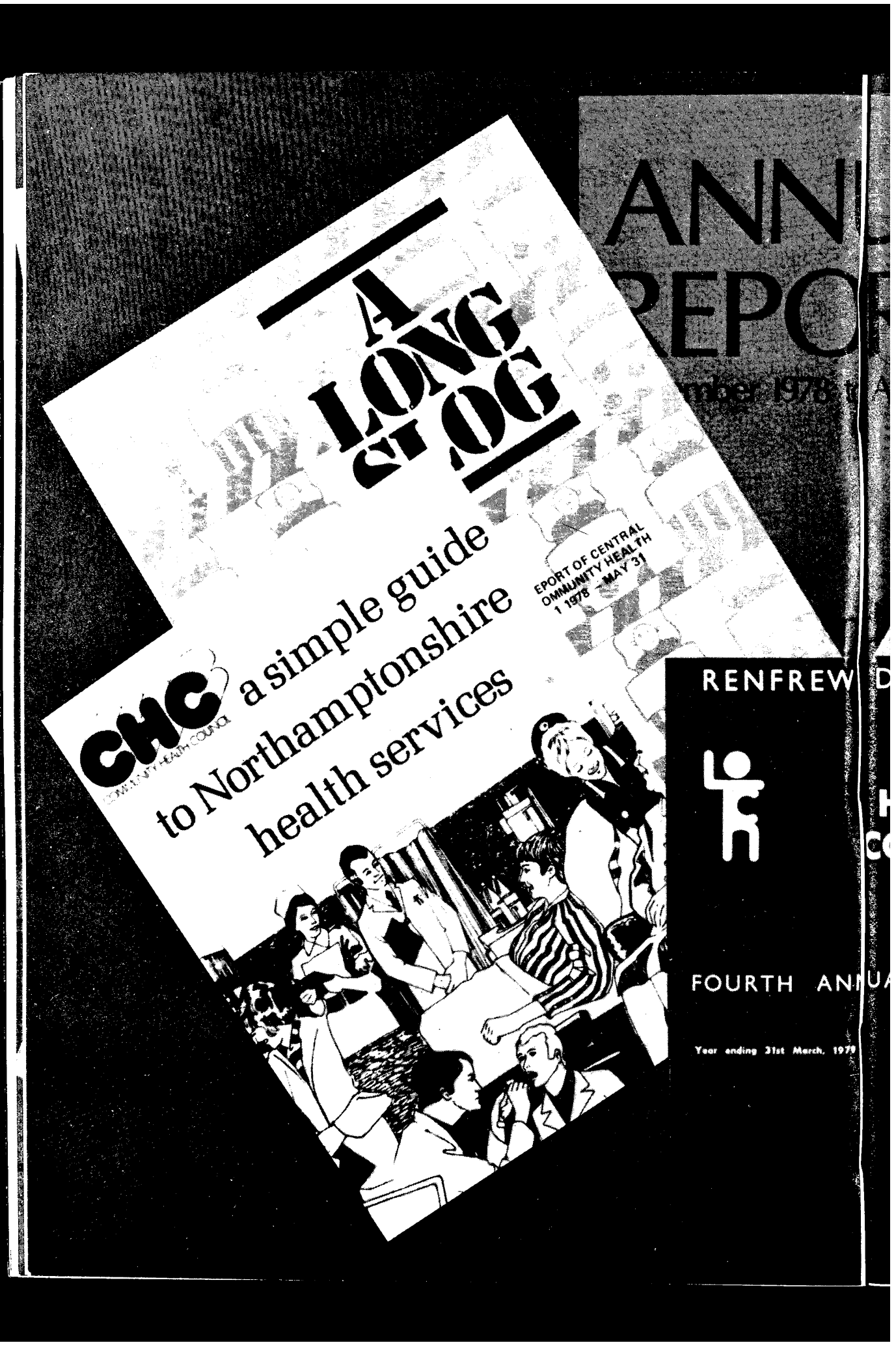
Since then, several CHCs have obtained additional workers through that scheme and through the Work Experience Programme. Another case is that of Medway Community Health Council, which has applied to the Manpower Services Commission for staff to investigate the employment needs of disabled people. These examples show that ambitious councils need not be hampered by their limited resources, and that by understanding the opportunities provided through national manpower policies the councils can not only do a great deal more work in their own district but can give new employees a most valuable and interesting experience.[38]

Working with each other

Community health councils have their own national organisations. There is an umbrella organisation, the Association of Community Health Councils for England and Wales (ACHCEW), which has gradually been putting together views and ideas from community health councils throughout England and Wales, the better to inform itself, the DHSS and other organisations concerned with the health service about the contribution that the councils can make. The Welsh Association of Community Health Councils, too, plays this role and has successfully applied to the Welsh Office for funds to develop publicity material that could be used throughout Wales to show the public what community health councils are doing.[47] Scottish local health councils also have their own national body: the Association of Scottish Local Health Councils.

Since the establishment of ACHCEW, community health councils have been considered increasingly by the DHSS as a suitable source of nominees for various important national advisory committees. One such committee is the Central Health Services Council which advises the Secretary of State on all matters relating to health policy. Helen Peston, a CHC member and former CHC secretary, has described her experiences of membership on the Central Health Services Council.[43] She observed, 'Given the endless network of consultation within the reorganised NHS I have often wondered if the CHSC is not an anachronism, and I may say that this view has been expressed to me by some of the professional members as well. However, I have been told by those who have been members for longer than I that there have been considerable changes, and that discussions in council meetings have become much wider and more controversial in recent years. Unless there is another change in the NHS Acts the CHSC will remain in existence, and I therefore believe that it is important that the lay voice should continue to be heard. Such a lay voice should always include CHC members.'

News about the activities of community health councils is spreading in other ways. Not only is there representation on national bodies, but CHC representatives are increasingly being asked to speak at national conferences and meetings. For example, in 1977, the annual meeting of the British Association for the Advancement of Science included a contribution from Pat Gordon, then secretary to City and Hackney Community Health Council. Her paper, published subsequently in *Providing for Health Services*, summarised the history of community health councils and listed a number of examples of their activities: giving information to the public and to the health authorities, dealing with complaints, being consulted on closures.[7] An article in *CHC News*, based on this paper concluded, 'CHCs have already demonstrated that their perspective is very important in getting the balance of services right. And it seems that the more they achieve, the more they are spurred on to do. They are still pushing forward the boundaries of what they can do and where they can be effective. In their short lives CHCs have aroused a lot of strong feelings: surely it is right to hope they continue to do so.'[5]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Have they been successful?

It is tempting to think that the creation of community health councils in 1974 automatically established a mechanism for hearing what the public has to say about the health service. But such a view is mistaken and this chapter will show what difficulties community health councils have encountered in trying to do the job they were given.

First then, what job were community health councils given to do? The NHS reorganisation Act 1973 gave statutory force to the belief that it was possible to separate two key functions in the operation of the health service. On one hand, management of services was given to the health authorities, while on the other, representation of patients' interests was given to the community health councils. From all the literature describing the functions of these two sets of bodies it becomes clear that, although health authorities are bound to be concerned about interests of patients, their main job is to manage in a professional and efficient way the resources available to them to provide health care to the populations they serve. In a complementary way, the community health councils are not expected directly to provide any health services and they have no resources with which to do this, although they are naturally concerned with the way the health services are offered to the community.* Their job is solely to give the public a voice to make its views known to the health service about the quality of provision for health care and prevention of illness.

Before the reorganisation of the NHS in 1974, the various

*Several community health councils have gone so far as to produce guides to local health services for their communities; for example, City and Hackney, and Ealing in London, and Northampton.

management bodies for hospital and community services were composed of individuals who were bound to take an interest in the public's view and were in some cases specifically meant to look after the needs of patients in their discussions and in making their decisions. But never before has there been a body distinct from the decision-making network that had *only* to concern itself with the public's view.

Learning the job

But, setting up the community health councils did not switch on the mechanism of representation, and it has fallen to the councils to find out precisely what this task involves. There are two aspects to it. On the one hand, the councils have got to learn how the health service works – and in 1974 this was a complicated business. With the confusion of reorganisation freshly evident and a great deal of uncertainty in the health service itself, the councils had to try and disentangle the various elements to understand the way health services were being provided, and this was not an easy job.

But simultaneously, they had also to learn the views among the public they were linked to. They had to discover who 'the public' was in any particular case, how it was going to be able to express a view, and how the community health council as an organisation was going to accommodate the views of its own members to the views that were being expressed to it by the public. Often, community health councils have found themselves not necessarily in agreement with some members of the public whose interests they must represent.

Many of the difficulties that have faced community health councils have simply been to do with the fact that they were new, and contained members who often had little experience of the kind of issues coming before them. They were also dealing with a health service that was itself trying to cope with the newness of reorganisation. So it is important to distinguish between those problems which have been simply a function of the newness and

those problems which are to do with the role that community health councils are trying to fulfil. Many of the problems of being new are resolving themselves as the newness wears off, and it is the next set of problems – those concerned with the role of representing the public's interests to the health service – which we shall now study.

They may be considered under three headings: first, access to information, knowledge and involvement in health service affairs; second, the problems of communicating effectively with the public; third, ensuring that the working methods and the membership of the community health council are 'switched on' to the tasks that are facing it.

Access

Taking access first, problems have arisen in obtaining information about the way certain health services work. Some councils have found their requests for explanations, or for statistics, being dealt with in a defensive way by some health authorities. Replies have been either unhelpful, or deficient, or have simply not been received at all. Because of this, community health councils have in some cases been severely handicapped because there has been no other way of getting that information. If the health authorities are not themselves prepared to provide it, the councils can be in difficulties.

Another form of the access problem concerns restrictions in visiting various kinds of establishments. Although community health councils have the right to visit health service premises, particularly hospitals and clinics, they have in some cases found it difficult to develop visiting patterns that really prove useful. Too often it has been a set-piece affair with the senior staff showing CHC visitors round in a very formal and elaborate way which does not necessarily enable the visitors to get a proper 'feel' of what the establishment is like or to talk to some of the staff and patients. In many cases this problem disappeared in time as the councils built up an easier relationship with the staff of

the institution concerned and were able to work out a mutually acceptable arrangement for visiting and reporting back. But in some cases, this is still a problem.

Community health councils have no statutory right to enter doctors' surgeries and health centres without the practitioners' permission, and this has in some cases given rise to a great deal of resentment. The councils have wanted to see what conditions are like for patients using the health centre or surgery and have found it impossible to gain access to visit and to discuss things with the practitioners. Many councils have got round this problem by inviting the practitioners to meet them on neutral territory to discuss their mutual interests in the service and to allay fears that they may be snooping or keeping an unfriendly eye on the doctor and his workplace. But some councils continue to find considerable problems in establishing good access to primary care facilities; health centres and surgeries in particular. This limits their ability to comment sensibly and in an informed way about the quality of primary care. They can only rely on what people tell them about their difficulties in, for example, finding a doctor, getting a home visit, or whatever the case may be.

Another dimension of the access question has to do with planning. Community health councils may find they have to rely on influence and persuasion to make their voices heard. The way the planning system has been designed and introduced in the National Health Service means they must establish early involvement if they are to be effective. Health authorities set up planning teams, both at area level and locally, of mixed groups of professionals who get together to establish the needs and priorities for particular services.[13] It is at this point that community health councils can have most effect if they choose to get involved. By commenting at an early stage on the ideas and intentions being discussed by the professionals, they can have a distinct impact on the proposals and recommendations.

In many cases, it has taken a long time for community health councils to be allowed to participate in planning teams and there are still several places where they are barred from involvement, either as observers or as members. This is a problem that needs serious attention because, without involvement in planning teams, the contribution that community health councils can make to the shaping of the services in the short and long term is quite severely limited. The consultations that health authorities are obliged to make with community health councils over their published operational and strategic plans are largely a ritual affair, in which far too little time tends to be allowed to the councils to work out and make known their considered comments. There is, understandably, such strong commitment on the part of the health authorities to sticking to what is in the published plans that they are unlikely to take much notice of any radical suggestions for change coming too late in the day.

Representing the public

The second set of problems has to do with knowing what the public wants from its health service. There has been a tendency for some community health councils to regard their own membership as a reasonably representative group of the population being served and, therefore, to assume that the views expressed by members will do as a public response to what the NHS has to offer. Certainly, there is a good deal of variety in CHC membership, although this has been characterised as predominantly middle-aged and middle-class.[26,27] But the membership of a council does not indicate necessarily predictable views about the quality and quantity of local health services. Generally, the membership leaves out people who tend not to get involved with the sorts of organisations which can nominate members – local authorities, political parties, trades councils, or voluntary bodies concerned with health and welfare matters.

So large sections of the community, and perhaps those whose views are most important to the health service, are frequently not

heard directly through the membership of community health councils, and it is therefore vital for the councils to go out and find out what the public thinks. The traditional way of doing this is to conduct attitude surveys or opinion polls of some sort amongst either the general population or selected groups such as the users of a particular service, the people waiting in the outpatients department, or mothers discharged from hospital after having their babies. Surveys of this kind are quite often useful but take a great deal of time and energy to organise, and sometimes the results can be challenged if the method has not been as scrupulous as critics would like.

The point remains, however, that whatever method the councils adopt, they certainly need to go out and discover what the public thinks. They need to adopt a variety of methods – surveys will not do on their own. They also need to try holding public meetings, advertising issues in the papers, organising special events and inviting the public along, using local radio and television to publicise the council's interest in different viewpoints, and so on.

Even the most gregarious councils have found it an uphill task to get public comment on the health service. It is still true that only a tiny minority of the general public knows of the existence of community health councils, and public attendance at the regular full meetings is low. Greater success has been achieved by holding public meetings in localities where people are concerned about a particular issue such as a closure or a change of service. Increasingly, community health councils are becoming better able to brief local reporters and prepare press releases about the issues and questions they are dealing with. But few community health councils can yet say with confidence that they genuinely represent the public which uses the health services in their district. Most can say they are having a good try at it, and that they are always on the look-out for new ways to do this and to improve their effectiveness. But, as a general observation, the councils have still got quite a long way to go before they can be

said to be well in touch with the different views that the public holds about the various services, and about how they might be improved.

Commitment

The third set of problems facing community health councils is the variability in commitment that different members show towards the work of the council. As a general rule, less than half of the members of a council will be actively involved: playing a full part in the council's deliberations, energetically involving themselves in visits and informing themselves about issues of concern to the public. The others are passive, probably turning up for the main formal meetings, and perhaps meetings of working groups, but not volunteering for much more and not really spending a great deal of their own time outside the formal meetings on such work as reading pamphlets and documents, writing papers, arranging visits, discussing issues with other groups.

So the workload – which is substantial – falls unevenly on the members. Those who are keen and choose to give a lot of time find extensive demands being made upon them. With only this quite small workforce, community health councils have perhaps been more limited in their effectiveness than they might have been if more members were actively involved in the work and better informed. The councils are not generally streamlined, powerful, efficient, and assertive organisations. In many cases, they are rather disorganised, willing but confused, trying their best in a rather amateurish way. Their financial resources do not enable them to buy much help, and the pay and conditions offered to their staff mean that only particularly dedicated individuals are going to be attracted to the post of CHC secretary. This has advantages, because commitment can develop, and the enthusiasm and energy for tackling the work are in many cases most impressive. But it is still true to say that community health councils are, in many cases, hampered by the

little time and involvement that most of their members are prepared to give to the work.

Being more effective

What are the solutions to these problems? Taking the last first, the commitment of members, it seems to me essential and possible for the next generations of CHC members to be rather differently motivated towards the job. At present it is left to voluntary bodies and local authorities to put forward the names of whoever they can find to take the job of CHC membership. Although some community health councils try to inform the nominating bodies of the responsibilities involved, too often unsuitable people are put forward – unsuitable in the sense that they are very busy and are not able to give a lot of time, or that they are not particularly interested in the style of work that community health councils have to adopt, that is to say predominantly the committee style of operation. Community health councils are still rather low-status organisations and if busy people are offered membership to other organisations perhaps they will find that more attractive.

So it is essential for community health councils and for regional health authorities (as the establishing authorities) to ensure that the nominators are clear about the time required to work effectively on a community health council and the sorts of obligations that membership entails.* These demand an interest in learning more about the way services work, in going out and listening to the public, in hearing what they have to say, in mounting all sorts of activities to give the public information, to obtain information from the public, and so on. Sometimes the work will involve 'pressure group' activities – lobbying,

*Circular HC(76)25 states 'Experience has shown that in order to carry out their role effectively, members of CHCs should be prepared to devote a considerable amount of time and energy to their Council's work. It is important that appointing bodies should take account of this, and confirm with prospective members that they can undertake the necessary duties, before putting forward nominations.'[12]

campaigning – and at other times very tactful and detailed work will be required to deal with complaints or personal problems that individuals may have. Effective briefing of nominating organisations to invite people who are potentially interested and available, encouraging them to sit in for a few times on CHC activities, would help to ensure that future generations of members will be better able and more committed to perform the job. And this will increase and improve the work-force available to each community health council.

The problems of access can be dealt with quite simply. It could be a rule, rather than a suggestion as it is at the moment, that community health councils be admitted to health service premises of any kind. It could be a rule that community health councils be admitted to meetings of family practitioner committees. It could be a rule that they be admitted to participate in the planning teams of the districts. These could be directives from the DHSS. The rules need stating much more firmly. At the moment, health authorities are merely *urged* to let community health councils get involved in planning teams and on family practitioner committees.[1,40] It is not a requirement: this could be changed.

The question of improving the council's knowledge of what the public wants is rather harder to tackle. There is no quick and easy answer. Community health councils will have to continue to find new and different ways of interesting the local public in their activities and find new and different ways of listening to what the public wants. They will have to improve their abilities to sample opinion and to test reactions to given changes. There are many people who use the health service and whose reasonable needs are not being met. It is a slow and steady working at this problem that will probably provide the answers, and many community health councils are fully aware of this. It is simply not possible to just 'switch on' public involvement: you have got to work very steadily at it. There are always going to be some people who are

not the slightest bit interested in discussing the health service, how it works, whether it could be improved. But it is important to get at those other people who *are* bothered, who *do* wish to see improvements, and to listen to what they have to say in a sensitive and an interested way. The next chapter takes these points a little further.

The future

The future of CHCs will depend upon the outcome of reactions to the government's consultative document, *Patients First*[17], which has followed the report of the Royal Commission on the National Health Service.[45] The commission reported that '. . . CHCs have made an important contribution towards ensuring that local public opinion is represented to health service management.' (para 11.35) The commission thought there was, nevertheless, some uncertainty and confusion about the role of community health councils. This had been confirmed by Professor Kogan's research on the workings of the NHS, conducted at the commission's request.[46] The commission reported, 'It is almost impossible to determine from the available evidence whether or not CHCs are fulfilling their functions of representing consumers and channelling local opinions to health authorities, and five years is not long enough for any new institution to realise its full potential.' (para 11.7)

The commission singled out three points where it thought changes should be made.

1 Community health councils should be encouraged to find shop front premises in the high street (or similarly accessible places).

2 The councils should be assured access to family practitioner committee meetings by right.

3 Councils should be given more resources to enable them to inform the public fully about local services.

These three recommendations are very supportive and would, if implemented, considerably assist the councils in doing a more effective job. They would each strengthen the capacity to understand and try to match what the public wants with what

the NHS could provide.They are a positive response by the commission to the evidence it received from community health councils. (It is interesting to note that most councils submitted evidence to the commission.)

In addition, the commission commented on the role of community health councils in helping people make complaints. It reiterated the observation made as long ago as 1973 by the Davies committee on hospital complaints procedure[18], and again in 1977 by a select committee of members of parliament[19], concerning the need for simple straightforward and effective mechanisms for dealing with patients' complaints. The DHSS has had little success so far in managing to gain wide enough acceptance of various proposals to improve the arrangements for dealing with complaints about hospital or family practitioner services. The commission reported, 'Since no procedure is likely to be known or immediately understandable to all who might have cause to use it, there is a good case for making the CHCs' role in complaints procedures a more active one.' (para 11.25) The commission went on to suggest that the councils should 'make it their business to ensure' that all hospital patients were readily provided with information about complaints procedures and knew they could seek advice from the council. But in undertaking to develop their work as the patients' adviser more fully, the commission suggested that community health councils should share the burden between their secretaries and members and other volunteers. They could also consider employing lay people to act as patients' advocates, based in health centres and hospitals, ready to take up patients' problems promptly and informally.

This shows quite a strong commitment by the royal commission to the community health council's role as the patient's friend and is consistent with a fundamental theme of the report that the NHS is first and foremost a service to patients. Not only would this recommendation serve as an aid to patients, it would help the councils '. . . on the much wider front of influencing health service provision to meet the needs of patients'. (para 11.30)

The handling of complaints is a controversial matter, and some community health councils who have tried to be active about it have met fierce opposition, particularly from the family practitioner services. There is still a great deal of reluctance to admit that suggestions on, or scrutiny of, professional activity by lay people should be considered. Yet it is surely the hallmark of a mature and confident service that it can not only admit things may go wrong from time to time but also accept responsibility for introducing remedies suggested by consumers or observers, if these are reasonable.

In many instances, the hospital and family practitioner services are responsive and helpful to such comments. But it is still true that a significant number of NHS staff and family practitioners cling to unneccessarily defensive attitudes.

From the sort of cases described by the Health Service Commissioner in his periodic reports of complaints he has investigated, it is clear that many of the reasons why things go wrong have to do with avoidable misunderstandings or failures in communication. It seems surprising that these trends do not diminish as lessons are learnt. Perhaps, with the royal commission's report to support them, community health councils may be able to assist the service to eliminate these unnecessary and distressing lapses more effectively. At any rate, the idea of a 'patients' advocate' is no longer new, and is a well established feature in such areas as legal and welfare rights, retail goods and services, and housing.

The anxiety that professional staff may feel about encouraging community health councils to play a fuller part in handling complaints is understandable, but unfounded. Two commonly expressed fears – that the councils will encourage irresponsible or trivial complaints, or that they stimulate greater numbers of complaints to be made – are not proven. Community health councils cannot afford to behave in anything other than a

responsible manner in acting as the patient's friend. If they appear to be vindictive, or to intervene without sufficient care or tact, they will quickly lose credibility and will be bypassed by those needing help, or dismissed by those who could provide remedies.

The royal commission also gives support to the development of patients' committees. These are one way in which consumers can work cooperatively with professionals to improve primary care services.[42] The commission reported that about 20 such committees had been established in health centres and group practices. The commission seemed impressed with this development and ' . . . would like to see positive steps taken to encourage the setting up of such committees and recommend that financial support should be given to enable them to get off the ground'. (para 11.34) This will encourage those councils who want to promote the idea with their local general practitioners. It represents an indirect way in which councils can help patients to help themselves and their doctors to improve important details of the primary care service with little fuss and, often, with significant positive improvement in the doctor-patient relationship.

The commission made a number of observations about the administrative structure, two of which have direct relevance to community health councils. First, in response to the overwhelming call for simplification, the commission suggested there should normally be only one management level below the regional health authority. This could best be achieved by splitting large areas, or merging small districts, to create more single-district areas, of a scale sufficiently local to be capable of managing the effective provision of the full range of services. The commission did not suggest this as a blueprint but rather as a more appropriate pattern that could be worked out for each area. The consequences for community health councils are important in that it has yet to be made clear who would be obliged to respond to a council's suggestions and requests. The commis-

sion thought that the rigid 'one community health council per district' model need not be followed, and that councils could be retained where districts were merged if this were agreed locally. There is already evidence of this because district mergers were being considered and arranged in several areas before the commission reported. Nevertheless, the report confirmed the view that administrative boundaries can be adjusted to suit local needs, and that this should be done in full consultation with all the relevant interests, including community health councils.

Second, the commission suggested that family practitioner committees should be abolished and their functions taken into the area health authority's responsibility (this is already the case in Scotland). It pointed out that if this were done, its recommendations about allowing CHC observers to attend FPC meetings could be modified to permit CHC observers access to the meetings of the area health authority that would perform FPC functions.

However, there is one further observation about the functions of area health authorities that the commission made which rather blurs the role of community health councils. The commission hoped that its recommendations for structural reforms would bring the health authorities closer to their task of planning and providing services, and because each level (region and area) would have authorities composed largely of laymen not employed by the NHS, they would be 'able to represent patients easily'. (para 20.52) The original idea of the 1974 reorganisation was that management should be separated, as a function, from the job of representing patients' interests. But the commission rejected the idea that the NHS could be more responsive to the public, either by transferring it to local government control or by requiring health authority members to be directly elected. It seems, therefore, to have reached a compromise by suggesting that members of a health authority as well as members of a community health council should represent patients' interests. If this were implemented, it would have to be judged whether the

result improved matters or whether it produced duplication of some activities (visiting hospitals, commenting on plans from the consumers' viewpoint) to the detriment of other interests.

The prospects for community health councils were summarised in 1979 by Mike Gerrard, secretary of the Association of Community Health Councils for England and Wales.[25]

1 They should receive working information from health authorities in manageable form, in adequate quantity, and in good time. There should be no argument as to what is necessary for them to do their work.

2 They should receive all relevant reports from outside advisory bodies and inspectorates, *and* reports prepared by health authorities' own inquiries, working groups, and project teams. It is not reasonable to assume that they would deal less responsibly than other bodies with matters of genuine delicacy.

4 They need an extra member of staff to deal with information coming in and to conduct necessary research to enable its interpretation and presentation to members in a purposeful way.

3 They should be free to spend their budgets on staff, on premises, on publicity, or in other ways, subject to normal financial checks; the idea that regional health authorities are somehow financing the councils out of their own pockets should be discredited.

5 Appropriate gradings for CHC staff, and a code of practice for their employment, should be established. Within this, the councils should be free to agree terms with prospective employees without outside pressure from regional health authorities.

6 They should be given a defined role in the planning of family practitioner services and their integration, or

coordination with corresponding services provided by the health authority.

7 The DHSS should finance a national publicity campaign for community health councils, using all principal advertising media.

8 The association should take responsibility for the wider public health interests of the councils and should develop its publicity, information and research roles.

In conclusion

What is already clear from the first five years of operation is that many interesting and exciting developments can take place if a well informed and committed community health council is prepared to take the initiative. The ACHCEW manifesto, the royal commission's recommendations and other proposals, would each help to strengthen the councils, but perhaps their greatest opportunity to develop lies in their collective experience. By learning from each other and exchanging information and views, they can ensure that their ability to represent the public is made most effective.

Community health councils cannot, and should not, be the only ones responsible for giving the public a voice in the NHS. Other methods (patients' committees, self-help groups, parliamentary debate) need to develop simultaneously so that a variety of approaches and initiatives can be tried. It seems clear that, whatever financial and administrative arrangements are made for the NHS, there are going to be persistent and difficult problems concerning the goals of the health service and the methods by which it tries to achieve them. It is by no means clear, for example, what the best balance between care and cure will be, or whether improvements in health would be best pursued through the NHS or in other ways. But what does seem evident is that, throughout consideration of these issues, the people's voice should be heard.

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community health councils after five years
by Ruth Levitt

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