GRADUATE MANAGEMENT COURSE

COMMUNITY HEALTH COUNCILS:

IS THE WATCHDOG BARKING UP THE WRONG TREE?

1. CONTENTS

2. ACKNOWLEDGEMENTS

We wish to express our appreciation and thanks to the Area Administrators and Community Health Council Secretaries for giving up their time to answer our questions and discuss the subject of CHCs.

We would also like to thank Mr. J. Hughes (Course Tutor) and Mrs. M. Emery (Course Administrator) and many of our colleagues at the Manchester Business School for their advice and assistance.

Last but not least we would like to thank the members of the public for their co-operation.

3. PROJECT TEAM

The project on Community Health Councils was undertaken as part of a 5-week Graduate Management Course at the Manchester Business School from 24th October - 25th November 1977.

The project team consisted of six National Administrative Trainees:

Mr. Roger French and Miss Lesley Grimshaw (North Western RHA)
Mrs. Margaret Mawhinney and Mr. Ian Pilkington (Mersey RHA)
Miss Janet Kells (Northern Ireland Staffs Council for the Health and Social Services)
Mr. Simon Yates (Welsh Office)

4. TERMS OF REFERENCE

To:

Examine the effectiveness of four CHCs in the North-West of England in:

i) Representing the public's views to the Health Authority

ii) Informing the public of the present and future policies of the Health Authority.

5. BACKGROUND

5.1 In January 1974 an NHS Reorganisation Circular, HRC(74)4 was issued by the Department of Health and Social Security on the arrangements for setting up Community Health Councils in the reorganised National Health Service.

The Circular gave the following definition on the Purpose of Community Health Councils:

> "Community Health Councils will provide a new means of representing the local community's interests in the health services to those responsible for managing them. In the reorganised National Health Service management of the service and representation of local opinion will be distinct but complementary functions, entrusted to separate bodies but working in close relationship. Successful administration of the service will depend on a continuing and constructive exchange of ideas between Area Health Authorities (AHAs) and the Community Health Councils (CHCs); the AHA will then be aware of local opinion on needs and deficiences in the Service, and the community through the CHC, will know of the action and intentions of the AHA and of the problems and constraints with which it is faced. To be effective this relationship will call for positive effort and goodwill on both sides. The Secretary of State believes that this system will be seen to be mutually beneficial to those who operate and plan services and to those who use them. Membership of the Councils will give a worthwhile and satisfying role to many of the public-spirited people who take a particular interest in the quality of their local health services."

To fulfil these requirements the CHCs should be consulted before any substantial developments or variations in the service are to be taken and should receive information from the AHAs relevant to any major decisions in local planning and policy.

5.2 Membership of each Community Health Council is made up of at least one half local authority appointees and one third from voluntary organisations. The remainder are appointed by the Regional Health Authority. In representing the public of it's district, in health matters, the membership of each CHC should cover as wide a cross-section of people as possible, who reflect fairly the prevailing views of the district.

A pilot study by Klein and Lewis (New Society 28.11.74) found that most CHC members view themselves as the "brokers" or link-men between the NHS and the consumers. The survey questioned members as to how the CHCs had tried to find out the interests of the consumer, and three main methods seemed to be used.

(1) Some CHCs saw their own members as representing the community interests; an approach which leaves the burden of identifying problems on the CHC members. The interests of the member may not, in themselves, be representative of the community and suggests members must be fairly perceptive.

(2) This approach was to advertise widely the existence of the CHC and to ensure that the members were readily available at specified times. This may be a more efficient way of sounding out public opinion, but still has the drawback that only those members of the public who are sufficiently motivated to articulate their points to the CHC will be heard.

(3) The final approach and perhaps the most unsatisfactory way of representing the whole community, was to take account only of all the most effective pressure group interests. This aggravates the worst dangers of the previous method, and can lead to the interests of intense minorities being examined at the expense of those of the less vociferous majority.

5.3 More recently, the Evidence to the Royal Commission on the National Health Service by the North Western Regional Health Authority (Feb.1977), indicates that the Authority feels that the CHCs are not truly representative of consumer interests in their present constitutions. However, with greater participation by voluntary organisations, a more representative view could be obtained and the progress already made to date, accelerated. The RHA maintains that in the period since CHCs were established, some difficulties have been demonstrated. These have been of a practical nature, i.e. not arranging their business around that of the AHAs and thus risking publishing information before it has been to the AHA meeting; also the fact that CHCs often mis-interpret their own role.

5.4 This brings into question whether CHCs have, in fact, fulfilled their originally intended role or established themselves under a different aegis. In our surveys, we attempted to ascertain whether the CHCs studied have become effective under their original terms of reference or have followed a different line of development.

6. METHODOLOGY

6.1 The basis of the study was survey interviews with members of the public in four different Area Health Authorities. These included:

(i) A heavily industrialised urban area with a declining city centre population (Area A).

(ii) A historic city and market place at the centre of a rural area (Area B).

(iii) A large suburb of a major conurbation (Area C).

(iv) A medium sized, prosperous, industrial town (Area D).

In order to gain the confidence of the people interviewed and to encourage frank and open discussions, it was decided not to reveal the identities of the Authorities involved.

6.2 The interviews were conducted in the centre of the Areas concerned and as far as possible on the 'neutral' and busy thoroughfares and in town centres. The number interviewed was 400, being 100 from each Area - and the respondents were evenly divided between male and female and spread across the age ranges. The Questionnaire is included in Appendix III.

6.3 To assist the team in it's findings two further Questionnaires were prepared for use when interviewing respectively CHC Secretaries and Area Administrators. These enabled a structured 'feedback' to be obtained from the questions posed. (see Appendices I and II.) A summary of findings is included in this report.

6.4 A wide range of material was also used including information from the King's Fund Library, Manchester Business School Library, Community Health Councils, North Western Regional Health Authority and the Lancashire Area Health Authority.

7. SUMMARY OF THE INTERVIEWS WITH CHC SECRETARIES

7.1 In this investigation it was essential to discover what the CHC Secretaries saw as their role and what degree of effectiveness and influence they believed that the Councils had. A Questionnaire (see Appendix II) was used as the basis of the interviews although in practice a wider range of issues were discussed and opinions given. The team members noted with interest that none of the CHC offices were widely advertised or particularly easy to find.

7.2 All the CHC Secretaries but one felt that the councils were as representative as possible. They felt that CHCs could not be representative in any truly democratic sense. However, the existing membership provided a fair representation of public opinion. The Secretary in Area C believed CHCs to be unrepresentative in age, outlook and method of appointment. The Secretary of Area D felt that the quality of membership was improving as Local Authorities began to send members with useful skills and knowledge rather than simply those with the right political affiliations. The interest of the members could be seen by a good attendance record and good input into the work of the CHC.

7.3 All the Secretaries considered the media (press, radio and TV) to be the most effective method of reaching large sections of the public, with particular emphasis on local radio. It was generally agreed that meetings did not attract large audiences, the best response came to topical and local issues such as the Abortion Bill, NHS cut-backs and closures. With the exception of Areas B and C who did little, the CHC Secretaries distributed leaflets to clinics and hospitals, and sent reports and minutes to libraries and to the Town Hall. The Secretary of Area A had a full monthly schedule of talks and meetings. In an average month Area A dealt with 27 problems, gave 6 talks, and had 9 pieces in the press or on radio.

7.4 Relationships with the AHAs were for most of the Secretaries rather distant and sometimes strained. One CHC Secretary was the exception in having very good personal relations with the Area Officers. It was found that there were much fuller, more informal channels of communication with Districts. There was a consensus of opinion that the AHAs were reluctant to give CHCs any more than routine information and even this was slow in appearing. One CHC Secretary felt that the AHA gave information to the CHC which they were going to make public anyway. There appeared to be a difference between what the CHCs and the AHAs considered to be 'important'. Similarly the timing of the release of

information was disputed as the CHCs felt they were not given information early enough or involved in proposals at an early stage.

7.5 The CHCs used annual reports and special reports to give information on their work and public opinion to the AHA. The Secretary of Area C criticised the fact that the AHA did not publish replies to the CHC Annual Reports but answered them via the AHA Minutes. The Secretary of Area B said that he would send reports to the Region if he believed it would increase the chances of getting any action.

7.6 The CHC Secretaries in general felt that their position would be helped if they were centrally financed. The Secretary of Area B saw this as increasing their independence and giving greater weight to their role of providing information on public views to the AHA. One CHC Secretary felt that the DHSS often were more interested than the AHA in the findings and information from the CHCs. Two of the CHCs discussed their lack of suitable staff saying that the present grades were not high enough to attract people of the calibre needed to do the job. The Secretary of Area B suggested that CHC Secretaries should be drawn from people outside the NHS since former NHS staff were not seen to be, and in many cases did not feel themselves to be, independent of the AHA.

7.7 There was mixed opinion on the degree of influence that the CHCs had on the AHAs. The Secretary of Area C felt that their influence was very limited except perhaps on issues that were controversial. The Secretary of Area A felt that in conjunction with other action groups a great deal could be achieved. In Area B the Secretary saw influence over the AHA as a result of the Authority's sensitivity to bad publicity. Only in Area D did the AHA ever actually seek to find out CHC views on issues. Three of the four Secretaries felt that the CHCs were effective and could be even more so, and were not simply a shadow AHA. Some CHC Secretaries felt that at times the CHC members misinterpreted their roles but that the CHC had a real value, especially in seeking out public opinion. The Secretary of Area D believed that the CHC could provide a clearer vision as Authority staff were effected by internal policies and pressures of work. However, the Secretary of Area C believed that little was done by the CHC that could not have been done by the AHA, except that in response to public complaints the CHC could try to change management policy. He further believed that it would take 5 - 10 years before the CHC would be recognised by the public and the AHA as a body of value with a definite and useful role. In Area D the Secretary felt that, unlike the AHA the CHC could react spontaneously,

unconstrained by policy and bureaucracy.

7.8 All the Secretaries agreed that surveys were the best method of testing public opinion on specific issues. The Secretary of Area C expressed the view that members had to be pushed by the Secretary to do anything about testing public opinion. In Area D the Secretary agreed that surveys were useful, he also used questionnaires and letters and was interested in getting a DHSS research grant to develop the information finding process.

7.9 It was evident that the CHC Secretaries felt that the CHCs had a positive role to play in the NHS. At the same time, it was apparent that they felt that the AHAs were not as helpful as they might be, and that by implication their role of representing the public interest suffered. This was equally true of their role in reflecting the views of the Authority to the public.

8. SUMMARY OF THE INTERVIEWS WITH AREA ADMINISTRATORS

8.1 Our enquiries into Community Health Councils were made meaningful by interviews with Area Administrators establishing the impact of CHCs in the different Areas we examined. To give some structure to our interviewing scheme we used a common format of questions (Appendix III) for Administrators. Our interviews, however, were not confined within close limits by this method and ranged widely over topics which were obviously of interest to both interviewers and interviewees.

8.2 There is no reliable method of quantifying the responses which Area Administrators gave to our questionnaire but we think it useful to give a summary of the views which were expressed to us.

8.3 In Multi-District Areas we found it was common for CHCs to maintain regular contacts only with the respective District Management Teams. Although there was - naturally - no fixed pattern of meeting in all of our Areas, there was evidence that officers of the Area Health Authority (or DMT) and CHCs met informally or exchanged correspondence above that which was required by statute. Members of the respective bodies, however, met only formally and often only once a year to discuss the CHC Report (except for CHC observers attending monthly AHA meetings which appeared to be of limited value because of their formality).

8.4 Area Administrators stressed that CHCs were invited to attend AHA meetings and that complete sets of minutes (and papers) were distributed as a matter of course. Similarly DMT members were in some Areas invited to attend meetings of the CHC to report on matters of interest.

8.5 Nevertheless it was clear that the range of information passed on by the AHA was limited in many Areas to regular AHA papers or on items which Areas thought might be of interest to the CHC.

8.6 The statutory obligation of AHAs to consult with CHCs on certain items such as closures, together with district plans, to a large extent determined whether such a process would be undertaken. The point was made that, in Area C for example, the timing of public statements, rather than content, often restricted the consultative process. There was, however, the acknowledgement that it was preferable to be completely open with such a body rather than force the CHC to obtain information from unofficial (and possibly distorted) sources.

8.7 Views were divided on the effectiveness of the CHCs in representing the views of the AHA to the public. It was acknowledged by Area B that in the CHCs communication role possible distortion could occur purely by the CHC adapting information to suit its own style but in other Areas doubts were expressed as to whether the CHC actually 'got the message across'.

8.8 Area Administrators felt that CHCs did have a legitimate role to play as an independent public watchdog but not (as some CHCs had attempted) as a quasi-managerial body. Area A felt that because CHCs were not accountable to anyone that the CHC and AHA bodies should be merged especially as the membership of the two bodies was normally drawn from the same cross-section of the public. It was strongly expressed in a number of Areas that there was a need to streamline the consultative process and prevent another management/semi-professional constraint being added to the managerial system of the Health Service.

8.9 There was some discrepancy in the replies to the question of whether CHCs accurately reflected the public's views to the AHA. Area B felt that the CHCs were reasonably effective but Area C considered that any management team with sufficient experience would be aware of what public opinion was and that its AHA would be at least as qualified as a CHC to deliberate on such matters. Other Areas also questioned the ability of the CHCs to reflect public opinion accurately.

8.10 Following the series of interviews, with the Area Administrators of the AHAs described earlier in this report, it was evident that they had yet to be convinced 'en bloc' of the merits of CHCs and that co-operation was on the whole inclined to be in accordance with the letter of the law rather than the spirit. This is not to say that the Administrators had dismissed the concept of a Community Health Council out of hand but that they had yet to be shown that the CHCs had a universal goal and the will and ability to perform such a function.

9. ANALYSIS OF PUBLIC SURVEY

Q.1 Aim - to find out the present situation - how satisfied the public are with their present information about the AHA, i.e. the proportion of satisfied demand.

Q.2 Aim - to ascertain the % of persons seeking information, i.e. the demand for information.

Q.3 Aim - to ascertain the present pattern of information, i.e. how the public currently receive their information.

APPENDIX IV

Q.1. The continuous Black line columns represents the % in each Area satisfied with the present level of information i.e. A = 22%, B = 22%, C = 8%, D = 20%

Q.2. The dotted line columns reveal the % in each Area seeking more information, i.e. the actual demand for information A = 72%, B = 72%, C = 59%, D = 78%

The difference i.e. A = 50%, B = 50%, C = 51%, D = 58% reveals the level of unsatisfied demand for information, i.e. the room for improvement.
A and B have the same level of unsatisfied demand. Area D had a slightly less satisfied demand for information and a slightly greater expectation for information with a consequently greater % of unsatisfied demand. Area C showed a significantly lower % of satisfied demand (8%) and significantly lower expectation for information thus giving a false impression of unsatisfied demand (51%) - if the preceding factors are not taken into account.

Q.3. The survey showed that generally people derived their information from the mass media, i.e. TV, Newspapers and Radio and in this order of priority. Very little information was gained from CHC literature, yet significantly there was a fair proportion of people who specified that they received information from personal contacts and some from the Area Health Authority

Q.4 Aim - to find out the present situation - how satisfied the public are with the present system of representation, i.e. the proportion of satisfied demand.

Q.5 Aim - to ascertain the percentage of persons seeking representation, i.e. the demand for representation.

Q.6 Aim - to ascertain the present pattern of representation

FINDINGS IN APPENDIX VI

The continuous black line columns show the % in each Area satisfied with the present system of representation, i.e. A = 39%, B = 24%, C = 29%, D = 38%.

The dotted line columns show the % in each Area seeking representation i.e. the actual demand for representation A = 96%, B = 94%, C = 94% D = 87%
The difference i.e. A = 57%, B = 70%, C = 65%, D = 49% reveals the level of unsatisfied demand ie the area for general improvement. Therefore it is concluded that the persons residing in Areas A and D felt that they were better represented that those in either Area B or C, but the level of unsatisfied demand was greater in A than D because the people in A had a higher expectation than those in D. The people in Area C felt that they were less well represented and their demand for representation was high and consequently the level of unsatisfied demand was higher at 65%. The persons in Area B felt they were least well represented though they had a high expectation, thus their level of unsatisfied demand was the highest at 70%.

APPENDIX VII reveals that generally looking at the four Areas together people felt that they were more likely to approach their health authority directly than any other body. After the AHA people thought that their MP would be the person who they would normally approach. After the MP people thought the Council and lastly people thought the CHC. Quite a large proportion would approach other agencies and again a fair % were classified as "don't know".
Looking at these differences in greater detail it is interesting to see that in Areas A and D a significantly lower proportion would approach their council. The most remarkable feature perhaps is that in Area C only 7% as against 38/39% for others would approach the AHA. This was coupled in Area C by a significantly lower percentage in Area C who would approach their CHC, a higher percentage going to other agencies and a significantly greater percentage of "don't know".

Q.7. Aim - to ascertain the % of persons having knowledge of CHCs

Q.8. Aim - to find out how people had heard of CHCs

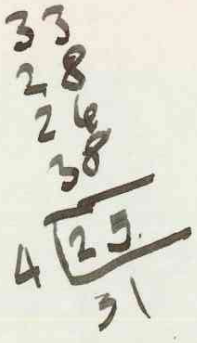
Q.9 Aim - to find out the % of persons who have had direct contact with the CHCs.

Q.7 and Q.9 were designed to establish the effectiveness of the CHC as a vehicle for representation and information.

APPENDIX VIII relates to Q7 and Q9

The full continuous line columns represent the % of persons who have heard of CHCs, i.e. A = 33%, B = 28%, C = 26%, D = 38%.
The dotted lines within the columns reveal the % of persons who have had some actual contact with the CHC. These smaller columns are an indication of active involvement with the CHC, whereas the other larger columns are an indicator of passive knowledge or awareness
Area A = 3%, B = 4%, C = 5%, D = 3%

Q.8 The survey revealed that the majority of people who had heard of CHCs had done so through the mass media, very few through CHC leaflets, but again a high proportion had heard through personal contact.
The findings correspond to those of Q3, i.e. how people obtain information on the health service.



10. SUMMARY OF FINDINGS

10.1 The results of the survey showed that there was a generally low level of public awareness of AHA policies. In one Area this was as low as 8% of those interviewed. When actually asked, a significantly higher proportion of people expressed a desire to know more about AHA policies in their area. (see Appendix IV)

10.2 A majority of the people spoken to obtained their information on the local health service via the mass media - television, newspaper and radio - and very few mentioned or had seen CHC literature. However, a fairly high percentage indicated that personal contacts with their GP, a friend or Health Authority personnel were good sources of information. The results indicated the CHC played no major or effective role in briefing the public on local AHA policies.

10.3 The Area Administrators who were interviewed intimated that they did not see the role of the CHCs as the Health Authority's public relations consultants. They felt that the AHAs themselves were able to keep their public informed. It should be noted here that the NHS Reorganisation Circular HRC(74)4 says:

> "Successful administration of the service will depend on a continuing and constructive exchange of ideas between Area Health Authorities (AHAs) and the Community Health Councils (CHCs); the AHA will then be aware of local opinion on needs and deficiencies in the service, and the community through the CHC, will know of the actions and intentions of the AHA and of the problems and constraints with which it is faced. To be effective this relationship will call for positive effort and goodwill on both sides."

10.4 The interviews with the CHC Secretaries revealed that they think it is their role to inform the public on health matters but there are two major drawbacks at present to this function.

1. The AHAs do not inform the CHCs on intended policies early enough in their formulation to permit thorough and effective discussion.
2. The channel of communication between the public and the CHCs is inadequate. The methods used to inform the public are not good enough.

The CHC Secretaries voiced intentions of greater and improved use of the mass media to try to improve this weakness. Some were aware of the importance of personal contact in passing on information.

Some were also aware that the inaccessibility of the CHC offices which were surveyed does not encourage the public to use the service. The public survey revealed the ineffectiveness of the CHCs methods of distribution of information and literature. This raised the idea that there is not point in producing literature if no-one is going to see it.

10.5 The interviews revealed that there was a fundamental difference of opinion between the CHCs and the AHAs on what issues were important enough for consultation and over the timing of the release of information. Again the NHS Reorganisation Circular HRC(74)4 should be quoted:

(Para.33)

"Information about plans for development of health services and in particular about any important variations in services affecting the public such as ..... the opening of a new service or the closure of an existing service, should be given freely to the CHC. It is important that the CHC should be brought in during the formative stages of development proposals ....."

In practice the survey indicated that the AHAs follow the letter rather than the spirit of the law, i.e. there was nothing to indicate an attempt on the part of the AHAs to develop the role of the CHC as envisaged in the original circular.

10.6 The survey revealed that relatively few people feel that the public have a say in influencing the formation of policies of their local AHAs. However, the vast majority spoken to felt that it was important that their views should be taken into account. When asked who they would approach to express specific views on the local health service, (see Appendix VII) apart from one Area the largest proportion said that they would go to the AHA itself. Overall the smallest proportion of the people said the CHC. People also expressed preferences to approach their MP, Local Councillor or an agency such as the Citizens Advice Bureau.

10.7 The survey indicated that the public do not see the CHC as a channel to express views on their local health services (Appendix VII). The CHC Secretaries accepted the opinions of the members as representative of public opinion but they had no system of finding out whether this was really the case. Their system of feedback is inadequate and does not allow them to make the AHA aware of public opinion before policies are decided upon. The Area Administrators felt that the AHAs were as

representative a socio-economic group as any CHC. They regarded the CHCs as another obstacle in an already cumbersome decision-making process. The CHC Secretaries countered this by saying that their members had an element of spontaneity and an independence of action which the AHAs

10.8 Roughly one third of the people interviewed had heard of a CHC. However, very few had had any direct contact with a CHC. Most of the sample who had heard of a CHC said their information had come from the mass media and very few through CHC literature. Again a high proportion had heard through personal contact. The CHC Secretaries said that they were aware of the importance of using the press and all but one are investigating means to develop the potential of the media in reaching the public. The figures in Appendix IX reflect the impression that the CHCs are not effective enough in advertising their existence and assessing public needs.

11. CONCLUSIONS

11.1 The conclusion which can be drawn from this survey in accordance with the terms of reference, to which we are necessarily restricted, is that:

> CHCs are not, at this point in time, successfully fulfilling the role for which they were designed, either in disseminating information to the public or accurately representing public opinion to the AHA.

11.2 The following information, however, needs to be taken in conjunction with our basic conclusions to formulate a more accurate assessment of the work of the CHC.

11.3 As has already been stated it is obvious that there is within the public a very high level of unsatisfied demand for knowledge about health policies and associated matters affecting them. It is equally clear that this high level of demand arises as a result of ineffective communication of information. Consequently the CHCs are not very successful in passing on information to the public. However, it is also fair to say that most of the AHAs surveyed had very mixed feelings about the real value of CHCs and that as a result the quality and quantity of information passed on to CHCs restrict this aspect of their work. Furthermore most AHAs fell into the pattern of just sending Minutes and Agendas to the CHCs and because they thought that the AHA was just as representative as the CHC this meant they were not actively involved in many matters and were certainly not considered in the context of working partners.

11.4 Generally CHC Secretaries felt that they had achieved a great deal via such activities as Psychiatric and Geriatric Working Parties and indicated that they wished to participate in Health Care Planning Teams. However, it is clear that this is not in keeping with the intended functions of the CHC as detailed in Health Circular HRC(74)4 and to this extent the team considered that the CHCs were confused as to their role and this represented an attempt to perhaps 'jump on the management bandwagon'. This diversion of the energies of the CHC was also remarked upon by Area Administrators.

11.5 It was also apparent that the public's demand for knowledge is not being satisfied because the CHCs are ineffective in utilising the media to transmit information. However, some of the CHC Secretaries indicated that they are aware of this deficience and in future they would make use of professional P.R. officers and hopefully create a bigger impact on

the public by taking 'shop front' offices in busy thoroughfares. It was significant to note that CHC offices at the time of the survey were typically difficult to find. CHC Secretaries on the whole thought that television was the most effective means of 'getting the message across' together with extensive coverage in local newspapers.

11.6 The team considered that it was essential that CHCs reviewed their means of informing the public of the current issues in their local Health Service because the percentage of persons who read CHC literature (which was published and distributed profusely) was minimal in every Area surveyed.

11.7 Individual CHC Secretaries felt that only when a significant, and contentious, issue arose would they be able to generate interest amongst the general public. Therefore it appears that many CHCs have adopted what may appear to be a compromise attitude in that they tend to promote mainly the ideas of certain 'active' segments of the community. The team felt that in doing so the CHCs were not meeting their obligation in representing the general 'public interest'. (HRC(74)4)

11.8 Nevertheless the team recognised that criticism of the composition of the membership of the CHCs, of sometimes being drawn from restricted socio-economi groupings, was secondary to the problem of establishing an effective machinery for contacting the public and ensuring 'feedback'. It is important that the secretary has an alternative and authorative source of information regarding public opinion to that of the more active though numerically small members of his CHC. Further to this the team would strongly emphasise that the initiative ought perhaps to be from the CHC Secretaries themselves and instead of relying on the public coming forward to them, they ought to make the best possible use of any opportunity for exploiting the local media in trying to reach the public. Thus the flow of communication from the CHCs to the public will become a two way process avoiding a situation whereby vociferous (and well organised) minorities manipulate situations to further their own aims and objectives.

11.9 This is not to ignore the view, which has been drawn to our attention, that CHCs as public bodies are a recent innovation and that other organisations have taken as long as ten or fifteen years to make appreciable impact on the public consciousness. Further, as a representative body we found CHCs possessed a refreshing independence and spontaneity and were perhaps generally more active than other bodies established to protect the consumers interests.

APPENDIX I

INTERVIEW OF ADMINISTRATOR QUESTION SHEET

1. How much contact do Officers/Members of the A.H.A. have with the Secretary/Members of the C.H.C.?

2. Do you give out standard information (i.e. reports and minutes) to the C.H.C. regularly?

3. Do you provide other information only on request?

4. On what issues would you normally consult with the C.H.Cs?

5. Do you think that the C.H.C. accurately and effectively informs the public of Health Authority decisions/policies?

6. Do you think that the C.H.C. has a legitimate role to play in representing consumer interests to the Health Authority?

7. What role do you think they should play?

8. Are C.H.Cs. effective in representing the views of the public.

APPENDIX II

C.H.C. SECRETARY INTERVIEW: QUESTION SHEET

1. How representative of the public do you think the C.H.C. is?
2. How often does your C.H.C. meet?
3. Do you have extra-ordinary meetings on any issues of local importance or urgency?
4. How good is the attendance of your members?
5. How committed are your members to the aims and functions of the C.H.C.?
6. Have you a press briefing session?
7. What kind of information do you give the public? Is it only routine or do you make an effort to give them up to date information, e.g. on changes in local strategic plan or health education etc.?
8. What distribution methods do you use?
9. What is the catchment area?
10. What sort of information do you give A.H.As.?
11. What information does the A.H.A. give the C.H.C.?
12. What sort of relationship do you have with the Area officers?
13. How regularly do the A.H.A. consult the C.H.C. on non-routine matters?
14. Do you feel that you can influence A.H.A. policies?
15. Do you feel that the C.H.C. is a really effective public voice or a shadow A.H.A.?
16. Do you think that there is anything that the C.H.C. has done that could not have been done by a group from within the Authority (officers, member or both?)?
17. Have you any other means of testing public opinion other than via the members of the C.H.C. (who may have vested interests, e.g. voluntary groups), e.g. by survey, public meetings etc.?

APPENDIX III

SURVEY QUESTIONNAIRE

1. Do you know anything about the present or future policies of your local Health Authority?

2. Would you like to know more about the present and future policies of your local Health Authority?

3. Where do you obtain your information on the health service in your area?
   a) TV
   b) Radio
   c) Newspapers
   d) Health Authority
   e) CHC literature
   f) Other - please specify

4. Do you think that your local Health Authority takes account of the publics' views in forming its policies?

5. Do you think that your local Health Authority should take account of the publics' views in forming its policies?

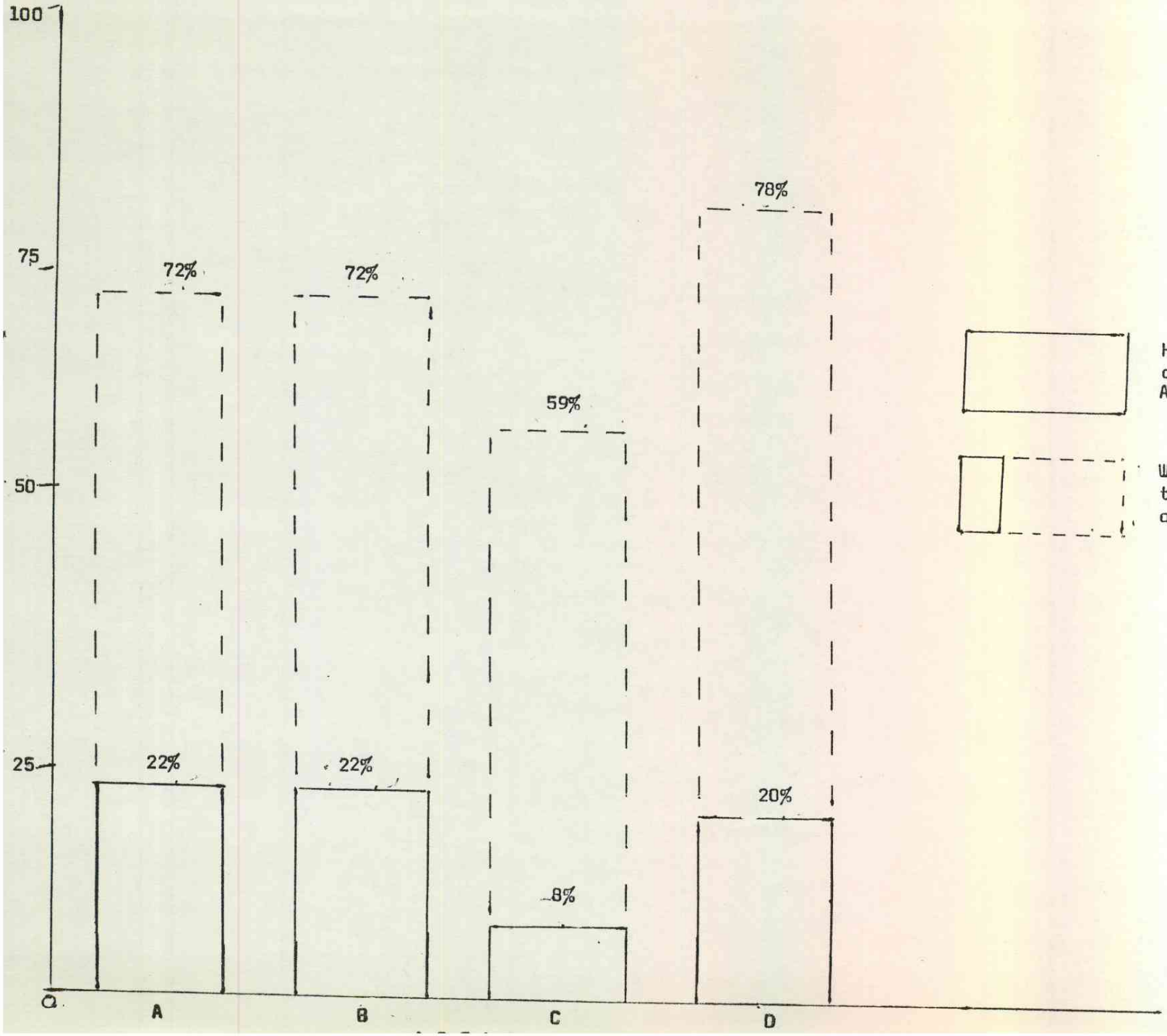
6. If you had any views or opinions to express about the Health Service in your area, who would you approach?
   a) MP
   b) Council
   c) Local Health Authority
   d) CHC
   e) Other - please specify

7. Do you know that a body called the CHC exists?

8. If so through what means:
   a) TV
   b) Radio
   c) Newspapers
   d) Local Health Authority
   e) CHC leaflets
   f) Other - please specify

9. Have you ever contacted or been contacted by the CHC?

APPENDIX IV


100
75
50
25
0
72%
72%
59%
78%
22%
22%
8%
20%
A
B
C
D
Has knowledge about the present or future policies of the AHA
Would like to know more about the present and future policies of the AHA

APPENDIX V

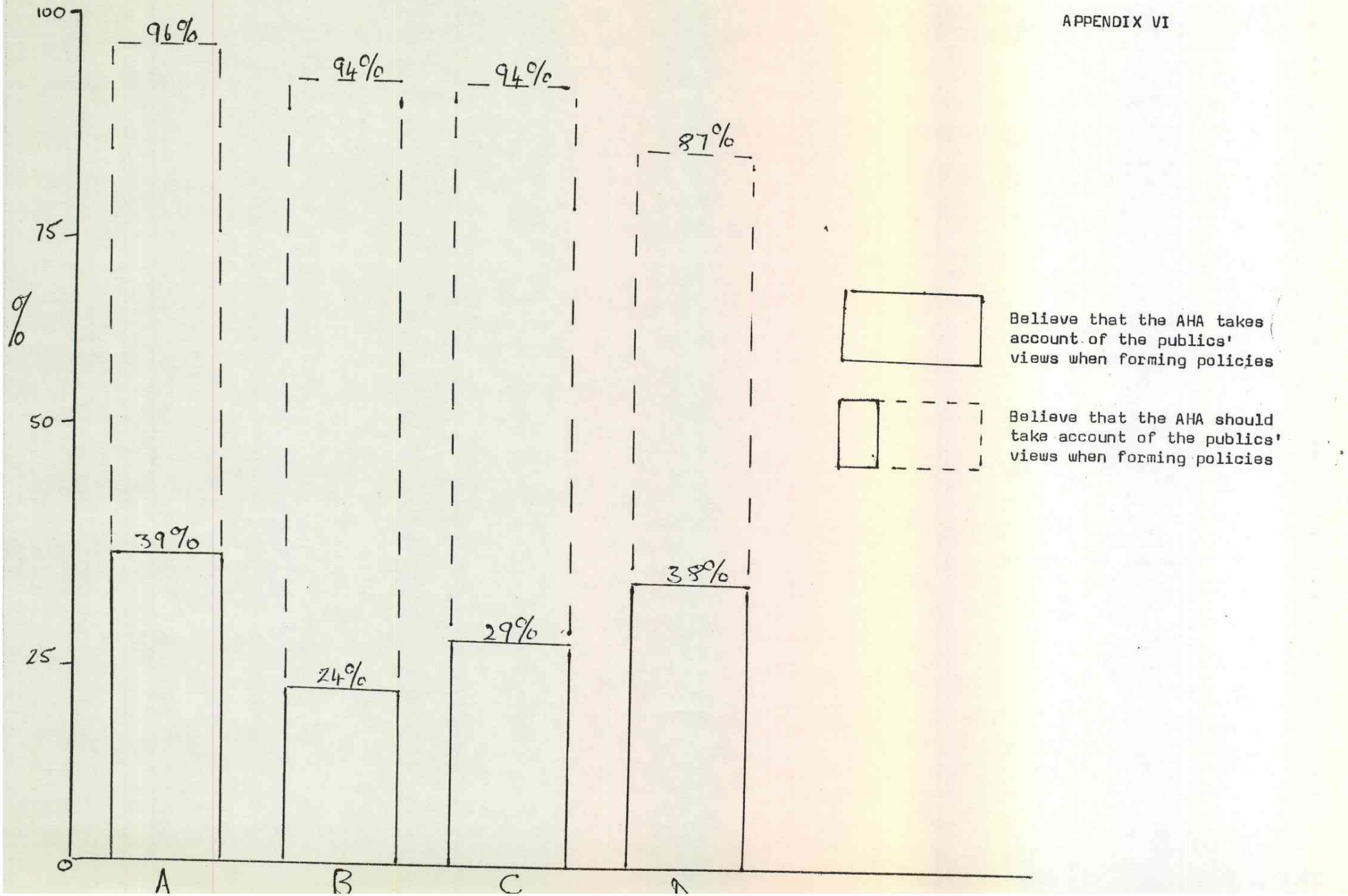
Where do you obtain your information on the health service in your area?

Q3 - results being expressed as a oercentage of Question 1

		22% A	22% B	8% C	20% D
a)	TV	68%	45%	13%	33%
b)	Radio	36%	-	-	33%
c)	Newspaper	72%	10%	37%	42%
d)	Health Authority	9%	45%	13%	17%
e)	CHC literature	4%	-	-	8%
f)	Other	-	-	37%	16%

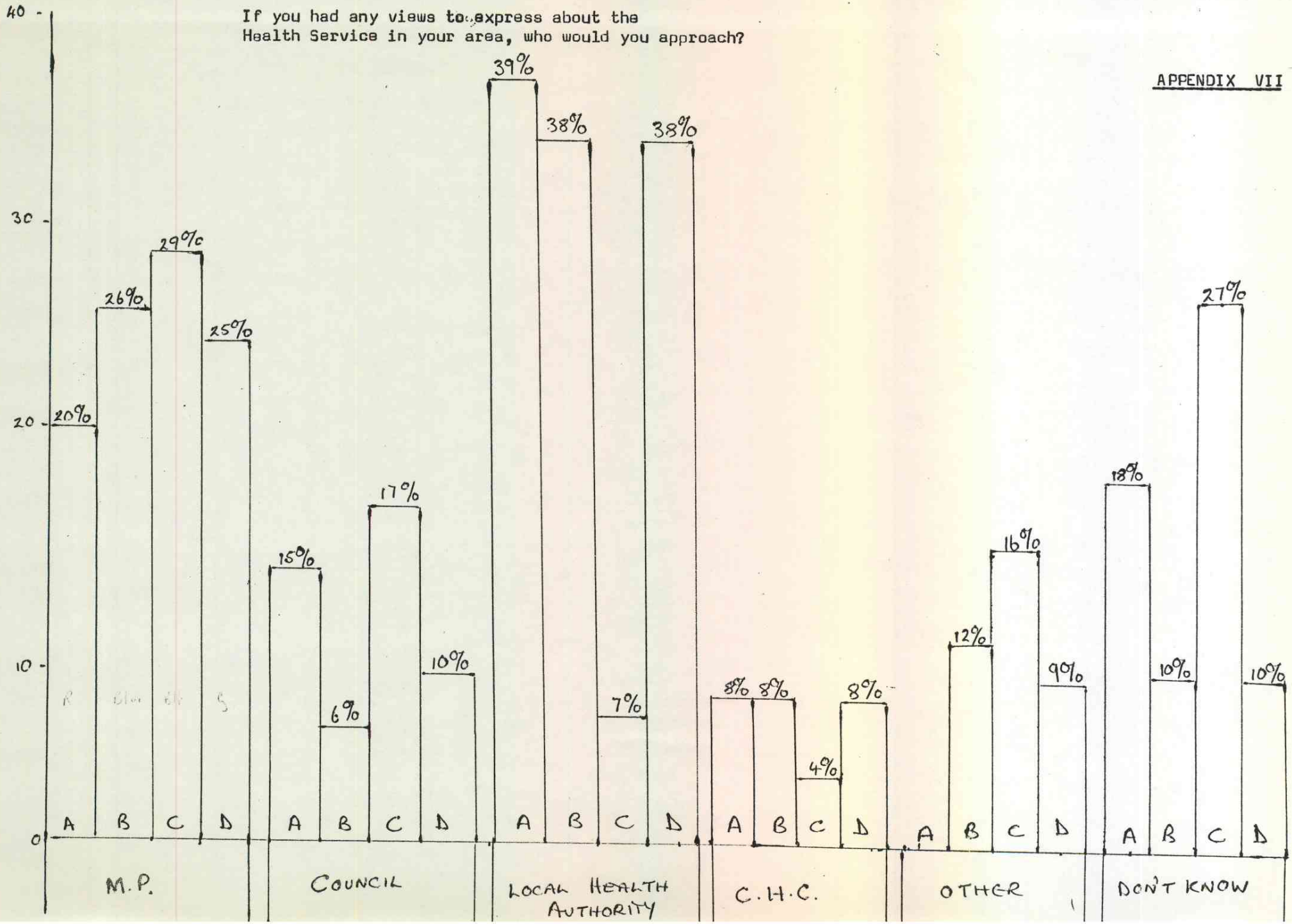
i.e. personal contact
Citizens Advice Bureau
Social Services
Central Information Office

APPENDIX VI

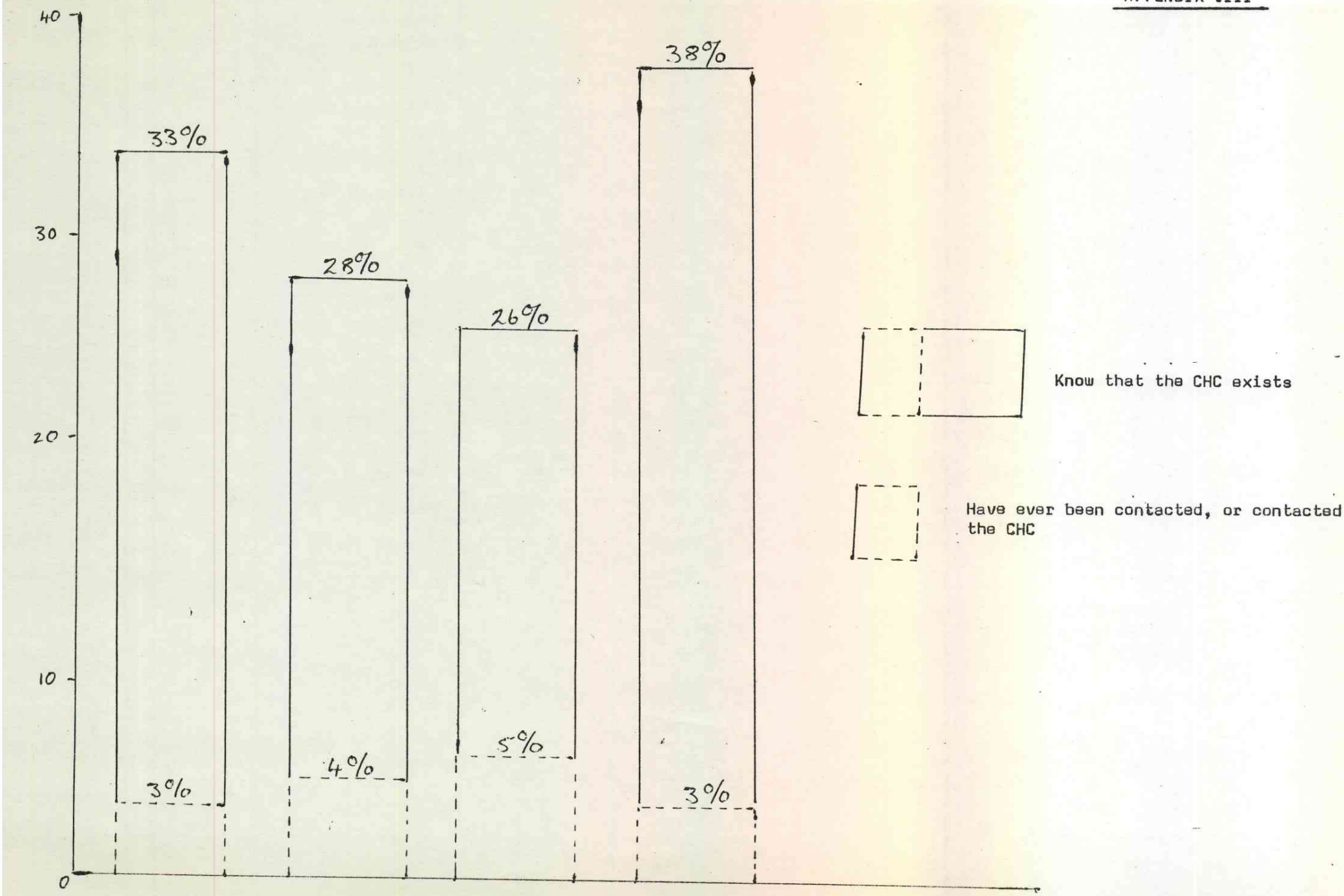

100
75
50
25
0
%
96%
94%
94%
87%
39%
24%
29%
38%
A
B
C
D
Believe that the AHA takes account of the publics' views when forming policies
Believe that the AHA should take account of the publics' views when forming policies

APPENDIX VII

If you had any views to express about the Health Service in your area, who would you approach?



APPENDIX VIII



APPENDIX IX

Q8 expressed as a percentage of Q7 being Averages of A,B,C,D.

a)	TV	- 36%		
b)	Radio	- 6%		
c)	Newspapers	- 24%		
d)	Local HA	- 4%		
e)	CHC Leaflets	- 6%		
f)	Other	- 24%	-	personal contact work doctor councillor voluntary services or don't know