CHAPTER 5: THE NORTHERN RHA - A CASE STUDY

The Northern RHA's approach*

The Northern RHA, the subject of the case study, is the northernmost RHA in England. Its area is bounded by the Scottish border to the north, the Irish Sea to the west, the North Sea to the east and by the northernmost boundaries of Lancashire and North Yorkshire to the south. It presides over nine AHAs which are as follows: Northumberland; Cumbria; Durham; Cleveland (each coterminous with a non-metropolitan county of the same name); Newcastle-Upon-Tyne; Northern Tyneside; Gateshead; Southern Tyneside, and Sunderland (each coterminous with a metropolitan district of Tyne and Wear county with the same name). The five areas in Tyne and Wear county plus Northumberland are not divided into districts. Cleveland has three which are: North Tees; South Tees, and Hartlepool. Durham has four: Durham; Darlington; North West Durham, and South West Durham. Cumbria has three: West Cumbria; South West Cumbria, and East Cumbria (although there are special management arrangements in East Cumbria because part of it looks to the North Western RHA for much of its health service provision). The RHA offices are situated in Newcastle in the extreme east of the region which is the only teaching area.

The Northern RHA took its duties as establishing authority for CHCs very seriously. In January 1974 it set up an ad hoc committee comprising the chairman and four members of the RHA to deal with CHC establishment. The committee was served by senior administrative

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*This section is based on an article written in conjunction with two ex-colleagues: J. D. Emerson, J. S. Mackeith and D. Phillips. 'Establishing Community Health Councils: the Northern Region's approach', Hospital and Health Service Review, April 1975, pp.131-133. The article was basically descriptive, none of the interpretative material in this section is drawn from it. It is reproduced in full in Appendix 3 below.

staff and was advised initially by a DHSS regional officer. It met five times between February and July. The chairman of the RHA took a substantial interest in CHCs and expressed a commitment that they should be effective consumer watchdogs. Other members of the committee did not share this enthusiasm and indeed one commented that he thought CHCs were a waste of money. When undertaking their job however members took a business-like approach and appeared to act impartially. The RHA implicitly delegated its executive functions to the committee. In March a retiring hospital group secretary was seconded to the RHA to help in the establishment process as co-ordinater. He worked with the Councils of Social Service and the AHAs to co-ordinate membership and staff, finance and accommodation. Two junior RHA administrative officers were temporarily seconded from the RHA to perform secretarial functions for the emerging CHCs (one of them was later to become a CHC secretary). Once all CHC members had been appointed the committee was disbanded. The RHA chairman continued to take an active interest and attended all inaugural CHC meetings.

From the beginning the RHA sub-committee decided to place thoroughness before speed of establishment although it was mindful of the need to establish CHCs without delay. It took great pains to enter into adequate consultations, as can be seen from the following discussion of the way it performed its tasks as establishment authority.

<u>number and size of CHCs</u>: prior to the convening of the sub-committee the RHA had sent a letter to non-metropolitan county councils and metropolitan (but not non-metropolitan) district councils asking for their views on the number and size of CHCs in their areas. It was stated in the letter that it would be exceptional to have more than one CHC in each district and it was also noted that the RHA expected membership of the CHCs to be at the upper end of the 18-30 range.

The RHA even before making any detailed plans accepted that a probable consequence of its non-directive stance would be large CHCs.

Only the county councils had replied by the time of the first sub-committee meeting,[1] and one problem became obvious as a result of this consultation: the boundaries of health districts do not necessarily coincide with those of local authority districts or those of natural communities. Cleveland County Council, for example, pointed out that the South Tees district comprised two distinct communities, Middlesbrough and Langbaurgh, and made a claim for two CHCs. The geographically large county of Northumberland was entitled to only one CHC and yet it comprised several districts with insular communities. Northumberland County Council therefore suggested a CHC with 36 members having three semi-independent sub-committees. Grass root feelings were stronger, Northumberland Rural Community Council made representations for three CHCs and in the House of Commons a debate on the inadequacies of community representation in the NHS in Northumberland was initiated by the M.P. for Berwick-Upon-Tweed.[2]

The situation was further exacerbated by a RHA decision to propose two CHCs for the East Cumbria health district. This was taken on the grounds that the district was split in two administratively because of a regional overlap in service provision. The south eastern portion of Cumbria had previously come under the auspices of the Manchester Regional Hospital Board and was subsequently to look to the North Western RHA for much of its health service provision. Therefore the only exception to the "one CHC for each district" rule was made primarily with reference to NHS administrative convenience rather than in relation to definitions of "community".

The RHA thus decided upon 17 CHCs, two for East Cumbria and one for every other district and unitary area. The size of the CHCs was

arrived at after a lengthy process. The local authority views, previously canvassed, were taken into consideration at the first sub-committee meeting on 12 February when a draft list of CHC membership sizes was drawn up. This was sent to the non-metropolitan county councils and to all district councils. In the light of the response to this a final list was drawn up. This was then sent to the local authorities for confirmation. The results of the process are set out in tabular form below.

TABLE 5.1 - CHC SIZE IN THE NORTHERN REGION

AHA	CHC	LA's First Ideas	RHA's First List	Final Size
Cleveland	Hartlepool	24	24	24
Cleveland	North Tees	30	30	30
Cleveland	South Tees	*	36**	36
Cumbria	E. Cumbria	30	30	30
Cumbria	S. E. Cumbria	18	18	18
Cumbria	W. Cumbria	26	26	26
Cumbria	S. W. Cumbria	26	26	26
Durham	Darlington	25+	25	25
Durham	Durham	25+	30	30
Durham	N. W. Durham	25+	24	24
Durham	S. W. Durham	25+	28	28
Gateshead	Gateshead	—	28	30
Newcastle	Newcastle	—	32	30
N. Tyneside	N. Tyneside	—	26	26
S. Tyneside	S. Tyneside	30	24	36
Sunderland	Sunderland	—	30	30
Northumberland	Northumberland	36/	36	36

* Cleveland County Council proposed two CHCs for this district, with memberships of 28 and 26.

** The RHA suggested splitting the CHC into two subcommittees, each with 18 members.

/ Northumberland County Council wanted the CHC to be split into three sub-committees, each with 50% local authority appointees.

Abbreviations: L.A. = Local Authority

Cleveland and Cumbria County Councils appeared to work on the general assumption that the largest districts should have a membership of thirty and that the others should have proportionately fewer members. The RHA was in complete agreement with Cumbria and the disagreement over South Tees was the only problem with Cleveland. A compromise was worked out here where the RHA allocated more members than the DHSS guidelines advised so that two sub-committees, each with a membership of eighteen, could be established thereby giving Langbaurgh its own sub-committee, if not a CHC. Langbaurgh District Council was not satisfied with this but was overruled as will be seen below.

Durham County Council on the other hand put in a bid for at least 25 members in all its CHCs. The RHA increased the membership size in two districts and decreased it in one on the basis of population. Northumberland County Council asked for its CHC to have three sub-committees each with 50% local authority membership. The RHA agreed to this. The metropolitan district councils because of their committee timetables were not able to discuss CHC size before the RHA sub-committee met. The sub-committee therefore sent its own recommendations to these councils. These recommendations were based generally on population factors but extra numbers were suggested for Newcastle CHC because it was in a teaching area and for Gateshead because of the catchment pattern of one of its large mental illness hospitals. Southern Tyneside and Gateshead metropolitan district councils suggested larger membership, which was agreed to, and Newcastle Metropolitan District Council requested a smaller membership which was again agreed to.

This throws an interesting light upon the way in which the membership for individual CHCs was allocated. The RHA chose to arrive at CHC size by three different methods, all related to the consultation process. Where it had felt forced to refuse requests for additional CHCs, as in

Northumberland and South Tees, it attempted to compensate the communities involved by giving them very large CHCs with six more members than the maximum advised by the DHSS. Where the local authorities had made suggestions based roughly on population size the RHA had agreed without comment and where this had not happened the RHA, as a senior official remarked, "made a suggestion which was arbitrary but related to population size" which it then negotiated with the relevant local authority. In general then the RHA arrived at CHC size through the consultation process using population size and the recommendations of local authorities as its guiding principles,[3] and its overall non-directive approach led it towards large CHCs except in the extraordinary case of South East Cumbria. If it had so chosen it could have used other criteria.

local authority membership: RHAs were in a difficult position over local authority appointments because they had to leave the local authorities to decide amongst themselves how many seats each relevant authority should have, and the RHA could intervene only if the local authorities were unable to come to a decision. This process could be very complicated because very often one county council and six or seven district councils (sometimes from two or three different counties) could be involved. The Northern RHA approached this problem in an ingenious manner. In the first consultations (when, it will be remembered, it did not consult the non-metropolitan districts) it asked the county councils not only what size they considered the CHCs should be, but also how the local authority seats should be distributed. This was then used as a basis for consultation between county and district councils. It was fortuitous that the only councils which did not reply, the metropolitan districts, were in the areas where local authority membership was least problematic because the metropolitan counties were in no way involved and the CHCs had catchment areas coterminous with the district councils.

The county councils allocated a larger number of places to themselves (and a smaller number of places to the district councils) than the district councils thought appropriate, but in most areas agreements were reached amicably. There was a major difficulty however in South Tees where Langbaurgh District Council not only wanted two CHCs but also wanted more representation than Cleveland County Council wished it to have. This was eventually solved without recourse to formal RHA arbitration. There was a similar difficulty in Cumbria where South Lakeland District Council was in dispute with Cumbria County Council which was only solved immediately prior to the inaugural meetings.[4]

The way in which the RHA tackled the problem of arriving at local authority membership placed the non-metropolitan county councils in an advantageous position over seat allocation. So even in this area where the RHA had least formal control, the way in which it chose to set about its consultations significantly affected the configuration of CHC membership in relation to the balance of seats between the county and district councils.

voluntary body membership: the procedure for arriving at voluntary body appointments to CHCs was an extremely complex one in which the RHA had a great deal of discretion. The Northern RHA chose to be non-directive with regard to the substance of the procedure but did attempt to ensure that it took place swiftly. The selection procedure fell into three stages: compiling lists of voluntary bodies; determining which bodies should take part in selecting members, and convening meetings to undertake selection.

The RHA had a duty to ask AHAs and local authorities to suggest voluntary bodies with an interest in the NHS. This was done and the resulting lists were amalgamated. For most CHCs the amalgamated lists contained between 80 and 100 names but Cumbria County Council produced

lists for its CHCs which in some instances had over 500 names. The lists comprised all voluntary bodies known to the council, whether concerned with health or not. Meanwhile interested voluntary bodies were contacting the RHA asking for their names to be included in the lists. The RHA also had to publish an advertisement in the local press inviting voluntary bodies to apply for inclusion. This was done on February 21st, with a closing date given as February 28th. Unfortunately this was contrary to Regulation 7(2) which stated that one month had to elapse before the lists were closed. This caused considerable protest and a question was asked in the House of Commons,[5] which embarrassed the RHA. It then made amends by keeping the lists open for the required period of time. The advertisements were couched in legalistic terms as can be seen:

NATIONAL HEALTH SERVICE

Northern Regional Health Authority: Community Health Councils

Members to be appointed by
Voluntary Organisations

A Community Health Council is to be established to represent the interest in the Health Service of the Public in the following Area: (name of area)

In accordance with the provisions of Section 9(5)(b) of the National Health Service Re-Organisation Act 1973 at least one third of the members of each Council are to be appointed in a prescribed manner by bodies (other than public or local authorities) of which the activities are carried on otherwise than for profits.

Voluntary Organisations active in this area with a strong active interest in Health Matters or which provide a service for National Health Service patients or which have a special interest, in a particular National Health Service institution or institutions in this area are invited to apply for inclusion in the list of voluntary organisations which are to be asked to appoint members to the appropriate Community Health Councils.

Applications should be forwarded as soon as possible and not later than 28th February, 1974 to:

Regional Administrator,
Northern Regional Health Authority,
Benfield Road,
Walker Gate,
Newcastle upon Tyne, NE6 4PY.

At the end of the initial round of consultations the sub-committee had lists which ranged in size from the low 70s to around 600. Its first task was to remove from the lists bodies which were not eligible because they were profit making. Then it organised the lists into three sections. The sections were defined as follows:[6]

> Section 1
> This section lists organisations which appear to have an active and close interest in health services in the district covered by the community health council and are suggested as organisations to be invited to join together to appoint members of community health councils.
> Section 2
> This section lists organisations which appear to be less closely involved in health services, but some of which nevertheless might be added to section 1.
> Section 3
> These organisations are put forward as having only a minor interest in health services or as being not appropriate to be involved in selecting members of community health councils.

The sub-committee was most generous in its interpretation of which bodies had an interest in the health service. Section 3 was used for bodies which by no stretch of the imagination could be said to have an active interest in the NHS, such as bridge clubs and flower arranging societies, and it was used almost exclusively to deal with the lists sent by Cumbria County Council. It would be interesting to speculate upon the implications of differentiating between sections 1 and 2, but the sub-committee pre-empted any such discussion by amalgamating these sections because of demarcation problems. When the lists were finalised all bodies which had applied or had had their names put forward were included except those which were ineligible because they were not voluntary bodies or (relating to the bodies nominated by Cumbria County Council) those which obviously had no connection at all with the health service. Local authorities were consulted on these final lists and no local authority raised any objections. The final lists varied in size between 70 in Northern Tyneside and 115 in East Cumbria. In general the Cumbria CHCs

had the highest numbers but this was solely due to Cumbria County Council's over-inclusive lists and the sub-committee's reluctance to exclude any body which might be relevant.

The RHA had approached the National Council for Social Service (NCSS) about the appointing procedure before the sub-committee was set up. Armed with the NCSS's guidance the sub-committee decided to delegate this task in its entirety to local Councils of Social Service. The sub-committee's co-ordinater visited all relevant councils to discuss details and then on 18 April chaired a meeting of councils which was called to make procedural arrangments. At this meeting he recommended that councils follow the selection procedure advised by NCSS but explained that they were free to use whichever procedures they wished. The advice he gave was in the most part non-directive although he did advise them to try to achieve as wide a spread of interests as possible. In only one substantive area was he directive and this related to specific DHSS instructions that war pensioners' and miners rehabilitation centres' interests must be represented on certain CHCs (1 member on 1 CHC and 2 members on each of 2 other CHCs).[7] With regard to timetabling the RHA attempted to impose a time limit on the councils of April 29th which gave them only 11 days to convene a meeting to choose which voluntary bodies were to select members and for the bodies concerned to make their selection. The councils prevailed upon the RHA to postpone this deadline to the beginning of June. In fact all voluntary body nominations were received by the RHA before the end of May.

The RHA, by refraining from deciding which voluntary bodies with an interest in the health service should be excluded and by delegating the task of selecting voluntary bodies, chose to exercise minimum influence over which bodies should be involved in the selection process. Only in two instances was it at all directive: its unsuccessful attempt to speed up the process and its insistence that war pensioners' and miners

rehabilitation centres' interests should be catered for within the voluntary body membership rather than within its own.

RHA appointees: its approach was very different over the appointment of the remaining members because the RHA itself had to choose the members, it was a job it could not delegate. Also the RHA chose to express a bias towards ex NHS authority members, thereby deliberately restricting access to membership from "other bodies" which might not otherwise be represented, recommended for consideration in the DHSS guidance.[8] The minutes of the sub-committee's meeting on February 26th make this stance quite clear:

> It was agreed that when discussing this matter (RHA appointments) in due course, in addition to taking account of special interests not already represented in members appointed by local authorities and voluntary organisations, the Regional Health Authority should ensure as far as possible that their appointments were of members with a knowledge of the Health Service.

The process started (even before the sub-committee was set up) in December 1973, when the chairman-elect of the RHA sent letters to all HMC members under the age of 70 who had not been appointed to AHAs, asking them if they were interested in serving on CHCs. The response to this was higher than expected. The sub-committee, decided to postpone selection of RHA appointees until after the voluntary bodies and the local authorities had appointed members in the hope that they would chose some ex HMC members. As it happened the RHA had to choose its members before it had access to the local authority nominations because of the tardiness of some local authorities in appointing members.

The RHA sub-committee, armed with the list of willing ex-HMC members, consulted the AHAs and the local authorities and then drew up a master list of nominations. In one or two districts there were not enough eligible nominations so the co-ordinater approached relevant AHA members and NHS officials to get additional nominations. When there were enough nominations for each CHC the sub-committee started the selection

process. The first task was to exclude nominees deemed to be ineligible. These came into three categories; first those over the age of 70; secondly those resident outside the district, and thirdly local authority councillors. The first two categories were in line with DHSS guidance[9] but the third was a unilateral decision made by the RHA through its sub-committee on the grounds that local councillors already had adequate representation. Then the sub-committee discussed the nominations, with individual members commenting on nominees known to them. Then they looked at the membership of each CHC (or as much of it as had been determined) observing the interests represented among the voluntary bodies. First priority was given to ex-HMC members with an interest in an area not already represented, and second priority was given to ex-HMC members per se.[10] When the lists were finalised they were sent to individual members of the RHA for comment and to the local authorities.

In appointing its proportion of CHC membership the Northern RHA thus behaved in a much more directive way than previously. This is quite understandable. The RHA felt a commitment to ex-HMC members who had been excluded from health service authority membership by the reorganisation and it was easier for it to appoint people with whom it had had close contact as opposed to "other organisations" which would have been difficult to contact for nominations within a restricted time period. Nevertheless the RHA had changed its style here and deliberately favoured ex-NHS authority members at the expense of other eligible groups.

<u>preliminary arrangements for staffing, accommodation and finances:</u> these matters did not take up much time prior to the establishment of CHCs. The co-ordinater had just started to make informal approaches to retiring NHS personnel with regard to CHC secretaryships when the new DHSS guidance was issued. It was then decided that advertisements should be placed for the posts just prior to the inaugural meetings so that the CHCs could expedite the selection process. With regard to

accommodation all area administrators were asked to find premises for each CHC (3 offices) on NHS property not adjacent to either AHA or DMT offices, which could then be offered to the CHCs. The RHA acted on the understanding that the CHCs would wish to appear to the public to be independent of AHAs and DMTs and so asked for separate accommodation but was loth to suggest non-NHS premises because of the costs. The RHA did not look very closely into the budgeting of CHCs but it did suggest a figure of £200,000 pa.. for all its CHCs i.e. about £11,750 each.

preparations for innaugural meetings: apart from the preliminary moves made on CHC accommodation the major preparatory task undertaken was the production of a CHC "handbook" which gave the following information: 1, general NHS information; description of the functions of DHSS, RHAs, AHAs and FPCs; a short discussion of the different tasks of members and officials, and a description of the tasks of Joint Consultative Committees; ii, CHC information; details of the establishment, membership, staffing, financing, accommodation, functions, constitution and proceedings of CHCs, and matters to which they might give attention (all culled from Regulations and Guidance); iii, names, addresses and appointing organisations of CHC members; iv, names of members and officials of RHA, AHA, FPC, RTO, ATO and DMT, and v, details of health service institutions, staffing and budgets in the area and district. The booklet brought together in one volume much of the basic information necessary to CHCs in the first few months of their existence. Coupled with this the area or district plan was made available after the inaugural meeting which altogether provided an information service to CHCs which was not matched by any other RHA.

the inaugural meetings: these were held in July, except for the South East Cumbria CHC which was unable to meet until September. The RHA chairman attended each meeting and acted as chairman until the CHC elected its own chairman. The regional administrative officer responsible for CHCs and the co-ordinater were also present at each meeting as

was the chairman and/or vice-chairman of the relevant AHA. For most meetings members of the ATO or AMT and/or the DMT were present except in one instance where the DMT did not attend the inaugural meeting but expressed the hope that the CHC would invite it to its first business meeting.

The agenda was the same for all the meetings and was as follows: i, address by RHA chairman; ii, election of chairman; iii, election of vice-chairman; iv, appointment of secretary - membership of appointing committee; v, questionnaire from the Centre for Studies in Social Policy; vi, proposed seminars for CHCs; vii, accommodation; viii, date, time and place of next meeting; ix, any other business.

The RHA chairman's address, the first agenda item, was a long speech. It was welcoming and encouraging but was in many places more directive than one would have expected and therefore needs to be quoted from at length. (The subtitles are added for the sake of clarity). After introducing the NHS authority members and officials present the chairman discussed the <u>election of chairman and vice-chairman</u>:

> Your first duty is to elect a chairman. You will have to decide whether to do it now or at the next meeting. Perhaps you will think about this while I am speaking. It is a matter of some urgency as there are many things which we wish to discuss with him at an early opportunity. The things which have to be discussed are: accommodation; frequency of meeting; appointment of secretaries and clerical assistance. It is difficult to do any of this until a chairman is appointed.

He therefore strongly emphasised at the beginning of his address that a chairman should be appointed without delay. He then went on to say that the inaugural meeting was the only one which RHA and AHA members and officials would attend as a right.

<u>the nature of CHCs</u>:

> there have been some harsh and stupid things said about the concept of CHCs. They have been called "watchdogs without teeth" and "bodies with power but not responsibility." These, and other modern catchphrases are not true. They set a tone which

I deplore. They are a bold and imaginative step in the democratic control (sic) of the health service. As representatives of the public, it is your duty to pass on to the AHA, and through them, to the RHA the requirements of the public. You have the right to be consulted on all substantial developments and changes in the health services in your district. You can issue a report to the AHA at any time, and must do so at least once a year. The AHA must reply to this report. You can visit all health service premises, except for general practitioners' surgeries. I would ask you not to visit as individuals or on an ad hoc basis. You have enough teeth to do considerable good to the service, or damage if you misuse your powers. There is no reason why the relationship between the CHC and the authorities should not be a constructive and happy one. We all have the same purpose - to make the NHS as efficient as possible.

This is in general an encouraging statement although there are two points which give rise to concern. The first is the assertion that CHCs are a bold and imaginative step in the democratic <u>control</u> of the NHS. This could easily give a misleading picture of CHC powers to members. The second is more serious: "I would ask you not to visit as individuals or on an ad hoc basis." This was picked up at one meeting where a member said "Unless this is an instruction it must be changed immediately." The co-ordinater took up this point and said "This would cause very great resentment." The RHA, in making this request, was acting within its powers as establishing authority to lay down conditions for inspecting premises[11] but was making it very clear from the start that it was taking a hard line. This of course greatly restricted the CHCs' ability to see informally at first hand how hospitals are run on a day to day basis.

<u>matters over which there may be friction without an effort from both sides:</u>

a) bread priorities are set by the Secretary of State, and she is responsible to Parliament. The duty of the RHA and the AHAs are set out in the booklet you were presented with.
b) plans put to CHCs are governed by DHSS policies and funds.

c) you must be aware of the past history of plans in order to be able to understand them. Some projects have already been got under way and you must accept the status quo, although criticisms and recommendations for alterations will be welcomed. Please be sure you know enough before you commit yourselves to a course of action.

d) invite AHA people to your meetings to explain proposals and answer problems.

e) the press and public are normally allowed into meetings. It will be up to you to exclude them when matters are being discussed which may, if widely known, be prejudicial to either the public or a private individual. I have in mind matters of an individual's illness or salary.

f) visits should be prearranged. Staff are mostly dedicated and conscientious people doing a magnificent job in difficult circumstances. I suggest that you exercise tact when you visit.

g) consider the health needs of your district as a whole. Don't be parochial.

h) plans sent to you for your consideration and comment are worked out with the benefit of expert advice from medical, nursing, financial and administrative staff. Some hospitals have to be closed down to provide a better service for the public. Funds should not be used for outdated premises. Feel free to criticise, but be constructive.

i) the duty of the health service is to prevent and cure illness. It is not the duty of the NHS to provide hostel accommodation for the mentally ill, the mentally handicapped and the old. This is the duty of the local authority social services department. We either cure or relieve complaints. We do not send granny to the geriatric ward to die any more.

j) for some time the RHA and the AHA will be working under considerable difficulty. They are short staffed and many people are in new jobs. Many of the staff, young and with considerable ability, will take time to learn their new duties. Please be understanding.

Although it was a salutary exercise to tackle areas of potential disagreement the message which seemed to come over, particularly from b), c), h) and j), was that the CHC was expected not to question the judgement of NHS officials. It is regrettable too that the RHA chairman stressed the CHC's, rather than the AHA's, responsibilities. He did not mention e.g. that the CHC had the right to appeal to the RHA if it thought the AHA was not being helpful. Overall the list appears to

be one-sided. This highlights the problem of the establishing authority having an interest in the bodies to be set up.

He then went on to discuss the composition of CHCs and the period of office for members. He gave a lengthy talk on NHS finance and finished by mentioning that seminars would be held for CHC chairmen, members and secretaries.

It was noted above that the RHA chairman in his introductory speech had strongly emphasised the need to expedite the election of chairman. Under agenda items two and three - the election of officers - he was even more forceful. At the first few meetings he said "You may decide either at this meeting or later on the appointment of chairman. I would like to stress that there is some urgency about this matter as things such as accommodation and the appointment of secretary have to be dealt with. Would you like to decide?" If a member proposed postponing elections the co-ordinater advised against it thus: "There are many things which need to be done. First there is some urgency over the appointment of a secretary. Secondly there is the issue of accommodation." If this was not convincing enough (which it was not on three occasions) the RHA chairman then stated that there had already been delays in establishing CHCs and said "it would be unfortunate if there were even more delays." Placed in this situation the CHC, a body only just convened, with no cohesiveness, had very little choice. After the first few inaugural meetings the RHA chairman did not even put the choice to the CHCs, he just assumed that an election would take place immediately. Every CHC in fact elected its chairman at the first meeting.

When it came to nominations the RHA chairman asked the nominees to give an indication of their experience. Given the health service authority emphasis of his introductory speech other things being equal

the whole process encouraged the election of RHA appointees or other members with HMC experience to be elected. Ten out of the seventeen chairmen elected were RHA appointees. Given that the RHA appointed only one sixth of the membership one would expect at most 3 chairmen to be RHA appointees. The northern region had by far the highest proportion of RHA appointees as chairman in the country. In one instance in fact the RHA chairman went out of his way to influence a CHC to be predisposed towards a RHA nominee by warmly recommending him to the council just before the election.[12]

It is difficult to see why the RHA chairman was so insistent on the CHCs making instant decisions about their chairmen unless he wanted to ensure that "pro-NHS authority" members were elected. The matters of accommodation and staffing were not urgent at all (pace the RHA chairman). Another month or two would have made very little difference on these matters.

Over the chairman's period of office the RHA chairman gave them the choice of either one year or the remainder of the member's tenure (either 2 or 4 years). He did not mention the possibility of appointing a caretaker chairman. When the CHC chairman was duly elected the RHA chairman offered to stand down from chairing the meeting after suggesting that the person who came second in the ballot for chairman should be appointed vice-chairman. Some CHCs agreed to this while others requested fresh nominations.

The fourth agenda item concerned the appointment of secretaries. A block advertisement for the posts had been placed in the press at about the time the inaugural meetings were being held. The co-ordinater gave the following speech:

> To save time the posts for the whole region have already been advertised. It is now up to you to constitute an appointments sub-committee. The secretary will be employed by the Regional Health Authority but, other things being equal, we will accept your choice. The sub-committee will have

> five members plus a representative from the region, probably myself, and an outside assessor who will not have voting rights. The number five has been agreed by consultation with the staff associations. It is expected that the chairman and the vice-chairman will sit ex officio on the committee. I would therefore ask you Mr Chairman whether the council agrees that the chairman and vice-chairman should be on the committee and, if so, for three other names.

The RHA was thus putting some pressure on the CHCs to appoint secretaries as soon as possible. Indeed all but one of the secretaries was in post by October 1st.

Agenda item five was the reading of a handout from the Centre for Studies in Social Policy concerning their request for copies of CHC agendas and minutes and their national questionnaire for CHC members. This was followed by a discussion under agenda item six of seminars for CHCs. One for chairmen and vice-chairmen had been arranged for the middle of October. A further regional seminar was being arranged for secretaries and one was being arranged by the RHA and relevant AHA for each individual CHC. Accommodation was discussed under item seven with the co-ordinater giving suggestions about possible locations. The final business item was the date of the next meeting. The RHA chairman in most cases suggested a meeting in September which was normally agreed upon.

<u>the Northern RHA - an assessment</u>: the RHA's approach fell into two distinct phases: phase one encompassing the determination of the number and size of CHCs, local authority and voluntary body membership, and preliminary arrangements for staffing, finance and accommodation; phase two encompassing selection of RHA membership and organising the inaugural meetings. The first phase was eminently non-directive. The RHA engaged in protracted consultations and went out of its way to be impartial. The only occasions where it attempted to be directive concerned timetabling the voluntary body appointment procedure (in which it failed) and insisting that certain interests were represented in the voluntary body nominations rather than its own.

During phase two however there was a marked change in emphasis. The RHA in appointing its own nominees decided to give first preference to ex-HMC members and to give to the voluntary body sector the duty of ensuring that war pensioners' and miners rehabilitation centres' interests were represented. If it had continued with its previous non-directive approach it would have ensured that those interests were represented amongst its own nominees, thus freeing five more places for the voluntary bodies, and would have given more weight to "other bodies" at the expense of ex-HMC members. As noted above ex-HMC members were deliberately favoured in order to maximise the proportion of CHC membership with NHS (and particularly hospital) management experience. Similarly the RHA chairman's address at the inaugural meetings was "NHS management oriented" and the emphasis given to the immediate election of chairmen gave ex-HMC members an enhanced opportunity of being elected. It can therefore be concluded that the RHA wanted to influence the CHCs by nudging them towards a "NHS management" viewpoint rather than a "community representation" viewpoint. The RHA was scrupulously fair in its interpretation of regulations and guidance but at the same time tried very hard to ensure that CHCs would be sympathetic to NHS management interests.

Was then the Northern RHA pro-CHC or anti-CHC? In phase one it certainly appeared to be pro-CHC and in phase two it was encouraging, although it is difficult to look upon the questions of RHA appointments, election of chairmen and the style of the introductory address as mere aberrations. Yet it was certainly not thoroughgoingly anti-CHC because it exerted no influence (where it had a right to do so) over the appointments made by voluntary bodies. The answer appears to be that the RHA was in favour of CHCs but saw them in the same way that the old RHB had seen HMCs - as primarily NHS rather than consumer based bodies. The RHA could be described as "anti-community health

councils" but very much "pro-community health councils." This interpretation explains the lapses in non-directiveness which all emphasised the health service authority facet of CHCs.

The approaches of other RHAs

There is very little detailed information available about the way in which the other regions set about the task of establishing CHCs. The only published work about the establishment process nationwide is an article by Klein and Lewis in Health and Social Service Journal[13] supplemented by an unpublished report.[14] Other information was gathered by the research worker's attendance at meetings in other regions, particularly the Yorkshire region. The only parts of the establishment process about which there is much information are: timing and consultation; CHC size; voluntary body appointments, and budgeting.

The general approaches of the RHAs over timing and consultation differed considerably. Two RHAs managed to get the first of their CHCs established in April 1974 by being highly directive and by undertaking only the most perfunctory consultations.[15] Most of the others finished the establishment process between May and September but a few took considerably longer. In general RHAs which took longer to establish CHCs did so in order to fulfil their consultative commitments but at least one RHA (West Midlands) deliberately procrastinated because it did not approve of the CHC concept.

Similarly there was considerable divergence in the size of CHCs. Klein and Lewis point out that the differences in size "seem to be related less to population than to the policies of the various regions."[16] Some regions gave all their CHCs near the minimum membership (e.g. South West Thames with 24), while others went for the maximum (e.g. North Western RHA with 30). The Northern region is interesting because although its average membership is one of the

highest (over 28) it has the largest range of membership of any region, between 18 (the minimum) and 36 (over the normal maximum). Even when the three CHCs with extraordinary membership size (South East Cumbria, 18; Northumberland and South Tees, each 36) are excluded the average membership is 27.5, still a high figure.

For the purpose of analysing voluntary body appointments the selection procedure will be split into three parts: compiling lists; selecting from the lists, and arriving at nominations. There is some disagreement over the value of the advertisements placed in the press. Jack Hallas, in his booklet CHCs in Action, claims "the volume of response from voluntary bodies to the advertisements publicising the creation of councils was enormous,"[17] whereas Klein and Lewis assert "there is general agreement that the advertisements were a failure in terms of attracting applications from voluntary organisations."[18] They then went on to enumerate some of the RHAs' provisional lists. The lists they give for the Northern region are incorrect (they give the final ones and not the original ones, which in some of the Cumbria districts leads to a difference of over 300). Their figures for Yorkshire are also incorrect, for the same reason (they are again adrift by very large amounts, as much as 200 in some instances). Also the lists they quote have excluded some voluntary bodies which applied in response to the advertisements (a considerable number in e.g. the Yorkshire region). Klein and Lewis' conclusions are therefore open to doubt because they are based (on at least two occasions) on the wrong sets of figures. On the other hand Hallas is perhaps overstating his case. He states that there were over 1,000 applications from voluntary bodies for the 17 Yorkshire region CHCs.[19] This is true, but many of the applications were made before the advertisements went to press.

From the data which is available it is evident that there was a great deal of enthusiasm throughout the country from voluntary organisations. Klein and Lewis however dispute this saying "Some regions were, in fact, so disappointed by the initial response that they went out to trawl for candidates - particularly where certain candidates, e.g. immigrant groups, were not represented at all."[20] The explanation of this is quite simple. These RHAs were only "trawling" for candidates who could be appointed by the RHA as well as by voluntary bodies e.g. immigrant groups. If they were appointed by the voluntary bodies then there would be no need for the RHA to appoint them, and this left the RHAs free to appoint people with a knowledge of the NHS. Therefore the disappointment of some RHAs did not concern the <u>number</u> of voluntary body applications but the <u>range</u>, and specifically concerned those bodies with only a marginal interest in health which DHSS had asked RHAs to consider accommodating in their own appointments.

There was a great divergence between the RHAs in selecting from the lists which voluntary bodies should take part in appointing members. Here the Northern RHA was the most non-directive of regions. Mersey RHA did some extensive pruning arriving at "selection panels" comprising approximately 20 bodies from original lists of up to 120. Yorkshire was even more restrictive, in one case selecting as few as 11 voluntary bodies to make the decision. Yorkshire RHA had a heavy bias towards hospital oriented bodies and "traditional philanthropic" bodies in its selection. In one selection panel of 29 bodies, 8 were hospital Leagues of Friends, 10 were traditional philanthropic bodies (Round Table, Lions, Womens Institutes, etc.) and only 5 patient group bodies were included (NSMHC, NAMH, NAWCH, OPWA and Age Concern*). Bodies such

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* NSMCH = National Society for Mentally Handicapped Children;
NAMH = National Association for Mental Health;
NAWCH = National Association for the Welfare of Children in Hospital;
OPWA = Old People's Welfare Association.

as the Patients Association and disease oriented organisations had been specifically excluded by the RHA. In Yorkshire, as in some other regions, Councils of Social Service and voluntary organisations with an interest in health generally were bitter because the RHA had taken upon itself (as it had the right to do) to exclude from the selection procedure some voluntary bodies which had a major interest in health matters. Yorkshire RHA was extremely secretive about its appointment procedure. The author had to leave one of its meetings when it was found he was not an accredited voluntary body representative.

There is again some divergence between regions on arriving at voluntary body nominations. Most regions followed a similar procedure to the Northern RHA by delegating the job to councils of social service, some gave the councils guidance over procedures, others did not. Some regions, including Oxford and Yorkshire, organised it entirely themselves. In Yorkshire the Regional Administrator himself conducted the meetings, and was highly directive in his approach.

With regard to the budgeting the Northern RHA had allocated £200,000 for its CHCs in their first full year's operation, i.e. about £11,750 each. Klein and Lewis note that RHAs tended to allocate between £8,000 and £15,000 pa per CHC.[21] It is difficult however to make very much sense of these figures because it is not clear whether CHCs would be charged for using NHS facilities and accommodation at market rates.

The Northern RHA therefore was enlightened in its general approach compared with other regions, particularly with regard to CHC size and voluntary body membership. Some regions were highly directive in these matters and acted in a manner detrimental to the independence of CHC. membership. The exclusion of voluntary bodies with a valid claim to be included by RHAs which did not wish to see them represented on

CHCs could continue indefinitely as the RHA was given the duty of keeping the lists of voluntary bodies up to date. Some RHAs in effect banned a voluntary body, or group of voluntary bodies, from CHC representation by the simple expedient of keeping its name, or their names, off their lists.

It is unfortunate that there is no information available about the RHAs own appointments and the RHAs' approach to the inaugural meetings. One piece of information is available however about the chairmen of CHCs which may throw some light upon the Northern RHA's approach to the inaugural meetings. That is that nationally 29% of chairmen of the newly appointed CHCs were RHA appointees[22] compared with 59% in the Northern region, i.e. the Northern Region had twice the national average of RHA appointees being CHC chairmen. The Northern RHA was therefore more non-directive than most with regard to voluntary body membership and CHC size, but, because of its directive approach in the inaugural meetings, ended up having its own appointees massively over-represented in the vital post of CHC chairman.

The executive process

The RHAs' tasks in executing their duties under the Act and regulations aided by departmental guidance, were greatly complicated by the large amount of discretion given them and by the complexity (and ambiguity) of some regulations and parts of the guidance. The RHAs' role in creating CHCs should have been neutral or as near neutral as possible, the job they were doing was to ensure that Parliament's will was executed. But the RHAs were interested parties and it would have been impossible for them not to have influenced CHCs. Many of them set out deliberately to mould CHCs to their conception (not Parliament's) of how CHCs should function.

Therefore RHAs were given too much discretion. They should have been given enough discretion to allow for special local circumstances but not enough to allow them operationally to redefine the role and function of CHCs. Admittedly the Act was vague about this, but enough undertakings had been given by ministers (particularly with regard to CHC independence) to guide DHSS in drawing up regulations and guidance so as to limit RHAs' discretionary powers. This could have been done as follows:

A more realistic deadline could have been set for CHC establishment. This would probably have been about six months after the Appointed Day. The CHCs it is true would have missed the first six months of the reorganised NHS but altogether this may not have been a bad thing. It would have given the NHS authorities a chance to settle down and would have enabled CHCs to have been created through a genuinely consultative process. DHSS could have given clear criteria for determining the size of CHCs. There is no reason why all CHCs should not in the first instance be given the same membership, say 30. After a year or two the individual CHCs themselves could have negotiated changes in membership size if they so wished.

The appointments procedure for local authority representatives was successful because it was left entirely to the local authorities. Some regions let the voluntary organisations organise their own appointments themselves. This could have been mandatory. If the RHAs were given no opportunity of influencing the voluntary body appointees then they could rightfully claim to have health service interests represented in their appointments. The incoming 1974 Labour Government by changing guidance on the appointment of secretaries took a step in the right direction, giving the CHC the right of choosing its own staff. A similar step could have been taken over CHC accommodation if

CHC budgets had been put into the province of DHSS (or a national CHC body) rather than the RHAs. This again would have overcome the problem of regional disparities. Similarly the regulations could have insisted that the CHCs had a rotating chairmanship for the first few months of their existence.

If these steps had been taken then the RHAs' tasks would have been much simpler and less contentious in the execution. These steps are in line with the Act and ministerial undertakings. Why then were they not taken? Klein and Lewis quite correctly state that DHSS took a recessive role in the establishment process and they attempt to explain it as follows:[23]

> In adopting this strategy the central policy makers appear to have made a virtue of necessity. Since the criteria for selecting CHC members were by no means self-evident - and since there might well be conflicting views as to which interests should be represented, and how - it suited the DHSS to decentralise the implementation process. In this way the DHSS was able both to demonstrate its belief in local decision-making and to cushion itself against the inevitable criticism which would be made by disappointed would-be members of CHCs. Uncertainty about the aims being pursued and a wish to diffuse blame reinforced the desire of the administrators to devolve the burdens involved in initially setting up CHCs.

The DHSS actions seem more akin to "passing the buck" than to "making a virtue of necessity." If DHSS had grasped the nettle and told the RHAs to devolve the appointment procedure of voluntary body members to the voluntary bodies instead of giving them a choice it would have escaped all blame and would have provided real "local decision making." There can therefore be no question that the DHSS's approach left the RHAs with too much discretionary power. The alternative course of action suggested above would have enabled CHCs to have been established in a way giving the RHAs much less control over their destiny. This would have fulfilled both the letter and the spirit of the law because the Act gave the duty of establishing CHCs to the Secretary of State, not to the RHAs.

CHCs in the northern region

membership: information about membership was gathered from membership lists held by the RHA and from the tables in the statistical appendix to the Klein and Lewis report.[24] The average response rate to their survey from the northern region CHCs was 67.2% (slightly higher than the national average of 64.7%) but there was a wide range of responses from different CHCs. In five cases the response rate was between 50% and 59%, in five cases between 60% and 69%, five between 70% and 79% and two between 80% and 89%. The figures must therefore be treated with considerable caution and can give only an indication (probably biased) rather than a definition of membership characteristics. Detailed statistics and tables are given in Appendix 2 below, only the more important features are summarised here.

Both nationally and in the northern region the younger age group (15-44 years) is underrepresented on CHC membership, having only half the representation to be expected if CHC members' age structure matched that of the adult population. The over 65s are very heavily overrepresented in the northern region.[25] Fifty-five per cent of northern region CHC members were men, this was slightly lower than the national average. Social class distribution of northern region CHC members was near the average for all CHCs, but they were generally less well educated than average, and had the lowest proportion of university graduates of all regions. Church membership was slightly higher than average. Overall political party membership was lower than average but this hides a large overrepresentation of Labour Party membership at the expense of both Conservative and Liberal parties. The northern region members were considerably more experienced in health service management than most other regions' members.

The most striking difference between northern region and national CHC membership characteristics lay in voluntary body affiliation. Northern region members joined fewer voluntary organisations in general than members in other regions (with the exception of women's organisations). In particular these bodies with an interest in general health care (e.g. hospital friends) and special care groups (the mentally handicapped, mentally ill, disabled, children and maternity) were seriously underrepresented with the northern region coming bottom or nearly bottom in all of these categories. These peculiarities cannot be explained in terms of the pattern of membership appointment by the voluntary bodies themselves because there is a similar distribution of membership of these categories between the two thirds of members not appointed by voluntary bodies and the one third appointed by voluntary bodies. This situation led Klein and Lewis to comment:[26]

> The northern region is remarkable for being below the national average for all the special care groups. The reason for this could lie in the methods of selection adopted or in the ecology of voluntary organisations; it could be that these organisations are thinner on the ground in the Northern than in other regions.

Given that the selection of voluntary body members were left entirely to the voluntary bodies themselves the reason for this must lie in the relative sparseness of voluntary bodies interested in special care groups in the northern region.

<u>chairmen and vice-chairmen</u>: it was noted above that the RHA chairman exercised undue haste in promoting the election of CHC chairmen and vice-chairmen and it was asserted that in so doing the results of the elections were biased in favour of RHA appointees. Table 5.2 compares the proportion of CHC chairmanships accruing to members appointed by local authorities, voluntary bodies and the RHA in the northern region CHCs with the figures for all English regions and with the proportion

of CHC members appointed by the different bodies. Ignoring for the moment the northern region results it can be seen that for all regions the proportion of local authority appointees who became chairmen was slightly higher than the proportion of local authority appointees who were members. On the other hand there were considerably fewer voluntary body appointees and considerably more RHA appointees elected as CHC chairmen than would be expected.

TABLE 5.2

CHC CHAIRMEN BY APPOINTING BODY: NORTHERN REGION AND NATIONAL

Appointing Body	Northern Region Chairmen N	Northern Region Chairmen %	National Chairmen N	National Chairmen %	All Members %
Local Authority	6	35	91	53	50
Voluntary Body	1	6	31	18	33
RHA	10	59	49	29	17
Total	17	100	171	100	100

Source
Northern Region; from individual Northern region CHCs.[27]
National; from Klein and Lewis, Table 2.26, p.77.

The position in the northern region is radically different from both the national average and from what would be expected if the distribution of chairmen by appointing body were similar to that of the membership in general. Only 35% of the northern region chairmen were elected from local authority appointees compared with 53% nationally and 50% expected. Voluntary bodies were under-represented in the northern region, but even more radically than was the case nationally. Only one voluntary body appointee became a CHC chairman whereas at least five would be expected in proportion to membership appointment.

RHA appointees were therefore massively over-represented; 10 chairmen instead of an expected 5 in relation to the National average, or 3 in proportion to RHA appointed membership.

The northern region was the only one with such a high proportion of RHA appointees as CHC chairmen and was the only region where the RHA chairmen attended every inaugural CHC meeting and pressurised the CHCs immediately to elect a chairman. The Northern RHA, wittingly or unwittingly, played a vital part in ensuring that RHA appointees had a far higher proportion of CHC chairmanships than could reasonably be expected. Table 5.3 shows the situation of vice-chairmen in the northern region with regard to appointing bodies; the national average, and membership proportions.

TABLE 5.3

CHC VICE-CHAIRMEN BY APPOINTING BODY: NORTHERN REGION AND NATIONAL

Appointing Body	Northern Region Vice-chairmen N	Northern Region Vice-chairmen %	National Vice-chairmen N	National Vice-chairmen %	All Members %
Local Authority	10	59	69	48	50
Voluntary Body	4	23	44	31	33
RHA	3	18	30	21	17
Total	17	100	143	100	100

Source: as for Table 5.2

Here the figures for all regions are closer to the expected frequencies than for CHC chairmen. Local authority and voluntary body representation is slightly lower than expected and RHA appointees have a higher representation than expected. In the northern region representation of RHA appointees was less abnormal with regard to vice-chairmen than to chairmen, it fell below the figure for all regions and equalled the expected frequency from membership proportions. The

voluntary organisations were again under-represented with 4 members instead of an expected 5 or 6 elected vice-chairmen, and the local authorities were slightly over-represented with 10 members compared with an expected 8 or 9.

<u>the appointment of secretaries</u>: this was the first task of the CHCs in the Northern region once they had elected their officers. The organisational framework for the appointment procedure had been imposed by the RHA. The RHA had issued advertisements for the posts and had insisted upon an appointments sub-committee being formed immediately by each CHC comprising: chairman, vice-chairman, and three members. Some CHC members were strongly critical of what they considered to be the heavy handed approach of the RHA and wished to change the procedure. The RHA however would not agree to this, stating that the format had been agreed upon with the staff associations, although this does not seem to be a completely satisfactory explanation given that the jobs were being advertised openly.

In addition to the 5 CHC members each sub-committee had a RHA representative (in every case the co-ordinater), and an external assessor without voting rights was also present. In the actual appointment process the RHA in fact took a low profile. In no case did the RHA veto a CHC's choice although there was one instance where the RHA was not totally happy with a chosen candidate (a NHS official).

It is interesting to note that although the RHA took a non-directive role in the actual appointments procedure it may well have had an indirect influence on the outcome by its insistence upon the election of the sub-committee members at the inaugural CHC meetings. This is because RHA appointees were over-represented among elected sub-committee members, as can be seen from Table 5.4.