PART TWO

THE ESTABLISHMENT OF THE INSTITUTION

CHAPTER 4: THE ESTABLISHMENT PROCESS

The 1966-70 Labour Government established the principle that there should be public representation at the operational level of the reorganised, administratively unified NHS. The 1970-74 Conservative Government created the institution for carrying out this function, legislated for it, made regulations and issued guidelines. The 1974 Labour Government modified the guidance.

These national events provided a framework for the new CHCs but it was at the regional level that CHC establishment took place and this establishment process not only created the institutions but also had a large impact on the CHCs' potential character. Different RHAs had differing styles of establishing CHCs which led, at least initially, to CHCs having distinct regional flavours.

The timetable for establishing CHCs was very tight. DHSS guidance was issued in January and the appointed day was April 1st, 1974. This gave less than three months for the RHAs to undertake a lengthy and complicated procedure. There were three factors which led to the contraction of this timetable. The most important was that the CHC idea was still in the melting pot even as the NHS Reorganisation Bill was going through Parliament. This was not the case with the RHAs and the AHAs, they had been worked out in detail prior to the drafting of the Bill and the Conservative Government had brooked no changes in their legislative structure. Indeed these authorities were being established in "shadow" form even before the Bill became law. The second problem was that the Bill itself was delayed because of the pressures of a crowded parliamentary timetable. It should have reached the Statute Book much earlier in 1973. The third factor was the length of time the consultative process took after the passage of the Bill. A first draft of DHSS guidance appeared in August 1973 but it was not finalised

until the end of the year, although very few changes had been made as a result of these consultations.[1]

The change of government after the February 1974 General Election only affected the timetable with regard to the appointment of CHC secretaries, a task which was anyway not to be undertaken until CHCs had been established.

Procedures

The regulations did not give any deadline for the establishment of CHCs but the guidance asked RHAs "to aim to complete the initial arrangements for the appointment of members by 1 April 1974, and not later than 30 April."[2] In Parliament an undertaking was given on second reading that "there would be no question of any substantive decisions being taken about (sic) the regional or area authority until the watchdogs were in operation."[3] By December 1973 the minister promised "Our main aim is still to establish community health councils by 1st April when the new authorities take over operational responsibility for the reorganised services. At the worst this will happen in the month of April if not by 1st April."[4] A House of Commons written answer on January 22nd, 1974 asserted that CHCs would be operational by April 1st. The establishment process could only formally commence on January 21st 1974[5] but the guidance advised an immediate informal start. The RHAs had to complete procedures under the following headings.[6]

number and size of CHCs: the number of CHCs would not normally be problematic because the guidance advised "save in the most exceptional circumstances there should be a single CHC for each health district i.e. CHCs should match District (or area) Management Teams one for one."[7] There was more room for manouvre with regard to size of membership. The regulations had placed no limitations on the size of membership but in the guidance it was stated "the Secretary of State expects that the

great majority of councils will have between 18 and 30 members; probably most councils will be at the upper end of this range but it should be exceptional for any council to have more than 30 members."[8]

Six factors had to be taken into consideration when determining membership: the need to span a broad range of interests while keeping the CHC small enough to work effectively; the number of district councils involved and the size and distribution of population; the number of voluntary bodies interested in health; special interests, e.g. war pensioners, denominational hospitals and miners rehabilitation centres; special demographic factors such as a high level of immigrants or a seasonally fluctuating population; and "the need to keep sufficient places for the third category of members prescribed in the regulations (i.e. RHA appointees) whatever the pressure from the second category (i.e. voluntary body membership)."[9]

appointment of members: the first step in the appointment of voluntary body members was for the RHA, after consulting AHAs and local authorities, to draw up a list of voluntary bodies active in the district. The list had then to be augmented in the light of response to an advertisement placed in the local press asking voluntary bodies to nominate themselves. One month was allowed for this to take place. Then, after further consultation with local authorities, the RHA had to "determine which voluntary bodies are to be invited to take part in appointing members."[10] Finally the voluntary bodies had to determine the allocation of places and inform the RHA of the names of the members they had chosen.

For local authority appointments all the RHA had to do was to invite the local authorities (non-metropolitan counties and all the districts) to agree among themselves on the allocation of seats between them and to notify the RHA of their choice of members. For its own appointments the RHA had to consult with the local authorities before

making any decisions. "The intention is that these should be individuals who have a special knowledge of the health service, e.g. former members of Hospital Management Committees, Boards of Governors and Executive Councils and representatives of bodies such as women's organisations, trade unions, the Churches and youth and immigrant bodies who might not otherwise be appointed."[11]

convening inaugural meetings: RHAs, assisted by AHAs, had to draw up proposals for accommodation, staff and supporting services and then convene inaugural meetings "which should be held as soon as possible after 1 April, 1974."[12] RHAs were then to consult CHCs on premises, staff and budget.

Problems

There were three major problems involved with the timetabling. The first related to the time scale, the second to the consultative procedure and the third to the substantive decisions to be taken.

With regard to the time scale it was almost physically impossible to complete all the tasks between 21 January and 1 April and would have been very difficult to have completed them by the end of April. This left the RHAs in a dilemma. They could either strive to establish the CHCs on time (or as near to it as possible) by skipping consultations and imposing solutions, or create a delay of a matter of months in establishing CHCs by undertaking meaningful consultations and negotiating solutions. There were pressures on both sides, from Parliament in response to ministerial undertakings that CHCs would be set up on time, and from interested bodies to ensure adequate consultation.

Irrespective of the timing problem the RHAs were faced with a difficulty over consultation, particularly with local authorities. At each stage of the process the RHA had to consult with the relevant local authorities i.e. all non-metropolitan county councils and all

district councils in their region. This could involve consultations with more than fifty different bodies. The matters on which they were to be consulted were: the number and size of CHCs; their composition; the listing of voluntary bodies; selecting from these lists; and the RHA's appointees to all its CHCs. In addition the local authorities had to come together and negotiate among themselves the allocation of their nominations, which could be a very complex process in e.g. a 3 district area covered by one county council and 7 district councils. The problems for the RHA were: how seriously to take the consultation process, what to do if local authorities did not respond, or even more problematic, what to do if the local authority disagreed with the RHA.

The third problem area, concerning the substantive decisions to be taken, was in the long run the most important. The RHAs' job as establishing authorities was to execute a parliamentary enactment. They were hindered in the task of execution by the vagueness and ambiguities of the delegated legislation which provided regulations for the establishment of CHCs. At one end of the scale the problems concerned details, often concerning questions of national standards such as ordering the criteria for size of CHC membership in terms of relative importance or fulfilling duties to ensure representation of a range of diverse interests in the proportion of membership appointed by the RHA (normally at most five members). At the other end the RHAs were left to decide major questions of interpretation of legislation often with considerable long-term impact such as what sort of voluntary bodies should choose members and how should CHCs be established as independent bodies with regard to staffing and accommodation. The more important of these problems will be dealt with below.

Alternative RHA approaches

RHAs had to choose between being thorough and being expeditious. A thorough approach with lengthy consultations would be non-directive

in nature allowing interested parties to reach agreement. An expeditious approach would be directive, decisions would have to be taken by the RHA swiftly, without adequate consultation, in order to keep within the time limits. Every RHA therefore would have to choose an approach somewhere on a continuum between the extremes of non-directive thoroughness and directive expeditiousness.

Apart from the stance which RHAs had to take over thoroughness/expeditiousness they were also free to use the powers they had to attempt to strengthen or weaken potential CHC effectiveness. Indeed RHAs could not but be aware of the potential impact which their actions might have. A RHA which was in favour of strong independent CHCs (pro-CHC) might be expected to act in a different way to a RHA which wanted CHCs to be weak and ineffective (anti-CHC). Of course, a RHA could be completely neutral (or indifferent) but, as will be seen below, even neutrality will have a positive impact upon potential CHC functioning.

number and size of CHCs: RHAs had very little discretion over the number of CHCs (and eventually, after all CHCs had been set up, in only two cases in England were CHCs not coterminous with districts or unitary areas), but the complexity of the size criteria gave them a great deal of discretion over the number of members. The possible extremes were for all CHCs to have either large or small memberships (around 30 and 18 members respectively). The directive expeditious RHA would in general tend to go for small CHCs because this would speed up selection procedures and the anti-CHC RHA would probably do the same in an attempt to reduce the range of public representation and the number of people actively involved. The non-directive RHA would tend to find itself being pushed towards large CHCs by pressures from the consultative process, particularly with regard to local authority and voluntary body representation, and would need a sizable number of its own appointees in

order to ensure representation of "other organisations."[13] The pro-CHC RHA would also aim for large membership in order to ensure a wide range of representation and the maximum involvement.

appointment of members by voluntary bodies: this is a vital area where, owing to the way in which the regulations were drafted, the RHA could either exercise no choice at all or in effect ban some types of voluntary organisation from taking part in the selection procedure. The two variables which the RHA could control are the number and the range of voluntary bodies invited to take part in the selection procedure.

The non-directive RHA would obviously allow all interested relevant voluntary bodies to take part so the number would be large and the range would be wide. The directive expeditious RHA would, if totally ruthless, only invite as many voluntary bodies as there were seats for them on a CHC to take part, thereby speeding up the process immensely. In any circumstance it would limit the number of bodies involved in order to expedite the process. In all probability it would choose well established NHS or establishment-oriented bodies because these would be the most accessible and the decision could be taken de facto before the prescribed time limit of one month after the publication of advertisements (there is of course a proliferation of disease oriented and pressure group type of voluntary bodies - e.g. spina bifida, spastic, mental handicap; CPAG, NAWCH - and if one were included it would be impossible to justify the exclusion of others, the exclusion of all could be justified on the grounds of swift decision making.[14])

The anti-CHC RHA would act in the same manner, but for different reasons. By controlling which bodies appoint members the RHA exercises a great deal of influence over the quality of membership. NHS authority-oriented members would be much easier for the health service to cope with

than pressure group members and campaigners for specific needs groups and would be less likely to "rock the boat."

The pro-CHC RHA of course would take a very different line. It would encourage all actively interested voluntary bodies to take part and would encourage as wide a spread of relevant bodies as possible in order to get maximum involvement. It would also encourage joint selection of members where several voluntary bodies between them appoint one member.

appointment of members by the RHA: RHAs had no control over the appointment of local authority appointments (except in exceptional circumstances) so the only remaining appointments RHAs could influence were those they made themselves. The guidance lists two categories of members in this group, first those with experience of managing the NHS, e.g. ex HMC or Executive Council members, and secondly members of bodies which otherwise might not be represented, e.g. "women's organisations, trade unions, the Churches and youth and immigrant bodies."[15] Here one could expect both the directive expeditious and the anti-CHC RHA to appoint exclusively or predominantly ex-NHS authority members, for reasons of speed and "docility" respectively, whereas the non-directive and the pro-CHC RHA would tend to have a spread of members between ex-NHS authority members and representatives of the above mentioned bodies in order to ensure compliance with the guidance and to get adequate representation of community interests generally, respectively.

arrangements for staffing, accommodation and finance: the new guidance issued by the Labour Government over staffing took away most of the RHA's power, which had previously been considerable. It was now the CHC which was to choose the secretary and the RHA was given only neutral functions. But the way was still open for the RHA to attempt to influence the CHC. An anti-CHC RHA would do its utmost to ensure

that a NHS employee, preferably with long term NHS career interests, got appointed by the simple expedient of offering low salaries to non-NHS candidates. A directive expeditious RHA might wish to do the same, if only because it had a person lined up in compliance with Sir Keith Joseph's earlier guidance,[16] but this is only speculation. A non-directive RHA would not attempt to influence the CHC, neither in all probability would the pro-CHC RHA because even if it thought a CHC was making a wrong decision, interference in this matter would go against its commitment to the independence of CHCs.

Both non-directive and pro-CHC RHAs would give CHCs maximum possible choice of accommodation in compliance with guidance and in upholding CHC independence respectively whereas an anti-CHC RHA would attempt to ensure that the CHC was on NHS premises in order to associate CHCs in the public eye with the NHS authorities and also to enable the AHA to keep a close watch on it. A directive expeditious RHA would also wish to accommodate its CHCs on NHS premises because this would be the quickest and easiest way of discharging its duty. A pro-CHC RHA would make generous preliminary financial plans for its CHCs and an anti-CHC RHA would be parsimonious. The approaches of non-directive and directive expeditious RHAs could not be predicted.

convening inaugural meetings: RHAs had to convene inaugural CHC meetings once all members had been appointed but they were given no guidance at all on how to do so,[17] all they had to do was to provide temporary secretarial facilities and a venue. Obviously, no RHA, no matter how non-directive, would merely do this. The RHA would send a representative to inaugural meetings and might ask area and district representatives to attend. Its two most important functions at the inaugural meetings were to introduce the CHC as a new body to the NHS and to its role, and in creating an agenda (with particular reference to the election of officers).

With regard to introducing a CHC to its tasks a pro-CHC RHA would obviously take great pains to encourage a good turn-out of RHA members and senior NHS officials and in general would be very welcoming and encouraging. An anti-CHC RHA would either adopt a low key approach or would attempt to "guide" the CHC into a "safe" role. A non-directive RHA would not attempt to guide the CHC and might or might not be encouraging. A directive expeditious RHA would probably advise the CHC to organise itself quickly so that the RHA could expedite its final establishing functions concerning staff, finance and accommodation.

The RHA in performing its function as inaugurator had a crucial role to play, that is the drawing up of an agenda. The most important aspect of this concerns the elction of officers. It is the duty of a CHC to elect a chairman and a vice-chairman but it is not its duty to do so at its inaugural meeting, and neither regulations nor guidance give any advice to RHAs over this matter. The role of chairman in a new body, particularly one such as a CHC with an important function but little guidance on how to discharge it, is of vital importance. A hasty decision which turned out to be wrong could set back a CHC's potential effectiveness by years. The RHA in its convening role could exercise considerable influence as to whether the CHC should elect its officers immediately or wait until members got to know each other. An RHA could influence, by the introductory remarks of its representative, the CHC's choice of chairman if elected immediately. Furthermore, because of the presence of NHS authority members and officials a CHC might be tempted to elect a NHS authority oriented chairman through a process of association rather than a "community" oriented chairman whom it might otherwise have chosen.

It is evident that a pro-CHC RHA would only want elections to take place after the members had had a chance to get to know each other, it

would therefore enable the CHC to make temporary arrangements for chairing meetings prior to electing its permanent chairman. Of course the RHA would not try to insist upon this because that would be interfering with the CHC's independence. An anti-CHC RHA on the other hand would probably strongly encourage the CHC to elect a chairman immediately to provide the best opportunity for a pro-NHS establishment chairman to be elected. This is of course only speculation but the motives of any RHA which tried to encourage immediate elections rather than encouraging the CHC to make up its own mind would need to be questioned. Some interesting empirical evidence on this matter is discussed below in Chapter 5. Similarly a directive expeditious RHA would want officers elected immediately, not necessarily from any sinister motive, but in order to expedite completion of its establishing functions. A non-directive RHA of course would be non-directive, giving the CHC as much choice as possible.

impact upon CHCs: it is apparent that there are great similarities between the pro-CHC RHA and the non-directive RHA and between the anti-CHC RHA and the directive expeditious RHA approaches with regard to the impact upon CHCs as a result of carrying through the tasks involved in establishing CHCs. Both non-directive and pro-CHC RHAs would tend to create large CHCs with a wide range of voluntary body membership and a wide spread of RHA appointees. They would act neutrally with regard to staffing, give as wide a choice as possible over accommodation and would be non-directive over the CHCs' election of officials. Both directive expeditious and anti-CHC RHAs would tend to create small CHCs with a narrow range of voluntary body membership drawn from NHS authority-oriented and establishment-oriented bodies, and with predominantly ex-NHS authority members as RHA appointees. They would be biased towards NHS officers and NHS premises with regard to staffing and accommodation respectively and would encourage immediate election of officers at inaugural CHC meetings.

Although there may be some question about the validity of some of these assertions the overall pattern is clear. The large number of correlations is not accidental, they have a causal basis which is that CHCs will only be effective in their duty of representing the interests of the community to the NHS if, and only if, they are clearly independent of the NHS. The directive expeditious RHA, by imposing its will rather than the community's will, and taking the easy road to establishment involving the use of NHS oriented members and staff and using NHS accommodation, prevents the CHC from being independent of the service which it is established to monitor. The non-directive RHA, by distancing itself as far as possible from the CHCs it establishes and by being neutral, enables the CHC to develop an independent identity.

Even with the best intentions in the world a RHA taking a directive expeditious approach can only do the CHCs a disservice, no matter how soon they are established. A CHC can soon make up ground lost by being established properly at a date after the initial deadline but it would take years for a CHC to find its most effective identity after being established improperly but on time.