KF PROJECT PAPER

Number RC5 July 1980

Consumers, Community Health Councils and the NHS

Christine Farrell
Ruth Levitt

Based on working papers of the Royal Commission on the NHS

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Published by the King's Fund Centre, 126 Albert Street,
London NW1 7NF. Printed in England by Trident Services,
London SE1.

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July 1980
Price £1.00

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126, Albert Street
London NW1 7NF

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EDITORS' INTRODUCTION

This is the fifth in a series of pamphlets based on the working papers of the Royal Commission on the National Health Service (1976-79). The two papers reproduced here deal with an area of growing importance in the health service, consumer involvement. The growth of consumerism in the health service during the past decade is in part a reflection of the more general consumer movement which developed in America and subsequently in Europe during the 1960s. The papers consider complaints procedures in the health service, the voluntary contribution to the NHS, patient participation in general practice, and community health councils. The Royal Commission's own report emphasised the importance of public involvement in the NHS by devoting a whole chapter to the NHS and the Public (Chapter 11) and by asserting in the first paragraph of this chapter that 'The interest, support and influence of the public are essential to the well being of the NHS'.[1]

The first paper in this pamphlet, consumer involvement in the NHS, was written in 1978 and has been updated since the publication of the Royal Commission's Report. The second paper on community health councils was written for the Commission in 1978 by Ruth Levitt, who was the editor of CHC News from 1975 to 1978 and is now a lecturer in the School for Advanced Urban Studies, the University of Bristol. It was submitted to the Commission as a personal paper from someone who was in a position to take a wider view of the development of Community Health Councils but with a depth of knowledge which made that view an expert one.

These papers complemented a wide range of material made available to the Commission on these topics, through written and oral evidence submissions, discussions with health service workers and members of pressure groups and other written material on the subject. The views

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[1] GREAT BRITAIN. PARLIAMENT. *Report of the Royal Commission on the NHS* (Chairman: Sir Alec Merrison) London HMSO 1979 **Cmnd 7615** para 11.1.

expressed in these papers do not necessarily reflect the views of either the King's Fund or the Royal Commission.

We are grateful to the King Edward's Hospital Fund for London for giving a grant to enable this material to be published and to the Polytechnic of North London where this project has been based.

Christine Farrell
Rosemary Davies

CONSUMER INVOLVEMENT IN THE NHS

Christine Farrell

INTRODUCTION

Surveys of consumer reactions to NHS services have shown that the majority of patients are satisfied with the treatment they receive.[1] But there has been a growing feeling in the past ten years that the procedures which exist to allow patients (or their relatives) to express dissatisfaction or register complaints are inadequate. It has also been suggested that the existing procedures actively discourage patients from either making complaints or constructive suggestions.[2] In part this probably reflects the feeling that consumers should have a say in services which they use and pay for, but it is also based on research findings which indicate that a greater volume of dissatisfaction exists than reaches the stage of formal complaints.[3] In addition, a series of inquiries into the treatment of mental hospital and long stay patients during the 1960s revealed the inadequacy of the complaints procedure and the need for additional protection for vulnerable groups of patients.[4]

COMPLAINTS PROCEDURES

The National Health Service Acts in 1946 established only one formal procedure to deal with complaints against professionals who contract to provide family practitioner services. Doctors and others working in the hospital service as salaried employees were subject to internal discipline and the Minister of Health was and is accountable to Parliament, for the actions of NHS personnel. Individual patients could sue salaried and contracted professionals through the courts, if they wished. Local health authorities had no generally established procedures but complaints against their employees could also be directed through the courts. The 1973 National Health Service Reorganisation Act did little to change these 'established arrangements', but it did make provision for Health Service Commissioners for England and Wales.[5] Scotland established the same post in 1972, but the appointment was not filled until 1973. These three posts are currently held by the same person, CM Clothier QC, who is also the Parliamentary Commissioner (the Ombudsman), and the Northern Ireland Ombudsman at present. Northern Ireland introduced a Commissioner for Complaints in 1969, who is empowered to investigate complaints arising in the field of hospital and health service administration.

The following sections outline the existing complaints procedures, developments which have taken place since 1973 and the evidence submitted to the Commission which relates to complaints procedures. The material relates mainly to the situation in England and Wales except where otherwise stated.

Hospital services

Guidance to hospital authorities on handling complaints by patients is contained in a DHSS Memorandum HM(66) 15 issued in 1966. This covers, in general terms, the principles, considerations, and methods for dealing with complaints. Subsequently, three letters were circulated, two in 1966 and one in 1970, offering further guidance on the procedural aspects of independent inquiries and the provision of information leaflets for patients and instructions for staff about methods of making and dealing with suggestions and complaints.

At the present time, if a patient wishes to complain formally about some aspect of the hospital service, he must do so in writing to the district administrator responsible for that particular hospital. Informal complaints or suggestions may be dealt with on the spot by the head of a department. If investigations follow from either kind of complaint, the complainant has to be told of the outcome of the investigation and that he can pursue his complaint with higher authorities if he remains dissatisfied.

The Davies Committee on hospital complaints procedure, set up in 1971 as a result of the revelations of the inadequacy of these procedures through the Ely, Farleigh and Wittingham Inquiries, published its report in 1973.

The Committee identified gaps in the procedures and guidance which they felt were inevitable, 'because the provision of principles and guidance does not provide properly for handling suggestions and complaints'[6] They felt that an established Code of Practice was necessary in order to give a clear indication of essential procedures. Their report contains a detailed suggested code of practice, which has formed the basis of a consultative document, circulated to all interested parties by the DHSS. In a written answer to a Parliamentary question on 9 February 1976, Barbara Castle said that she and the Secretary of State for Wales had accepted the main recommendation of the Davies Report, 'that health authorities should have a uniform written code of practice for handling complaints' in the hospital service. Her answer and the draft circular extends the code of practice to all complaints about health services, except those which relate to family practitioner services.

The other major recommendation of the Davies Committee, that an investigating panel should be established in each health service region to investigate complaints outside the jurisdiction of the Health Service Commissioner (ie complaints which touch on matters of clinical judgement), was rejected. Instead, the Secretary of State asked for a review of the present jurisdiction of the Health Service Commissioners for England, Wales and Scotland, by the Select Committee on Expenditure. Their report was published in 1977. The reason for this rejection was concern that there might be an overlap of functions between the panels and the Health Service Commissioners, which would result in public confusion.

The Davies Report and recommendations were warmly received by all those organisations which represented the consumer. The rejection of the recommendation for investiating panels is thought by them to substantially reduce the spirit of the Committee's report. Professional reaction to the Davies recommendations was critical. In her article in Social Science and Medicine, Margaret Stacey quotes the British

Medical Journal's reaction on 5 January 1974, 'Doctors in Britain are already nibbling at the concept of medical audit: if they are to obtain public support in their resistance to the Davies proposals they must show a clear intention to create an effective system within the profession for reviewing quality of patient care'.

At the same time an article in *Pulse* (referred to in Margaret Stacey's article) put forward the suggestion that an extension of the Health Service Commissioner's powers would be preferable to investigating panels:— 'After a judiciously timed period of opposition to the Davies proposals has transpired, it (the medical profession) should allow itself to concede to an ombudsman's adjudication in clinical judgement'. The fact that this suggestion has been substituted for the Davies recommendation on investigating panels by the DHSS in its review of complaints procedure has given strength to the belief expressed by CHCs and individuals in evidence to the Commission, that the medical profession is not really accountable to anyone outside the profession. This would change if the powers of the Health Service Commissioner were extended to matters concerning clinical judgement or if some system of medical audit or peer review was introduced.

Family practitioner services

Complaints about general practitioners, dentists, opticians and pharmacists providing NHS services have to be made in writing to the FPC administrator within eight weeks of the event which gave rise to it. This procedure has remained basically the same since beginning of a health service in 1911.[7] Neither the 1946 Act nor the 1973 reorganisation made any substantial changes to it. The complaint must allege a breach in the practitioner's contract with the FPC. The FPC administrator decides whether the complaint is serious enough to warrant its referral to one of the FPC Service Committees. These are small bodies appointed by the FPC with professional and lay members. If it is referred, the Committee hears the complaint and gives the complainant and the practitioner a chance to present their cases and to call witnesses. The decision which the Committee reaches can be appealed against by either party. If an appeal is made, the Secretary of State can arrange for an oral hearing before a small committee where both parties can be legally represented. If, after this, dissatisfaction still exists, the complaint may be referred to the National Health Service Tribunal.

The main dissatisfaction or complaints against this procedure are that:

- it is a complex, time-consuming and expensive procedure which would deter all but the most determined;
- it is administered by the very people who are responsible for providing the service;
- the time-limit imposed on the initial submission is too short;
- matters of clinical judgement cannot be considered;
- the question of whether CHC secretaries can act for the patient and the difficulties of the legal aid system.

A consultative document on reform of FPC complaints procedures was circulated by the DHSS in 1978. The proposals suggested that committees for dealing with complaints might be independent; the time limit for submissions might be extended from eight weeks to six months, and service committees might also have the power to ask for case notes to be released for examination by the complainant. Consultation is still taking place on these proposals.

The health service commissioners

The 1973 National Health Service Reorganisation Act made provision for Health Service Commissioners for England and Wales. The Commissioners may be approached directly by members of the public, but only to investigate a complaint which has previously been sent to the relevant health authority. One exception to this is that staff may write directly to the ombudsman on behalf of a patient (or patients) who is unable to complain for himself. The Commissioner's terms of reference allow him to deal with complaints relating to the provision of the service, the organisation of hospital and clinics and administration. He cannot deal with matters concerning clinical judgement, with matters on which he judges that it is the complainant's intention to litigate, nor may he question the merits of a decision taken without maladministration. The complaints must be individual, not general.

Evidence to the Royal Commission on complaints procedure

Two distinct views emerged from the evidence on complaints procedure. One, mainly from professional organisations, opposing changes or developments on the grounds that encouraging complaints would reduce patient confidence and expose staff to unpleasant situations. The BMA commented that the new hospital complaints procedure 'seems almost designed to undermine the patient's confidence in his doctor at the time of admission to hospital'.

The other view put forward mainly by CHCs, some health authorities, individuals and organisations with an interest in the consumer, is that the procedures need revision because they are designed to discourage complaints and are administered by the people who are also responsible for providing the service. This case was put most succinctly by Trent Regional Health Authority:— 'It is felt that the existing arrangements are open to criticism on the ground first that the body which is responsible for providing the practitioners' services to the public . . . also decides whether a complaint is justified; and secondly that the machinery for hearing complaints about the performance of contracts and the quality of service provided rests entirely in the hands of the administering authorities and professions which are parties to the contractual arrangements'. The weight of the evidence supported this view.

THE ROLE OF THE COMMUNITY HEALTH COUNCILS

Community Health Councils came into being through the NHS reorganisation in 1974. Their task is to represent the views of local users of the health services to the health authorities. There are 228 CHCs in England and Wales. Half of their members are appointed by the local authorities, one third by voluntary organisations and one sixth by regional health authorities. Appointments are normally for four years and half the members retire every two years. Finance is provided by RHAs. Scotland has similar bodies called Local Health Councils and Northern Ireland has District Committees. The arrangements for these countries are similar to those in England and Wales.

No specific guidance has been issued about the role of CHCs but a DHSS Circular HRC (74)4 outlines their organisation and some of the subjects to which they might direct their attention.

Perceptions and interpretations of the role of CHCs vary. Some see them as watchdogs of local health services protecting the patients' interests and helping to develop local services to meet local needs. Others see them as powerless tools of area health authorities, being manipulated to serve the interests of administrators and practitioners. One view, expressed in 1974 was that the existence of CHCs would lessen the opportunities for the consumer voice to be heard rather than increase them, by replacing the lay person in management by management committees and teams: 'Whereas in the past consumers were represented after a fashion at all magerial levels, they are now to be organised into Community Health Councils . . . it must be noted in passing that even if these Councils work well (and many predictions are gloomy) they are no substitute for an effective consumer viewpoint available during decision making at all levels of health service management.[8] It is certainly true that CHCs have no managerial responsibility for the provision of services and many of them feel that they are powerless. In the past five years however, CHCs have worked at developing their relationships with district teams and officers and staff of AHAs. Many of them have also worked at establishing local needs and priorities and have collected information which they use to present a case to management and officials. Those who believe that CHCs have a part to play would endorse the view that: 'They are, through their knowledge of the way the NHS works, and through their involvement in the planning cycle, uniquely able to promote the more effective use of limited resources, particularly in relation to the needs of the local community.[9]

In 1974 and '75 attempts were made to increase the effectiveness of CHCs by allowing one of their representatives to attend AHA meetings with the right to speak but not to vote. The idea of a national association was floated and it was established in 1977. The DHSS agreed to finance CHC News and an information service in 1976. It is difficult to assess at this stage how effective CHCs have become in their overall role, but in respect of the part they have to play in advising and informing patients about complaints procedures there is some evidence that they are fulfilling a need. A conservative estimate of the number of complaints which flow into CHC offices each year has been put at 9000.[10] In 1978 the Health Service Commissioner received 712 complaints although he was only able to accept 138 of these as falling within his terms of reference.

The evidence to the Commission about the role of CHCs is concentrated on the questions of their ill-defined functions, the need to extend or curtail their power, and relationships with FPCs and AHAs. The evidence revealed uncertainties about the roles CHCs should and do play. Conflicting opinions were expressed about consultation, and whether they should be given a formal part in the decision making process. The position as stated by one body submitting evidence was:— 'Given a full democratisation of the management of the health service, it would not be necessary to have CHCs and there would be a considerable administrative saving. Short of this it has been suggested that the role of the CHCs should be strengthened by giving them some powers of decision in relation to the assessment of priorities.'

The feeling which emerged from the evidence was that the public should have a say in the decision-making process, but there is little agreement about how the consumer voice should be heard. Questions which need to be considered are:

- Should there be any change in complaints procedure?
- Should the consumer have a say in the NHS decision making process? If the anser is **YES** –
- How can the consumer voice be organised to facilitate the best use of NHS resources.

THE VOLUNTARY CONTRIBUTION TO THE NHS

The size of the voluntary contribution to the working of the NHS is difficult to asses accurately but it is obviously considerable. The service is to a large extent managed by voluntary members of health authorities and members of Community Health Councils are volunteers representing public opinion to the NHS. Apart from this, volunteers work within the service in many different ways. In its evidence to the Royal Commission on the NHS, the Volunteer Centre identified nine types of activities through which voluntary organisations contributed to the NHS. They were: befriending patients; skilled help in occupational therapy (eg embroidering, flower arranging); provision of specific services like canteens, libraries and trolley shops; entertainment; fund raising; special interest groups, eg mental handicap; self or mutual help groups; pressure group activities; and pioneering new forms of care, eg home from hospital schemes.

The size of the voluntary sector

The number of people involved in voluntary activities of all kinds is not known, but some indication is provided in a survey carried out by National Opinion Polls Ltd for the Wolfenden Committee in 1976. In this sample of 2,114 people 16% said that they had taken part in voluntary work during the preceding year, most of them working through voluntary organisations. The average time spent on voluntary work was said to be six hours per week. Extrapolating from this sample population, the authors suggest that 'five million people work voluntarily for an organisation each year, three million each week, and that some 18 million hours are worked weekly'.[11] Not all of them work in the NHS of course – but nearly two-thirds of all voluntary effort is said to be in the personal social services. Of the volunteers interviewed in the NOP survey, one-third worked with or for the elderly, a quarter with children and young people, and one-sixth with the physically handicapped. Very few mentioned working with the mentally ill or mentally handicapped.

THE WOLFENDEN REPORT

The Wolfenden Report had this to say about voluntary effort in the NHS: 'Since the creation of the NHS the size of the voluntary sector in health has been small. The recent transfer of the Ambulance and Family Planning Services to the NHS has meant further reductions in the voluntary sector; but bordering on the personal social services field there is considerable voluntary involvement in the care of the sick and the handicapped, in raising money for medical research and in first aid services.'[12]

Evidence for the last part of this statement is provided from 'locality studies' carried out by the Wolfenden Committee in three towns in England and two in Scotland. The aim of these studies was to produce a complete picture of voluntary organisations in each area. In the three English towns more than one in five (ie 22%) of all the voluntary organisations were involved in helping client groups or services in the health field (ie organisations for physical and mental handicap, mental health, hospital and health service). If organisations to help the elderly (excluding social and luncheon clubs) are included, the proportion rises to 25%. The proportion of organisations involved in these activities in the two Scottish towns was much smaller at 13%.

The Wolfenden Report does not make specific recommendations or suggest ways in which improvements could be made in the future organisation of voluntary activities. This, they say, would be 'particularly hazardous at the present time and would in any case be incompatible with the spontaneity of growth inside the voluntary sector' (p 193). The report identifies several areas of weakness: the unevenness of distribution and performance of voluntary organisations; the fact that some areas of need are neglected by voluntary effort; and that duplication and overlapping between one organisation and another exists. In conclusion, the Committee suggest that there is some room for improvement in the management of voluntary organisations and that every organisation should 'engage in deliberate self-examination about its aims, purposes, successes, failures and possibilities for redirection of its activities' (p 191). It also urges the government to take the initiative in working out, with the agencies, a collaborative social plan to make the best use of resources.

Evidence to the Commission on the voluntary contribution

The evidence to the Royal Commission was more fruitful with ideas and suggestions for ways in which the voluntary contribution to the NHS could be improved and extended, particularly in the field of community care. Age Concern suggested that DHSS should specify on which services voluntary organisations should concentrate and the central Nottinghamshire district nurses recommend that primary health care teams should incorporate a voluntary organiser. Other suggestions included coordination of hospital and community volunteers, the extension of voluntary health service coordinators, and an area card index to all facilities and organisations for use for the mentally handicapped. These suggestions point up one of the most valuable contributions of voluntary organisations which is their ability to initiate and try out at local level new methods of service provision.

The evidence also points to some of the difficulties of using volunteers in the health service. The relationship between the trade unions and voluntary labour, highlighted in the strikes of winter 1979, can be difficult. Permanent staff can sometimes resent volunteers and their jobs can be made more difficult by them. Indiscriminate use of volunteers is obviously unwise and the need for voluntary organisers to train and co ordinate their activities is vital. At the same time, it is obviously important to avoid 'bureaucratising' voluntary effort.

Almost all those who submitted evidence emphasised the importance of the voluntary contribution and the need to increase and improve liaison and collaboration with hospital and community services.

One important development which might well be considered under the voluntary contribution to the NHS is patient committees in General Practice.

PATIENT PARTICIPATION IN GENERAL PRACTICE

Recently, alongside the creation of CHCs as representatives of the consumer within the NHS, patient committees have evolved as a spontaneous expression of a few individual GPs' desire to improve or change their services in line with patient suggestions. The first patient committee was set up by Dr Alistair Wilson in Aberdare, South Wales, in 1973. Dr. Wilson has described the purpose and working of his committee in an article in the BMJ[13]. Briefly this committee represents patient views to the doctors working in the health centre and acts as a focus for regular monthly meetings.

About a year later, and quite independently, another patient group was established by a doctor working in the Whiteladies Health Centre in Bristol, Dr T Paine. This group has regular monthly meetings to discuss patient suggestions and health education matters. A volunteer scheme has been established with a community care coordinator in charge so that crisis and long term help by patient volunteers can be offered to others in the practice. Unlike the Aberdare Association, not all the doctors in the Bristol Health Centre take part in the scheme.

Welsh Consumer Council: Patient participation in general practice

In 1978, Ian Shaw produced a report for the Welsh Consumer Council (WCC) on patient participation in general practice[14]. The report is based on a survey of the first elected patients' committee in Britain: the Aberdare Health Centre Patients' Committee.

As background to the survey, the origins and the functions of the Committee are outlined. It was established in 1973 for a number of reasons: a new health centre covering a population of 10,000 had just been opened in Aberdare; there was a great deal of concern over needs of elderly patients in isolated areas; the view that less articulate patients needed representation in a decreasingly democratic NHS was gaining credence in the area.

The functions of the Committee were laid down as follows:

1. to participate with the doctors and other members of the Health Team in running the primary care service at the Health Centre,

2. to consider complaints and improvements in the service,

3. to provide health education, lectures and discussions; to teach positive and preventive health, including the early signs and symptoms of disease,

4. to communicate the opinions of the patients to other bodies, such as the Community Health Council, the health authority, local authorities, etc,

5. to improve the level of care available.

The survey relies on 37 interviews with patients, a postal survey of 22 members of the Patients' Committee with a response rate of 20; and interviews with a random 1 in 3 members of the Patients' Committee, 4 doctors and 1 social worker. Topics covered included recruitment to the committees, membership, attendance, public awareness, beliefs and attitudes about patient participation, perceptions of quality of treatment and ease of access to doctors, and the philosophy of 'open medicine'.

The responses analysed indicate that:

1 patients and doctors are in general in favour of the existence of the Committee. Indeed, without the co-operation of one particularly charismatic GP, it is clear that the Committee would not exist. A point which perhaps leads to the conclusion that in the areas where patient participation might be needed most, ie socially deprived inner city areas relying on single handed practices, the crucial support for establishment of patient committees would be lacking;

2 the only issues revealing any ambivalence are firstly, the Committee's handling of complaints which some doctors feel should not be their task, and are on the whole dealt with in a most co-operative manner, perhaps even preventing patients from pursuing alternative channels of complaint; and secondly, the concept of 'open medicine'. Doctors and ordinary patients agree that this is a delicate issue and that it should remain the doctor's private decision whether to tell all to the patients, although there should be more patient involvement in knowledge about treatment programmes. However, the Patients' Committee members were unanimous that patients have a right to know all;

3 most of the responses relate to low-key issues that doctors and patients are keen to see developed or improved, health education, community care, and the interface between primary and secondary care.

On the basis of the Aberdare survey, the Welsh Consumer Council made a number of recommendations on patient participation. They noted that the Aberdare experience was particularly important in view of the growing number of patient committees which in February 1978 formed the National Association for Patient Participation in General Practice:

1 committees should recruit members as citizens with an interest in the broad spectrum of health and patients' rights, not solely as patients representing particular patient sub groups. The latter

should be represented in semi autonomous sub committees.

2 the functions of developing preventive care and health education, and community care are clearly valid and approved areas for patients' committees. Their involvement in complaints or health centre administration requires more discussion and clarification.

3 rather than vague goals, committees need specific terms of reference: health education; the interface of primary and secondary care, etc.

4 the philosophy of 'open medicine' still provokes uncertainty amongst both doctors and patients.

5 patient committees must decide whether they wish to represent a practice or a geographical area.

6 the WCC feels statutory provision for patients' committees should be resisted; they should remain grass-roots organisations.

The report is a useful description of the first of the growing number of patients' committees. Aberdare illustrates the need for sympathetic support from health care staff; the dangers of a small cadre of elderly 'committee types' taking over patient representation (over 50% of the 25 committee members were involved in other health and welfare organisations in the district, with an average length of time at the practice of 38 years) and some of the issues which patients' representatives can appropriately and successfully grapple with, for example, Aberdare Patient Committee includes amongst its successes, improvements in ambulance services, and 100 health education lectures.

Recent developments

The number of patient participation groups has increased quite rapidly during the past five years. At a Royal College of General Practitioners seminar in December 1979, doctors, social scientists and consumers met to share experience of 26 such groups now operating. Dr A G Donald, chairman of the Royal College of General Practitioners, welcomed the spread of patient participation groups: they provided discussion forums and health education; they gave consumers more say in planning and provision of services; and they brought providers and recipients of care closer.

Successes claimed by patient participation groups included saving transport costs and staff time by fetching prescriptions and taking patients to services; encouraging more appropriate local facilities to be opened reaching social classes 4 and 5 and ethnic minorities, thereby persuading better use of services, and reducing the mismatch between what general practices offer and what the public wants. Reservations were expressed about some general practitioners' attitudes to the development of patient participation groups. Some GP trainees, for example, feel 'participation' equals 'interference and complaining'. The Department of General Practice at Manchester University is conducting an exploratory study of the development of patient participation groups in general practice and general practioners' attitudes towards them.[15]

REFERENCES

1 CARSTAIRS V *Channels of Communication.* Scottish Health Service Studies No. 11 SHHD 1970.

CARTWRIGHT A *Human Relations and Hospital Care.* London Routledge, Kegan and Paul 1964.

CARTWRIGHT A *Patients and their Doctors.* London Routledge, Kegan and Paul 1967.

McGHEE A *The Patient's Attitude to Nursing Care.* Institute for Operational Research and Human Resources Centre, Reading 1961.

Department of Health and Social Security and Welsh Office, *Report of the Committee on Hospital Complaints Procedures.* London HMSO 1973.

RAPHAEL W *Patients and their Hospital.* King Edward's Hospital Fund 1969.

2 STACEY M 'Consumer Complaints Procedures in the British National Health Service' in *Social Science and Medicine* vol 8 1974.

3 McGHEE A *op cit*

4 National Health Service. *Report of the Committee of Inquiry into allegations of ill-treatment of patients and other irregularities at the Ely Hospital,* Cardiff. Cmnd. 3975. HMSO, London 1969, reprinted 1970; National Health Service. *Report of the Committee of Inquiry into Whittingham Hospital.* Cmnd 4861. HMSO, London 1972.

5 NHS Reorganisation Act 1973, HMSO, London.

6 Department of Health and Social Security and Welsh Office,

Report of the Committee on Hospital Complaints Procedure. London, HMSO, 1973.

7 KLEIN R *Complaints Against Doctors,* Charles Knight, 1973.

8 STACEY M *op cit.*

9 LEVITT R *The Reorganised National Health Service.* Croom Helm 1976.

10 JOHNSON M 'Have you heard the one about the fly in the soup' in *Health and Social Service Journal,* 8.4.77.

11 HATCH, Stephen and MOCROFT, Ian, 'Voluntary Workers' *New Society,* Vol 40, No. 757, p24.

12 Report of the Wolfenden Committee, *The Future of Voluntary Organisations,* London, Croom Helm, 1978, p 36.

13 WILSON A *Patient & Participation in the Primary Care Unit.* British Medical Journal, 5th February 1977. Also the Lancet 1975 vol. 2 No. 497.

14 SHAW, Ian *Patient Participation in General Practice.* Welsh Consumer Council, 1978.

15 *Perceptions of Participation in General Practice:* an exploratory study of professional attitudes to patient participation groups. Paper available from J Wood, Department of General Practice, University of Manchester.

COMMUNITY HEALTH COUNCILS

Evidence for the Royal Commission on the National Health Service prepared by Ruth Levitt.

INTRODUCTION

I welcome the invitation of the Royal Commission to present this paper on community health councils. I should emphasise that the views expressed here are personal opinions, based on knowledge acquired since 1974 through my work with *CHC NEWS* and as a member of my local CHC.

In addition I should say that my remarks refer to CHCs in England and Wales and to local health councils in Scotland, but not to district committees in Northern Ireland. I have had minimal contact with this last group and I do not feel sufficiently well-informed to make any useful comments about them.

This paper will not call for any dramatic changes to the structure or functions of health councils. My basic thesis is that CHCs and LHCs are potentially a strong force for constructive change in the health service. It will take some more time before they achieve their potential, and I would therefore recommend that no drastic action should yet be taken in relation to them. This paper will attempt to analyse their development so far, and offer some thoughts about what may be expected of them in the future. I have arranged the discussion under six headings:

1 Lay involvement in the health service

2 Analysis of CHCs' work so far

3 Assessment of CHCs' success to date

4 Members and staff

5 Future role

6 Summary and recommendations.

LAY INVOLVEMENT IN THE HEALTH SERVICE

Community health councils embody a completely new principle in the health service: the statutory right of the public to see its interests represented to the management authorities of the NHS. But CHCs can also be seen as a development of the tradition of lay involvement which existed from 1948 to 1974. It is important to distinguish between the two.

a Traditions

Until reorganisation happened, the managing authorities of the hospital service included lay people, the health committees of local authorities managing community health services were mainly composed of lay people, and the executive councils administering family practitioner services also had some lay members.

I doubt whether this degree of co-operation between lay people and professional administrative and clinical staff was ever consciously thought out. Rather it was a consequence of the origins of health services in this country, which rest largely on voluntary effort and the growth of the welfare state. Nevertheless, by creating a network of appointed committees, on which lay people had their place, to plan and oversee the provision of services, an important instrument of accountability was established. The legislation setting up the NHS required the Minister to be personally accountable to parliament for the service, and this was achieved by making the managing authorities of each arm of the tripartite structure in turn accountable to him. There was a further element of lay involvement in the hospital service, through house committees and leagues of friends. These were not managing bodies, but supportive observers of the services which, through their membership, maintained close ties between the hospitals and the communities they served.

b Check on professionals

Another dimension of lay involvement in the management of health services is that the views and interests of professional staff can be questioned and challenged. Some mechanism to do this is advisable, given the huge amounts of public money that the health service consumes, and the obligation to ensure equality of provision for different patients in different parts of the country. This does not imply that professional staff neglect the best interests of the NHS, but that their personal aims can produce distortions in the aims of the service as a whole. Lay people can have the opportunity to bring about a better balance in the priority-setting and decision-making of the management. However, the system of hospital management failed to prevent some disturbing occurrences in the late 1960s, particularly in long-stay institutions, where investment in staff, buildings and equipment had fallen badly behind. Richard Crossman (the then Secretary of State for Social Services) held the hospital management committees and regional hospital boards responsible for this, and set up a professional inspectorate to help other hospitals where similar problems might arise. (This inspectorate exists now as the Health Advisory Service. It has no lay members.)

c New focus

CHCs were not included in the original design for the reorganisation, but appeared during parliamentary debate. It was realised that by creating management authorities composed of lay people and professionals where the clear responsibility was to improve planning and provision of services as a result of the application of management skills, the patient's point of view might be pushed to one side. So the separate task of representing the public interest, which carried no executive responsibility for providing health services, was allocated to community health councils.

Having been invented, CHCs were soon given a number of responsibilities for representing the interests of the public, which extend significantly beyond a concern simply for the interests of patients. By creating community health councils with this focus, and this one alone, the influence that the public may have on their health service has been cast in a fresh light.

ANALYSIS OF CHCs' WORK SO FAR

Since 1974 CHCs have had to try and work out what their responsibilities are. Circular HRC (74)4 did outline some of the matters to which community health councils might wish to direct their attention. But the suggestions were inevitably vague since neither the DHSS nor anyone else know specifically what CHCs ought to be doing. (The main problem was to make sure that the health authorities were doing what they ought to be doing). So in the past three and a half years it has been possible for CHCs to identify the problems that they can deal with and to work out methods that are likely to be effective.

The sorts of methods that CHCs tend to use are unexceptional; they meet together in committees and working groups, they visit hospitals and other establishments, they invite experts to come and explain services and problems to them, they read official literature produced both locally and nationally by the health service, they conduct surveys and investigations and they invite the public to their meetings and to their offices to come and express views and inform them of problems and needs. It should be emphasised however, that most people working with CHCs as staff and as members have had little experience of the way the health service works. In 1974 the complexity of the reorganised structure presented some daunting problems in terms of understanding who was responsible for what service, and from where decisions were taken and by whom. So another important aspect of CHCs' work in this early period was simply to learn about the way services worked on the ground. CHCs also had to get to know their local managers and to establish reasonable working relations with them so that some sort of information exchange and flow could be established. As a result the subjects that CHCs have concentrated on in this early period may reflect rather more the matters of concern to the National Health Service than matters of concern to the local community. To obtain views about health services from local people is in itself a considerable task.

The three broad areas in which CHCs seem to have become involved can be described as: individual help and advice, planning of health services and health education.

a Individual help and advice

By making their existence known in the community and by establishing contacts with local press, radio and television, CHCs have found members of the public coming to them to ask for information about services or to make complaints about particular services that have been experienced. And most CHCs regard this as an important part of their work. It may not for some be the major part of their work but it is nevertheless a significant, legitimate part of it. Indeed some CHCs who regard this individual help and advice as a major responsibility have on occasions become deeply involved in investigation of complaints about hospital and family practitioner services and this has given rise to some controversy about the proper role that CHCs can plan in these situations.

b Planning health services

The health authorities are obliged to provide CHCs with information about the provision of existing services and plans for development of the services, so a second important aspect of CHCs' work has to do with consideration of these various communications from the health authorities. They can take the form of planning documents, consultative documents, and other proposals to change or develop services locally. Of particular relevance here is the matter of hospital closures. CHCs have been give the specific task of commenting on hospital closures and health authorities are obliged to consult very fully with them. If the CHC opposes the closure the matter has to be referred up to the regional health authority and subsequently to the Secretary of State. Only the Secretary of State can override the CHC's continuing opposition to a proposed closure. Involvement in closure proposals has become significant, especially in the last twelve to eighteen months, and a number of CHCs have found most of their energies going into the consultative procedures that they themselves have to go through with local community groups and members of the public in order to comment on the health authorities' plans. In some areas, CHCs have been invited to joint planning teams. This offers a further valuable opportunity to understand and influence the development of services on behalf of the public.

c Health education

The third main area of work I have called health education. This does not really mean the same sort of thing as health education officers do for the health authorities. It refers rather to the interests that CHCs may have in promoting knowledge about health and informing the local population of measures that can be taken to improve health which may not be directly related to existing health services. Not all CHCs have been very active in this sphere, but it is an important area because some CHCs have made it the primary focus of their work, implying that **health** rather than **health services** is what they think they are about.

Assessment of CHCs' success to date

In order to say how well CHCs are doing, it is necessary to have some standards or expectations by which to judge them. This is not simple. Critics of CHCs can point to the lack of public knowledge or involvement with them; they can point to the very small proportion of hospital closures that have been prevented by CHCs; they can point to the low esteem in which CHCs seem to be held by many professionals in the health service. But are these objective observations? Are they reasonable statements at this point in CHCs' development? Above all, could anyone spell out precisely what CHCs should have achieved so far?

The differences in style and approach between CHCs are already evident. Although they have addressed themselves broadly to the same sorts of problems, the ways in which they are doing this and their expectations about the outcomes of their involvement have varied immensely. Some have established good working relations with their district management teams, and are finding that area health authorities and family practitioner committees recognise their efforts. Some CHCs are establishing links with organisations and individuals in the community to help them learn about the views and wishes of the public. Many of them are conducting surveys and inquiries into particular services and learning how to make use of the results they obtain.

In many areas and regions, the CHCs come together from time to time to discuss common problems and learn from each other's experience. Joint approaches are sometimes made to the authorities and to the public, where this seems to be an effective technique. Equally, individual councils are learning how to make the best use of their own resources; dividing the membership into small working groups, spending money on publicity, and obtaining outside help for particular projects, for example.

An acknowledged problem for all CHCs is to know exactly who is the public that they are obliged to represent. Clearly in a district with several hundred thousand people, only the minority are ever likely to know about the CHC or want to make contact with it. Inevitably, CHCs are forced to represent groups of interests within that community. In addition, health authorities can, by limiting the amount of information they are prepared to provide, limit the effectiveness of CHCs' work. Unless opportunities for real dialogue are established, CHCs will be in difficulties.

Each CHC has by right an observer at area health authority meetings and in some cases the observer is allowed to participate very fully in the discussions of the authority. In others, the observer is not in many ways different from a member of the public sitting in on the health authority's meeting. Nevertheless this opportunity to be present when the health authority takes decisions about services is a very valuable asset for all CHCs. In relation to family practitioner committees the minority of CHCs at the moment sit in on FPC meetings, and in any case, only on the public parts of the FPCs' agendas. Joint consultative committees open their meetings to the public and many of them have invited CHCs to send observers.

In order to benefit from these sorts of contacts with the health authorities CHCs need to be able to find members to attend regularly who can spare the time and who take an interest in the sorts of topics which will appear on the agendas of these bodies and who will effectively report back to the CHC. This in itself is a considerable demand on the resources of the CHC and not all councils see this part of their involvement as being very rewarding yet. However, in areas where it is seen to be of value CHCs can benefit immensely from this form of information exchange. Another side benefit from the presence of CHC observers is that health authority members have to take notice of the existence of CHCs and also see that CHC people are not all that different from themselves. In that sense it is an important piece of education for the health authority, perhaps as much as it is for the CHC. Now where health authorities resent the presence of CHC people or are hesitant about discussing delicate matters in public, CHCs may find themselves at a loss. The relationship between health authorities and CHCs depends above all on a degree of trust and the only way for this trust to develop is for each side to take the risk of expressing its views openly to the other. Each side needs to value the involvement and co-operation of the other and be prepared to be persuaded by arguments other than those from its own side.

There seems little doubt that some CHCs are already working confidently and enthusiastically, and that they are beginning to be a genuine influence. This is difficult to prove, but there are signs of it in the way the health authorities acknowledge the importance of CHCs' comments, and in the level of community interest that can be seen. Certainly, other councils are not moving so fast. They have yet to persuade the health authorities of the value of their involvement, and the local community appears to be largely indifferent to their activities. There are no particular regions or areas which stand out from the rest — rather there are great variations from council to council.

Members and staff

a Members

Although CHC membership is at the moment predominantly middle-aged and predominantly middle class, that kind of generalisation hides the differences between the CHC members in terms of their perspectives and in terms of their expectations. CHC members can be divided broadly into two groups, those coming from the local authorities and those coming from the voluntary sector. The majority of local authority nominees are elected councillors. And the majority of voluntary sector nominees are active members or staff of local voluntary bodies. Much has been said about the dichotomy between these two groups and their respective problems and benefits that they bring to the CHC. How much fact there is in all this is hard to say. Nevertheless, a commonly expressed view is that the 'political' CHC members tend to be poorer attenders of meetings and to take less trouble about becoming informed on health issues. It is also said of voluntary sector members that they have more narrow interests, that they do not understand how their contribution relates to the work of the CHC as a whole and that they tend to regard themselves as the only authority on the particular health issue or client group about which they have knowledge.

There may be some truth in all of these remarks but as generalisations they are not in my view an accurate description of different CHC members. Undoubtedly the first round of nominations to CHCs in 1974 was done by voluntary bodies and local authorities in ignorance of the responsibilities and commitment that would be required of new CHC members. Guidance issued to the nominating bodies before the 1976 round of nominations did emphasise that CHC members would need to give up considerable amounts of their own time on a voluntary basis to the work of the CHC and that people who were unable to make this sort of commitment should not necessarily be put forward, even if they were prominent members of the local community. To a certain extent this advice was taken but there still needs to be greater attention paid by the nominating bodies to the demands that CHC members are going to face. A higher proportion of non-elected members being put forward by local authorities may help in that the very heavy commitment that elected members already have to attend meetings and read papers puts enormous pressure on even the most willing local authority nominee. Equally from the voluntary sector perhaps the leader of a particular voluntary organisation is not always the best person to put forward for CHC membership, because of other commitments that person is likely to have.

Potential CHC members should now be able to spend some time at CHC meetings and in the CHC office before they decide whether to let their name go forward. They should be able to get some idea of the working methods and the likely demands in this way. Amongst the regional health authority nominees to CHCs there now has to be a trades council representative and a disabled person. CHCs themselves have now the right to suggest names to the regional health authority for suitable nominees and the CHCs may be in a far better position than the regional health authority to know who in the community from these two groups will be able to serve the CHC well.

The overall point here is that great care needs to be taken in putting forward names for CHC membership so that this vital resource, the members' time and energy, can be put to the best effect. If the CHC has a very active staff but a membership that already has too many commitments elsewhere, the CHC's achievements will be diminished. Only by continually making the work load, the commitments and above all the rewards of CHC membership known will the stock of CHC membership be enhanced. Clearly it will be desirable in time if a greater number of younger people come forward to be CHC members and if there is a bigger spread in terms of background and experience amongst the membership. This too will strengthen the ability of CHCs to be in touch with the needs of local people and informed about services and developments that the community wishes to see.

b Staff

In terms of CHC staff there is also a very broad spread of interests and backgrounds amongst people that have chosen to become CHC secretaries. The same thing applied to people who took CHC secretary posts in 1974 as applied to people becoming members at that time. There was no prior knowledge of the workload or the working conditions and applicants were taking something of a risk in making this choice of job. A number of health service employees opted for CHC secretary jobs in 1974, several of them close to retirement age anyway, who saw the opportunity to end their service with the NHS in this kind of work. Equally a number of much younger health service employees applied for secretaries' jobs in order to gain some experience in a different kind of work within the sphere of the health service, perhaps seeing it as a short term position. Indeed the original guidance, issued in 1974, suggested that the job would be particularly designed for young health service administrators who could be, in a sense, seconded to the CHC for a couple of years before returning to the main stream of the NHS. Later guidance from the DHSS emphasised the importance of open advertisement and competition for these posts and the value of bringing people from outside the health service into the work of CHCs and today I would guess that the majority of CHC secretaries have not had previous working experience in the National Health Service.

The age range of secretaries is still wide. There are secretaries in their mid-twenties and there are secretaries approaching retirement age. And each of them brings a particular set of assumptions and set of expectations to the work. It appears that in London many of the secretaries are youngish women, many of them graduates who have already had active jobs in community work of one sort or another and who have quite strong political views about the development of the National Health Service. Elsewhere other trends are visible, for example, a number of men in their forties who have retired from the forces after perhaps twenty years service, particularly as administrators, have seen CHC work as a natural next step valuing as they do the freedom to be their own boss, and to use their administrative ability to the full. A number of former clergymen have become CHC secretaries and of course a number of people working in administrative departments within the health service and in local authorities have seen CHC work as a natural development from their earlier experience.

This variety of people that has been attracted to CHCs to work as secretaries should be regarded as a considerable strength. If all CHC secretaries were of one mould it is unlikely that the sorts of developments that are now happening within CHCs would be occurring. In other words the contribution of the secretary is a vital part of the impact that a CHC can make. CHC secretaries cannot afford though, to neglect more mundane aspects of the job. They have to be efficient at managing their offices, at keeping minutes of meetings and producing papers and information that may be required by their members. In that sense they are servants of their members and they cannot afford to neglect this side of their work. But there is also tremendous scope for a CHC secretary to try out all sorts of ideas and initiatives and to persuade the members to support him of her in following these paths. And some of the most interesting work being done by CHCs owes a great deal to the energy and enthusiasm of the secretary. The importance of the right of CHCs to choose their own secretaries cannot be underestimated. By selecting from a field of applicants a person who will commit themselves fully to the endeavours of the CHC and will carry forward plans and schemes to develop the involvement of the community in the National Health Service CHCs have a very powerful weapon. The CHC secretary is, although technically a regional health authority employee, unlike any other employee in the NHS. S/he is answerable for his work to the CHC yet the work is very much suited to a self-starting individualist who will be prepared to take risks, make a fool of himself at times and yet carry the flag for particular causes and receive a lot of encouragement and support at times.

A secretary alone cannot achieve the potential of the CHC; only through the close and trusting support that can exist between CHC members and their secretary will this happen. Personal relations between the CHC secretary and the CHC chairman are usually closer simply because the chairman is likely to spend more time at the CHC office and in contact with the secretary than many of the other members. But a team of perhaps three or four CHC members and the secretary together guiding the other members and responding to ideas from the membership and from outside can be a very strong force in putting over the community's view to the NHS.

Future role

It is said by some that CHCs are watchdogs without teeth, that they lack effective powers and that they are simply a sop to the idea of 'consumerism'. I do not share those views. It seems to me that CHCs have tangible powers already. On paper they have the right to appoint their own staff, to call for information and be consulted on plans by the health authorities; to send an observer to AHA meetings, sometimes to be involved with planning teams in the districts and to play a very prominent part in proposed hospital closures. Their greatest power, it seems to me, is their access to the press, which enables them to publicise their activities and extend public awareness of health and health service issues. And by doing this bravely they can obtain more direct access to the people for whom the health service is provided than any other group within the NHS. This may sound paradoxical; after all those doctors, nurses, dentists and other practitioners working directly with patients have one-to-one contact all the time with their 'customers'. But where CHCs have the advantage is that they can listen to and address the public on a much wider range of issues and in a much more acute way than the health authorities and their staff have tended to do.

This relationship with the press tends to worry some people who feel that it can be abused, either by presenting misleading information or by polarising issues in a way that does not take account of the detailed positions that different parties might want to defend. Naturally, there are some consequences in using the press as an extension of the forum in which health service issues are discussed, but the level of public knowledge about health services and about the possibilities for change is still really very slight, although the interest amongst the public in health and illness matters is clearly considerable. For example the number of television programmes, radio programmes, magazine articles, newspaper features and news items dealing with health and illness topics is very great and these surely would not be presented unless there was a market for them. But the sorts of issues that CHCs want to communicate about with the public are not necessarily the most dramatic, the most headline hitting. It takes great care in briefing the press to make sure that the issues are honestly and thoroughly presented. Perhaps this has not happened sufficiently yet but as the press learn what thier role is and as community health councils themselves learn their responsibilities in presenting issues to the public, the quality of debate in the media is likely to improve. So this power above all is one that CHCs can use to extend their influence, to improve public knowledge of their role in the health service and to enhance the level of public discussion about health service matters.

Of course, the health authorities themselves could do all this if they wanted to but the tradition of exposing NHS decision making to the public gaze is not well established and health authority members and staff are still hesitant about exposing their activities for the press to report. This relative openness amongst CHCs is one of the reasons why the health authorities are suspicious of trusting them with information that may be delicate or may be difficult to handle. No one can order the health authorities to trust CHCs or vice versa — the trust will only come about, where it has not already begun, by the health authority members and staff seeing for themselves the value of close relations.

But the relations need not be too close; CHCs must not be 'contaminated' by management, if this means that they will take the NHS managers' worries for their own. If CHCs become too sympathetic and too identified with the problems of the management they will not necessarily do the community a disservice but they may fail to be fully aware of alternative views and alternative priorities that may exist amongst the public. So CHCs face a difficult task in finding the right balance between commitment to cooperation and trust with the health authorities, and openness with the public and willingness to express the public's views. It seems clear at this stage that of all the health service bodies with which CHCs have relations, the family practitioner committees present the biggest problems. This seems to be more to do with the contractual nature of family practitioners involvement with the health service than with the status or activities of FPCs themselves. Nevertheless, there has been a quite noticeable reluctance on the part of many FPCs to deal with CHCs in any formal way and many individual practitioners resent the involvement of lay people in health service decision making anyway.

If structural changes were brought about in the NHS this would be bound to have an effect on the position of CHCs. Two sorts of changes can be imagined. Firstly, the creation of more single district areas. Already, advice from the DHSS to the health authorities has suggested that one way of economising may be to merge some boundaries within multi-district areas and to create more single district areas. It remains unclear in these situations what should happen to the community health council. If administrative boundaries change the boundaries for representing consumers' views should not necessarily have to change. In cases where single district areas are being created or at least where district boundaries have been merged, there need not be any change in the CHCs' boundaries, all that happens is that a CHC has to learn to relate to an area management team instead of a district management team. Another consequence would be that it has to develop perhaps closer working relations with the neighbouring community health council if it is still in a multi-district area.

The second sort of structural change might be the amalgamation of family practitioner committees into the area health authorities. If this was to happen then part of the area health authority's agendas might include discussion of family practitioner services matters or there might be a separate group amongst the AHA membership dealing with FPC matters. Again, this would not necessarily imply any change for community health councils in terms of their own work. It might in fact enhance their access to information about family practitioner services and enhance their ability to influence these services if there was a more open attitude amongst the new bodies.

If, however, a complete tier in the management structure was removed either at area or at district level or conceivably at regional level then so many other things would change in the way the health service is administered that it might be that community health councils would have to change too. If, for example, the area health authorities were removed from the structure then CHCs would have to know to whom they related on planning matters specifically. If, however, district management teams were removed CHCs might want to be sure of further access to information about local health services from the area health authorities. A further possibility is that the nature of district management teams could be changed so that instead of being a focus for delegated responsibility from the area health authorities they might become a further tier of administrative authority with lay members not just professionals, managers and clinicians. If this was to happen, then the position of CHCs would be very ambiguous. Some people say that CHCs should in any case be elected because only by having this sort of relationship with the local population can they claim to be representing the community's interest — I do not share this view.

SUMMARY AND RECOMMENDATIONS

This paper has attempted to plot the position of CHCs four years after their creation and to assess some of their problems and some of their achievements in this short period. Many of the apparent difficulties and inadequacies of CHCs are due to their very limited experience and to the equally limited experience of the health service in dealing with them. Over time these will be less prominent features and the true contribution of CHCs will become evident.

I have suggested that there are three broad areas in which CHCs are active and that as they gain experience helping individuals in contributing to planning and improving knowledge and ideas about the promotion of health, they will establish themselves as a unique, effective force in the health service as a whole. It seems to me that their freedom from actually providing health services enables them to take a fresh, uncluttered look at the priorities the health service should be adopting. It also enables them to ask questions and raise issues that people working within the NHS may long ago have forgotten how to ask.

I would not recommend that community health councils' powers be extended through any legislative means at this stage and I would not recommend that CHC membership or staff should be derived in any different way from those presently in use. It does seem to me that the position of CHCs should be assessed very rigorously after a few more years have passed — perhaps by 1984 to see whether any trends have emerged which are not simply due to the newness of the concept. If structural changes in the NHS are recommended then the position of CHCs will have to be carefully considered. It may not imply any change for them but it may mean that lines of communication and lines of access have to be more carefully drawn and more officially established than they are at the moment in order to safe-guard CHCs' access to the information on which they depend.

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