'Patients First'

A personal view

R. K. Griffiths

This paper is a personal comment on paragraph 26 of the consultative paper 'Patients First'. It is based upon my experience of Community Health Councils at local and national level (Appendix 1). Ministers will no doubt receive much advice so this paper deals with limited aspects of the questions raised, particularly the value of independent representation, the size of administrative units, possible changes in the future and some sources of confusion about alternative proposals.

CONTENTS

INTRODUCTION

Community Health Councils are unique because they are both part of the health service yet independent. It is easy to understand that they are part of the health service but to ignore their independence is to gather only half of the story.

This paper begins with independence and dwells on it in order to show how it affects the way in which members and officers of CHCs behave. Independence also affects the relationships that the CHC forms with the community, with individual patients, with individual health service staff and with the managing Authorities. In turn these relationships are the building blocks from which the contribution of the CHC to the service is constructed.

The independence of CHCs is the thread which ties the story together. It has dictated much of the pattern of development of CHCs so far. The later sections of this document explore the future and show how best to use the thread of independence to stich together a better service.

1. Is independent representation necessary?

Paragraph 26 asks whether separate representation of consumer interest will still be needed in the proposed new structure. Independent representation is quite different in character from representation within the management structure. In particular independence produces a cluster of positive side effects which probably occur regardless of the size or complexity of the management structure.

1.1. Beneficial side effects of independence

1.1.1. Job satisfaction, dedication and objectivity

The output from CHC consists of policy statements, which may be replies to the initiatives of others or generated de novo within the Council. A variety of skills and methods go into the generation of policy but one of the largest resources is the time and efforts of the membership. Whether they are surveying the views and problems of others or speaking from their own experience active members soon see their imprint on CHC policy. This establishes a sense of purpose. Unlike the activity of Health Authorities, which has little meaning unless translated into treatments, CHC policy stands as a product of member activity in its own right.

Some members of the CHC will also be involved in negotiation with a view to securing the implementation of the CHC policy by others. They may find their task more frustrating but the fact that the CHC as a body can possess a body of experience which becomes hardened into developing policy provides a stable platform from which optimism can be refreshed and persuasion launched.

For the CHC staff there is the similar satisfaction of being a chief executive. The parallel with the entrepreneurial skills of the small business man, with dedication and imagination so essential to success is evident in many CHC secretaries. It is equally clear that this vitality would be lost if the CHC or its functions were to become part of the larger machine.

Dedication is not the prerogative of staff, many members work extremely hard. CHCs are able to find work for a wide range of talents among their members. The highly articulate are sent to speak and the very literate to read and write, but just as important are those who visit and listen.

Independence is vital to successful visiting because it makes possible a patient centred objectivity that is inevitably blurred by those who have also to consider professional and managerial views.

1.1.2. Credibility

The views of the community surface in many ways, through individual patients, from advice centres and through other voluntary and statutory organisations. It soon becomes clear to these people that the CHC is on the side of the patient. Even when battles are lost it is clear that the CHC has lost with the patient and not for them. This perspective is vital to the credibility of the CHC as an organisation and it is denied inevitably to the management bodies. Occasionally members of Health Authorities have sought to establish their 'consumer credibility' by making their independence from authority decisions very public. Their consumer pedigree has tended to rise in inverse proportion to their value as authority members. On CHCs their credibility is established by the organisation and they often become

less strident and more constructive.

1.1.3. The broad view

CHCs draw their membership from a wide variety of background and soon build up an organised connection which goes even wider. They are uniquely placed to act as a forum in which all sections of the community can consider health care. Independence allows the CHC to develop long term perspectives and to consider many dimensions to problems. Their statutory status allows them to negotiate access to the agendas of many Authorities and thus seek solutions that lie outside the narrower confines of Health Authorities. The CHC is often a catalyst, bringing change about through the action of others; keeping problems on the agenda until a solution becomes possible (Appendix 2). Independence provides the opportunity to be different and in a small organisation that has to live by its wits it is easier to find the courage to deny cautious negative and pessimistic notions and seek positive solutions.

It is inevitable therefore that CHCs have become involved in planning; 'deciding how the future should be different from the present' (Reference 1) and have often insisted on there being a long view as well as a short one.

1.1.4. Creation of public awareness

The CHC, because of its independence, runs far less risk in seeking publicity than the Authority with trade unions, managerial and professional interests to care about. CHCs have therefore been very effective at creating public awareness of health issues. CHCs receive about ten times more publicity in national and local papers (taken together) than the Health Education Council (Appendix 3). The effect of this is to alert the public to the important issues facing the NHS and very often to provide the CHC with important feedback from those who read the press. In order to establish good links with the media CHC members and staff have come to realise that they have to spend considerable time providing free information to journalists, much of which is not accredited when it appears in press. This unsung role must save the time of many NHS managers who would otherwise find themselves the butt of such enquiries.

The independence of CHCs not only makes them more credible in the eyes of the media but saves money into the bargain by pressing unpaid CHC members into service as public relations officers for the NHS. (If CHCs were abolished some of this load would fall on NHS staff. The administration would have three choices -(a) to see ill informed articles in print,(b) to waste administrator's and doctor's time answering queries,(c) appoint public relations staff. These options are expensive of either morale, time or money and the service can afford to waste none of these).

1.2. Direct effects of independence

A point, not often made, is that the independence of CHCs allows the management the option of ignoring the consumer point of view. Obviously Authorities must have strong reasons for taking such a course but it is an important option which becomes much more difficult if the management authority is charged with representing the consumer.

I suggest later that there should be a mechanism for formalising the process of disregarding the consumer view, just as there is a formal

process for consulting it. By such a means the tragedy and expense of Normansfield might be avoided. Assuming such a safeguard existed, it is possible sometimes to balance conflicting public, professional, trade union and other pressures if each is able to put their view point through a strong but independent channel. If the strength or independence of each channel is suspect then the administration of the service becomes suspect. The position of the British Medical Associaition gives implicit support to this proposition when it says that the community should decide about CHCs and that the professional representatives should be elected (Reference 2).

1.3. The market analogy

Health and Social Service Journal (29 Feb.) developed the market analogy. The most successful businesses are those who most accurately appreciate the needs of their customers but they do not expect their customers to run the business. The analogy with the independence of CHCs is very pertinent. The NHS consumer at the time of his need for the sickness part of the service (the vast majority) is not an independent operator. He is often deprived of mobility, anxious and highly dependent. Even in a private medical care system the customer cannot be relied upon to choose what is best for himself (witness the excessive hysterectomy, appendicectomy and cholycystectomy operation rates in the U.S.A. and Canada). The consumer of the independent contractor services is usually in no better position most often having to choose the nearest doctor, chemist or dentist. Sickness by its nature reduces independence. Community Health Councils are a way of persuading the well to think about the sick. Just as it would be wrong to expect the customers to run the business it is folly to try and run it as if the customers were not there.

1.4. Independence and balance

An independent consumer voice provides the service with a source of positive and optimistic advice from dedicated and credible people in the community. Furthermore it provides a mechanism for ignoring the capricious or negative. Without an independent mechanism the views of community representatives may either be ignored or become too dominant. In either case balance is far harder to achieve. An unbalanced service soon becomes scandously expensive or expensively scandalous.

2.1. Size of administrative units

Discussion of the future of CHCs has little to do with the size of administrative unit through which the NHS is managed. The NHS is so large and its activities so all pervasive that any fragment of it will always seem complicated in relation to the other activities going on in a similar size fragment of the rest of our society. If there were 2,000 Health Authorities their average budget would be £4 million. Most of the people who could be found to serve on such Authorities would not be in a position to supervise that size budget in their every day employment. This means that to the people who sit on lay Authorities the health service will always appear complicated. Smaller Authorities means members with smaller experience. Only if the health service were run at the street or neighbourhood level (Reference 3) might it begin to be called small or local. If this were the case another tier would be needed to pull together the activities of neighbourhoods. To seek to simplify the NHS simply by making administraive units smaller is to

chase rainbows. We have to accept that the NHS is complicated and find appropriate structures to handle that problem.

In seeking suitable units there has to be a reasonable compromise between the size unit needed for operational and strategic planning. Some specialties are only economic when dealing with large catchment populations (e.g. paediatric reconstructive cardiac surgery which needs about 15 surgeons for the whole U.K.).

There is a general opinion tnat tne present districts are a reasonable compromise. The Government should not however make unreasonable claims that the current district boundaries would automatically produce Authorities that are 'closer to the people'. In Oxford district such rhetoric rings very hollow, and in Kingston it sounds positively cynical. While some new districts may be a great improvement others will be just as complicated as current single district areas.

The smallest of the new districts, Kidderminster or Rugby perhaps, may appear too small to be viable as operational units; the larger districts such as North Staffordshire will appear massive and complicated even though they are obviously 'natural health districts'. What is needed is encouragement, training and security for competent managers; Authorities with a small enough membership to work effectively; clear terms of reference that give power to manage and credible and effective representation of the different interests that have to work together. It is for this reason that the Association of CHCs have suggested that professional representation on the new Authorities should be on an observer basis in parallel with the community tnrough CHCs. Logic would suggest that a mechanism be found for similar status for trade union representatives.

Given such a change it might be possible to reduce the voting members of the new district Authority to 12 or 15. Whether the local Authority should be represented by voting member or observer is a matter of judgement but the balance would appear to be in favour of voting member as a reflection of the executive role of the local Authority, while their interest as guardians of the community is reflected in their nomination of members to the CHC.

2.2. Implementation of a structure based on current districts

A number of arguments in favour of the current district pattern will already be familiar to the Ministers. Some adjustment should probably be made in London in order that the districts be more co-terminous with local Authorities. In general health districts will tend to be the same size or smaller than local Authorities responsible for social services. The number of health districts that span more than one local Authority should be kept to a minimum. A balance must be struck between the saving produced by having one Authority, and the extra complexity and resulting time wasting and mistakes caused by such problems as negotiating patient discnarges into two different social service networks.

The increase in numbers of districts will make cross district flows into a greater problem and resource allocation between districts will be more complicated for several years. Many district Authorities

will try to become self sufficient rather than negotiate with neighbouring Authorities. The problems of arriving at trading agreements between public Authorities should not be underestimated. Such things will be much more difficult than current negotiations between district management teams. There are a number of district managers who have no experience of working with an Authority. All these things may tend to push up the expense and difficulty of the reorganisation.

There will be a period of time - possibly 5 years - during which much attention will be focused on internal problems rather than the development of patient care. In the circumstances the input of professional advice and the community view will be vital if the interests of patients are not to suffer. There is thus an overwhelming case for leaving the boundaries of CHCs entirely alone for at least 5 years. After that time local negotiations to remove any anomalies could be commenced in those districts where there appeared to be too many or too few CHCs or where current boundaries seemed inappropriate. A few possible exceptions to this rule might arise where some of the current boundaries seem to mitigate against effective representation of the community. Such exceptions could be negotiated locally but the best advice from the Minister to Regions would be to leave the CHCs boundaries alone.

2.3. Recruitment of members to new Authorities

If most of the current districts in England are given Authorities a total of 4,000 (20 x 200) members will be required of whom 1,000 will be outside nominees of professional or trade union status. The members of existing AHAs might be expected to continue leaving approximately 2,000 new members to find. More than half the present CHC membership are due to lose their seats under the two term rule in 1980 and 1982 thus providing over 3,000 suitably qualified recruits, leaving some measure of choice available even if no suitable members could be found from other sources.

Current voluntary organisation seats on CHCs are over subscribed to the extent of 5:1 which indicates a ready pool of people in the community to replace those members who have to leave. There is a still greater pool available from parish and neighbourhood councils, trades councils, universities, polytechnics and so on, as well as the political connections currently used by local Authorities.

There can be no suggestion of a lack of possible members because only a change in the law would prevent the turnover in CHC membership. It is, in fact, a very opportune time to increase the number of health Authorities because a similar flood of 'trained' recruits from CHCs is unlikely in the future as non-statutory turnover smooths out the effect of the two terms rule.

3.1. Community Health Councils in the future

A number of recent public comments from a variety of sources have made statements of the general form 'Community Health Councils should be retained but their powers should be reviewed'. Few of these comments have suggested what form such a review might take or what the agenda might be. Much of the confusion that is said to exist about the role of CHCs arose because they came into being late in the 1974 reorganisation and had therefore to establish working relations with AHAs which had existed in shadow and substantial form for some while, and with FPCs which had had a former life as executive councils. The retention of

CHCs in the current reorganisation would remove most of this confusion at a stroke.

Criticisms that CHCs tend to dabble in management are unfounded because there is no mechanism through which CHCs can manage. They are not connected to the levers of power. Sometimes the most easily understood method of voicing a policy is to say how it should be done. Any manager who has not the confidence to resist this when he disagrees, or to accept it with good grace, does not deserve to be managing. Community Health Councils have also come to learn that sometimes the most easily understood criticisms are also the most easily misunderstood and adjusted their pronouncements accordingly. The fact that changes in CHC 'powers' are called for is an indication of the success of CHCs in using their rights to make suggestions. That managers should call for a reduction in the powers of 'toothless watchdogs' is also a wry comment on the managers concerned.

It would be fruitless to try and impose a single style on CHCs. Their job is to be'essentially local bodies becoming informed, concerned, responsible and responsive local forums for local discussion of health care' (Reference 4). Such a role as a local independent patient's voice demands that they be diverse, inventive and occasionally confusing to the outsider; such is the characteristic of local bodies in England. Most CHCs would agree with Mr. Jenkin when he said "I am totally opposed to the idea that you have always got to do everything the same way everywhere across the country. That, I think, is the nice tidy Civil Service view of affairs and I don't think it has to be that way at all; the country is very different and people may want to proceed in different way and I don't see why they shouldn't" (Reference 4).

The quotation was applied at the time to health Authorities but it is as appropriate for CHCs.

3.2. Possible changes in membership

It has been suggested that the mix of membership on CHCs might be altered. There seems little point in minor tinkering with the ratios. Two important options could be considered. First the Minister could advise local Authorities, RHAs and the voluntary sector to co-ordinate their appointments in such a way that the oversubscription of places was more evenly spread among the three sectors. Such guidance in the form of a ministerial letter or circular could provide a mechanism for mitigating current frustrations and finding locally appropriate solutions.

A more adventurous step would be to suggest that some of the local Authority places be set aside for direct elections. There is no reason why a ministerial letter could not suggest appropriate rules and funding for an experiment to be mounted in those areas where the CHC and local Authority felt it appropriate. This could clearly be accomplished within existing legislation and provide the basis for wider changes in the future depending upon experience.

3.3 Consultation with Community Health Councils

Some managers have always been reluctant to consult. This came rapidly to the surface following the Minister's letter to Betty Paterson and resulted in the two court cases at Lambeth and Guys. The later letter to regional administrators rectified the situation but the episode demonstrated the weakness of the law over consultation. The problems arose because of the temptation to misuse the proviso in the legislation which had clearly been intended only to apply to genuine emergencies.

The logical step for the future is to remove the proviso from the legislation in its present form. This would then mean that an instruction would be required by circular or other means to create local methods of dealing with emergency situations. In most cases such contingency plans could be agreed by the local Health Authority and the CHC quite amicably. Where this did not prove possible either party ought to be able to seek Ministerial or Departmental arbitration.

If the consultation mechanics were changed in this way the service would be spared the embarrassment of further court cases. The secondary effect is that the Minister could be sure that Health Authorities would not use one part of the Minister's policy (i.e. adherence to cash limits) to justify ruination of another policy (maintainence where possible of small hospitals).

Only through an effective public consultation can the interests of all parties be safeguarded.

A further change would be desirable which operates in the reverse direction. There should be a mechanism whereby the CHC can draw matters to the attention of Authorities in a formal manner. Provision for this exists in the legislation in that it states that Authorities should act on CHC's recommendations and should answer points made in the CHC's annual report. A ministerial letter or circular could lay down a code of practice. In essence it should provide for review by a third party (RHA or Minister) if an Authority failed to give an acceptable reason for failure to act on a CHC's formal recommendation. Such reasons ought to be publicly available. This might go some way to removing problems such as the inaction of the AHA over the CHC's criticisms of Normansfield.

4. Local versus national issues

Community Health Councils have a local perspective. On occasions the experience of one is of value to another; sometimes in teaching what to avoid, sometimes in showing a way forward. The National Association and CHC News exist to promote the exchange of such experience for the benefit of all. There are also occasions when changes in national policies will affect local issues and the National Association provides a forum in which such things can be discussed. Sometimes the lack of a national policy makes local progress difficult and the National Association is able to focus such concerns and help to press for the development of appropriate new policies. Current moves to try and 'close' the chiropody profession are a good example. In each case a snapshot view of CHC activity may give a mistaken impression that they are becoming concerned with things outside their remit; whereas more prolonged observation soon demonstrates the way in which local concerns are paramount in each case. It is unfortunate that the media, with their excessive concentration on events of a daily duration, tend to only give the snapshot view.

There are many instances when a CHC is blocked locally, when it suggests change on the ground, in which action is required at a higher level. In the past CHCs were often appalled to see vital policy issues passing like a shuttlecock between Area and District. It is to be hoped that the Region and the Department are not used in the same way in future.

There is a need for research in many areas and occasionally one well thought out project at National or Regional level would achieve more than many small ones. Such activity could be undertaken by the National Association but might lead to a charge of empire building. A possible solution would be to allow the Association of CHCs to make application to the DHSS Small Grants Committee. This would mean that the Department retained control over the total research expenditure but also allowed for good use to be made of the unique perspective available from ACHCEW without distorting the relation between local and national work in CHCs.

5. Alternatives to Community Health Councils

A number of alternatives to CHCs have been proposed. Patients First carries the implied suggestion that the CHC role could be carried out by Health Authorities. Cang (Reference 5) attempts to fit a model to CHC behaviour and extrapolates alternative proposals from this while another set of ideas come from Klein (Reference 6).

The Patients First alternative clearly conflicts with the concept of the independent voice developed in section 1. Even if it were considered sensible to have the customers running the business no method is suggested in Patients First whereby suitable 'customers' could be selected. No RHA has yet intimated that it has plans for revising its selection methods.

If CHCs were removed the Government would need to embark upon other consultation exercise in order to produce satisfactory arrangements for the selection of members. It is very unlikely that a demographically representative sample of Authority members would be the result of any recruitment process. There would then be a period of very uphill struggle in order to establish credibility with the community. A law that says you are representative does not cut much ice. With the immeasurable advantage of independence it still took CHCs several years in order to establish credibility. Without independence, with no background of goodwill and in a time of economic retrenchment, most Authorities would have no chance. The credibility of the new Authorities will be undermined in the media when they are forced to take decisions that are unpopular with professionals and the community. The result will be a further loss of morale at the best; at the worst the professionals will bypass the Authority, using 'clinical freedom' to justify anarchy. The strong will appear to prosper and the weak to suffer. The resulting instability will bring both public and private services into disrepute.

The alternative proposal by Cang, replacing CHCs with 'a loose federation of voluntary groups' fails to recognise the significance of a filing system, secretariate and the CHC News information system. Community Health Councils educate their own members. This saves the service a vast amount of time. Without administrative continuity it would be necessary for the service to re-educate each new pressure group as it came along. Community Health Councils and health Authorities have steadily developed their understanding and appreciation of each other.

Such a foundation is not possible if the community is represented by a 'loose federation of voluntary groups'.

Klein's proposal for splitting the CHC role into several bits spread between a chief officers' inspectorate and the citizen's advice bureau, similarly fails to understand the concept of independent representations described in section 1. The proposal to remove experienced officers from the service (even if only on secondment) is bordering on the foolish at a time when there is a heavy risk of further losses through the trauma of reorganisation. The advice as a patients' friend that is given by CHCs is based on their understanding of the service which is developed through their other functions. If the patients' friend role was separated from the other functions it would be done less well from the patient's point of view and probably with less understanding of the constraints on the service and a greater emphasis on legal process. The end result might be the added expense of American style defensive medicine.

Community Health Councils have been a success because they are both part of the NHS and independent of management. To interfere with either of these aspects would result in a job done less well and a real loss to both patients and service.

6. The success of Community Health Councils

No clear aims have ever been specified against which we can judge the record of CHCs. One of the features of an independent organisation is that it must, at least to some extent, decide its own role and objectives. Appendix 4 contains the annual reports for 1978 and 1979 of Central Birmingham CHC from which it is clear that the Council considers itself to be a success. Is that enough? The FPC, AHA(T), DMT and RHA that relate to this CHC are also in favour of retention of CHCs and yet there is no indication in these reports that the CHC has sought a sycophantic role. This CHC has also received copies of letters sent to the Department by individuals and organisations who have encountered its work in the community and they too are in favour of retention.

From this evidence we must conclude that some CHCs are scuccessful. If there was always total agreement between professions, managers and the public it is doubtful whether the need for reorganisation would ever have arisen. In fact there is a constant interplay as different interests coincide and then diverge as different views gain ascendency from time to time. At the moment the Minister is against large bureaucracies and large hospitals, a view only partly accepted by the professionals and planners. The Minister however would not claim that he was unsuccessful simply because his views did not find uniform acceptance. The presence of conflict is not a measure of failure. If there was a total lack of conflict between CHCs and the rest of the service one might be more suspicious.

Conflict of views is an essential part of life in a developing service and style counts for a great deal. Through the National Association and CHC News it has been possible for CHCs to learn from each other and develop ways of talking about problems that accentuate positive aspects and minimise the damaging effects of disagreement. Even brief reading of CHC News conveys the constant optimism shown by CHCs in the search for progress.

Community Health Councils have been criticised for trying to do too much and sometimes for saying so too loudly. As I have shown in section 1 the mechanisms exist for the service to ignore mistakes that CHCs are bound to make but the service has never before had an injection of so much enthusiasm and energy from the community. This huge input of voluntary effort has been created at a cost of about £4 million (in fact CHCs constantly underspend, unlike many health Authorities).

Individuals ought to stand on their own feet but sometimes they are more effective if they link arms. Community Health Councils have shown that a small amount of Government money spent in the right way can assist the whole community to help itself to a better health service. Surely that is how Governments ought to spend their money, priming the pump but not turning the handle.

Community Health Councils are the only body who could honestly claim to have put patients first all the time since 1974. It would be an especially sad irony if the current consultation on a document entitled Patients First where to remove the only parts of the organisation who have demonstrated that they know what the words mean and act on them.

RECOMMENDATIONS

1. The independence of CHCs should be retained and they should continue to be given adequate resources to carry out their role as a patients' voice inside and outside the service.

2. (a) The current district is the most appropriate geographical unit on which to base managing Authorities in the NHS.

   (b) Members of managing Authorities should exercise the role of non-executive directors. All other interests, community, professional, trade union, etc., should be represented by observers with speaking but not voting rights.

   (c) Boundaries of CHCs should be altered as little as possible at this stage.

3. (a) The Minister should issue guidance on ways of using existing regulations in order to introduce more flexibility into the nominations for CHC membership.

   (b) The Minister should issue guidance on ways of introducing direct election to CHC seats within the existing regulations.

   (c) The proviso to clause 20 on consultation should be withdrawn and guidance issued on locally negotiated contingency plans to cover the emergencies envisaged in the original legislation.

   (d) There should be a mechanism by which actions of managing Authorities can be reviewed by a third party when they persistently ignore a formal CHC resolution.

4. The Association of Community Health Councils for England and Wales should be allowed to make research applications in its own right to the DHSS Small Grants Committee.

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2. B.M.J. 29th March 1980, pp. 957-958.

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4. Jenkin, Patrick. Speech to Special General Meeting of Association of Community Health Councils for England and Wales.

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6. Klein, R. B.M.J. 9th February 1980, pp. 420-424.

APPENDIX 1

Dr. R. K. Griffiths - B.Sc. 1966 - M.B.Ch.B. 1969

Central Birmingham Community Health Council

Member since foundation in 1974
Vice Chairman June 1975 - June 1977
Chairman June 1977 till present

Association of Community Health Councils for England & Wales

Vice Chairman at foundation May 1977 until September 1979
Chairman September 1979 till present

Editorial Board of CHC News

Chairman June 1977 - February 1979

Medical Career

Basic Medical Science	-	teaching and research - 8 years
Hospital Medicine	-	Houseman and then clinical assistant - 1½ sessions 1969 - 1975
General Practice	-	5 sessions per week - 4 years
Community Medicine	-	Lecturer, Department of Social Medicine, Birmingnam since 1978

Publications

On aspects of bone structure and skeletal mechanics.
On medical education.
On Community Health Councils.
On Community Medicine.

Consultancy work

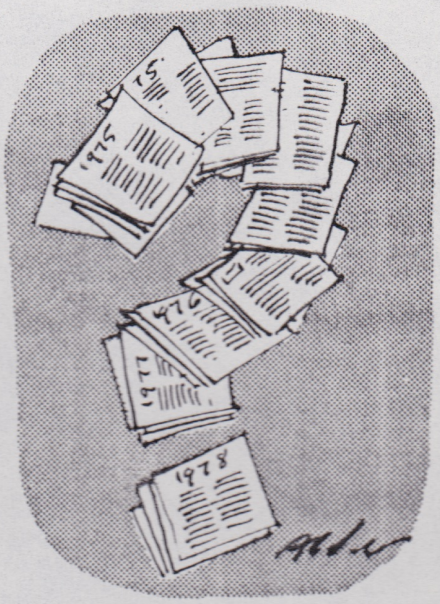
On aspects of Health Services for the National Consumer Council and the Open University.

I believe my experience gives me a unique view of the Health Service

HOW TO CATCH A HOSPITAL BUS

ROD GRIFFITHS Chairman of the Central Birmingham Community Health Council, plots the course of a transport campaign

Problem	Transport to Queen Elizabeth Medical Centre (QEMC). Current bus services drop passengers at one of three points each of which have special disadvantages in terms of distance and inconvenience for patients and visitors.
3.4.1975	Central Birmingham Community Health Council resolves to try and do something in response to complaints.
5.6.1975	Newly-appointed secretary writes to director of operations, West Midlands Passenger Transport Executives (WMPTE).
10.6.1975	WMPTE agree that discussion has been going on since at least 1973 but because plans for development of the site have been shelved so has the discussion. They suggest a meeting to ask what is a CHC?
20.6.1975	Summary of NHS reorganisation sent to WMPTE. General enquiries reveal that a 'university group' is working on the problem. (We never did find out who and no report has surfaced to our knowledge.)
25.7.1975	Following telephone call copies of current plans, as furnished by District Management Team (DMT), sent to WMPTE.
4.8.1975	WMPTE acknowledge receipt of plans. General enquiries reveal previous surveys of employees and visitors (1972) with distances travelled and mode of carriage.
22.12.1975	Dates discussed for meeting with WMPTE.
13.1.1976	First meeting: two main options emerge: a) re-route the number 21. b) a shuttle bus.
26.1.1976	Committee 2 at CHC discusses and opts for a) because b) sounds more expensive.
4.3.1976	Formally asked WMPTE to consider both options with further request for re-routing 21 in town to make access more convenient at that end.
9.3.1976	WMPTE say that they are looking into options.
10.3.1976	Following previous pressure, leader of council says he is 'talking at length' with director of operations.
29.3.1976	WMPTE ask us for up-to-date maps. Further copies sent (but see above 25.7.1975).
16.6.1976	DMT support the CHC proposals.
14.7.1976	WMPTE report that they would find it easier if the roads on the site had names. A test bus has been driven round the site. No major problems.



20.7.1976	DMT give the roads names and arrange for signs.
23.7.1976	Road names and new maps sent to WMPTE.
27.7.1976	Names acknowledged.
5.8.1976	We remind WMPTE (following Committee 2 meeting) that we are still interested in re-routing in town.
12.8.1976	WMPTE say re-routing in city is only possible when all city cross-flows are looked at.
19.8.1976	More pressure personally and by letter to leader of council.
22.10.1976	From leader of council "I will ensure that arrangements are made to see you so that there need be no further delay".
29.12.1976	We are told that transport committee have rejected the proposals on the grounds that a four-minute diversion of no 21 bus costs £33,000. An alternative cheaper route cuts out the university and medical school.
31.12.1976	Leader of council suggests that we should have further talks.
19.1.1977	Further talks. More details of different schemes needed.
28.1.1977	Letters in press condemning lack of action and present poor routing.
1.4.1977	To WMPTE asking them to send us the detailed costings on all routes. We find them hard to believe.
7.4.1977	WMPTE say survey analysis is still awaited but "we do not accept the view of your council that the existing route is unsatisfactory."
18.4.1977	Letter in press from patient at Solihull (not stimulated by CHC).
May 1977	County Council changes hands in election.
10.6.1977	Letter to new chairman of transport committee (Councillor Gilroy Bevan).
20. 6. 1977	Gilroy Bevan writes. Costing figures not available due to non-availability of details from other sources.
10.8.1977	We ask what happened to the surveys expected in April last? More press reports. *Sunday Mercury* does feature on poor transport to Queen Elizabeth Medical Centre. New chairman of transport committee says "it is not our job to take pregnant ladies to the maternity hospital" and says why doesn't the CHC run a bus?
31.8.1977	New CHC chairman writes to Gilroy Bevan. Explains why CHC cannot run buses and why they will not stop complaining. Proposes new meeting.

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Hospital Bus

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21.9.1977	Council gets rough figures from press so asks WMPTE for exact figures. Figures then supplied by phone.
20.10.1977	New meeting takes place. (Lavish lunch noted by CHC.) Meeting firms up on shuttle bus for experimental period. Road plan agreed. WMPTE would like an NHS contribution to costs. CHC suggest approach to QEMC trustees of endowment funds.
10.11.1977	CHC resolves "support for an experimental shuttle bus to service the maternity hospital and QE and link with the 21, 11 and new railway — provided that the data collected is made available to the CHC". (WMPTE have suggested that the service should start in May 1978 when train starts.) CHC approaches DMT for application to endowment funds.
6.1.1978	DMT make provisional approach to trustees and write to WMPTE.
1.2.1978	Trustees agree to contribute up to £10,000. DMT asks director of operations for a meeting.
10.2.1978	Director of operations passes letter to operations manager, south division.
20.2.1978	Operations manager, south division, passes matter to district roads officer for the area.
12.4.1978	Meeting between CHC, DMT and district roads officer. Small route changes and position of stops agreed.
5.5.1978	Report by district road officer to transport committee.
16.5.1978	Transport committee resolution. "That the committee approve the introduction of this experimental service subject to the traffic commissioners' approval for a period of 1 year". Approved at 12.20 pm.
19.11.1978	Bus starts running.

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Addendum

Since this article was written the data from the experiment has been analysed and the final plan of bus routes is to send the 21 bus along the route initially suggested by the CHC in January 1976. An additional new route will also run through part of the hospital campus close to the maternity hospital. These new routes come into effect April 1980. The 21 bus will also run around the centre of town along the route suggested by the CHC in March 1976.

The entire campaign has therefore lasted just over 4 years from suggestion to implementation. It is clear that few voluntary groups could sustain work over this period or negotiate access to the agenda's of the bodies concerned. If the DMT were to have pushed the proposal through the usual channels it would go from DMT to AHA via JCC to Metropolitan District Council and from there via the County Council to the transport committee. Because the CHC can use its independence and interpret its role as defender of the 'patients' interest' widely it is able to bypass the convoluted bureaucracy and act as the catalyst to bring the DMT and passenger transport managers together.