Consumer Representation in the Scottish Health Service
The Future of Local Health Councils

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Scottish Consumer Council

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1. Summary

The Scottish Consumer Council has always tried to promote and enhance the role of the consumer in the provision of health care. In relation to the NHS and Community Care Bill, in June 1989 we responded to the government's proposals for the Health Service outlined in the White Paper "Working for Patients" and the six accompanying Scottish working papers. Also, in February 1989 we submitted a paper, "Consumer Representation in the Scottish Health Service", to the Minister for Health at the Scottish Office.

This paper reiterates and expands on many of the points raised in these earlier papers. It sets out a precisely defined remit for Local Health Councils (LHCs) covering four main roles - those of 'Patients' Friend', the monitoring of services, setting standards and consultation and representation. Stemming from this remit it proposes a new structure for LHCs with a national health consumer council for Scotland and only one LHC per health board.

2. Introduction

The Scottish Consumer Council believes firmly that consumers of health services in Scotland need an independent voice to represent them; a voice as strong and as well heard as those speaking for management, health care professionals and trade unions. The need, in the absence of a free market, for consumer representation is a fundamental tenet of consumerism.

It is for these reasons that SCC supported the creation of Local Health Councils in 1975 and has since maintained strong links with individual councils and the Association of Scottish Local Health Councils. However, we are by no means satisfied with the working of the present system.

Although the National Health Service and Community Care Bill provides increased opportunities for the exercise of consumer choice, health service users are unlikely ever to achieve genuine consumer sovereignty. The power they lack as individuals needs to be compensated for by the authority of a body speaking for them.

To be credible and effective such a body needs to be independent of those who provide the service - the management. At present Health Boards have only a marginal role in representing the communities they serve. Moreover, this function is soon to be abolished, leaving Health Boards largely with the job of management. What is clear is that
whilst increased competition and choice will hopefully make Health Boards more sensitive and responsive to consumer needs, the boards cannot speak for consumers.

3. The Present Deficient System

At present, Local Health Councils have few specified functions, few resources and few powers. This stems partly from the imprecise and ambiguous remit given to them by NHS Circular (Gen) 90 and partly from the way in which they are structured and financed. As a result, the nature and quality of the work they do, and the usefulness of that work, varies greatly from one Health Council to another. In addition, the Association, which represents most Local Health Councils lacks resources, and also a formal input into health service policy-making and statutory status and power.

The Scottish Consumer Council believes that if health service consumers are to be adequately represented and the deficiencies of the present system of representation rectified then the remit of Local Health Councils needs to be clarified and, as a consequence, their finance and structure reconsidered.

4. The Remit of Local Health Councils

As already noted, the remit of Local Health Councils, as set out in NHS Circular No 1974 (Gen) 90, has led to much confusion and ambiguity as to their precise role in representing the interests of consumers. SCC is of the view that LHCs need a more precisely defined remit if they are to represent consumers in the best way possible. Furthermore, they need to be more accessible and have a much higher public profile than at present, (see para.9), and their members need to be drawn from a wide range of organisations and individuals.

Working from the basic consumer principles of information, access, choice, safety, representation and redress, we see four interdependent and overlapping roles for Local Health Councils. These are:

(i) 'Patients' Friend'
(ii) The Monitoring of Services
(iii) The Setting of Standards
(iv) Consultation and Representation
To perform these four roles adequately LHCs will need a formal right of access to all NHS establishments and facilities where NHS funding is being used for patient care.

Consumers of community care services also need representation. The remit of Local Health Councils should be extended to cover community care, irrespective of the agency providing that care.

4.1 'Patients Friend'

The role of 'patients friend' can be split into two separate functions:

(a) ADVICE AND INFORMATION: The provision of advice, assistance and information to individuals and community groups about local health services and patients’ rights. This can be seen mainly as a function for LHC staff to perform.

(b) COMPLAINTS: Enabling and representing patients who are pursuing complaints. At a formal level, this would involve suitably qualified and/or trained council staff and members actually representing patients on GP and other service complaints committees and external reviews.

We do not believe that health council staff and members should be allowed to sit on external reviews, GP and/or other service complaints committees since this would threaten their independence in representing the patient. However, local health councils could play a useful role in 'trawling' local community and voluntary organisations for lay members of GP and other service complaints committees. This would provide a consumer input into complaints procedures.

4.2 The Monitoring of Services

In order to make the Health Service more consumer-responsive, Local Health Councils should monitor consumer opinions, the provision and quality of local health services, the achievement of consumer-related performance targets and systems of complaints handling.

Many health councils already monitor services in one way or another - they inspect premises, interview patients and carry out consumer audits etc. This work keeps members involved and produces useful recommendations and outcomes. However, there is much variation in the nature and quality of monitoring from one health council to another and their work lacks a structured and co-ordinated approach at the national level.
If the monitoring of services is to be effective in informing management of deficiencies and helping them make improvements then there should be nationally agreed guidelines and standards on monitoring procedures. Those who undertake such monitoring need to be adequately and appropriately trained in these procedures.

The monitoring carried out by LHCs should be quite separate and distinct from that carried out by management in areas such as performance indicators and medical audit. But it is vital that the monitoring of service outcomes from a consumer point of view is seen as being on an equal footing with that of outcomes from a management and/or medical point of view. Thus, it is important that the type of monitoring undertaken by LHCs remains independent of management and does not become 'over-professionalised'. Indeed, there are specific areas such as consumer satisfaction in, and expectations of, health service provision which should be seen as the preserve of the LHC and should not be infringed upon.

There is of course a legitimate consumer interest in the results of management monitoring and medical audit and these should be available to the proposed national health service consumer body, Local Health Councils and the public. The national body and LHCs should have a right of access to this information.

4.3 The Setting of Standards

Through the application of consumer principles and the results of monitoring, Local Health Councils should help set specific consumer standards in the provision of health services at the board and national level.

Given that legislation about health boards' committees will be altered to allow a greater proportion of non-members to assist in their specialised functions, members of Local Health Councils can play a potentially crucial role on health board committees and working parties. This will enable them to promote consumer standards as a whole and also in specific areas of health care.

4.4 Consultation and Representation

If consumers are to be the primary focus of health service provision then Local Health Councils must be the first body to be consulted in the planning and delivery of health services. This would include the designation of 'core' services and the establishment of NHS Trusts. In this way, the views of the LHC could be circulated to interested parties at the same time as those of the health board. Again, LHC representation on appropriate health board committees and working parties would go some way to ensuring effective consultation and representation.
5. **A National Health Service Consumer Body**

The Scottish Consumer Council believes that there should be a separate and new national body to put over the consumer view at the national level and to coordinate and clarify the activities of Local Health Councils.

5.1 **Functions of the National Body**

(a) **National representation**

The national body should represent the consumer view at the national level. It should be the first body to be consulted in the planning and delivery of health services at a national level. Also, it should be represented on national committees concerned with the planning and delivery of health services. In addition, the national body would give views and advice to Ministers on health service policy and provide the Scottish Home and Health Department and the Chief Executive of the Scottish Health service with ideas and suggestions about changes and improvements in services.

(b) **Research**

Our own experience suggests that if the consumer voice is to carry conviction, it needs to be based on reliable research. The national body would carry out research and monitoring of consumer satisfaction with health services at a national level and would employ staff specifically for this purpose. In this respect, it would operate in a similar manner to the Scottish Consumer Council.

The body would also be able to commission and/or give funds to individual health councils or consultants to carry out research.

(c) **Coordination**

One of the main tasks of the national body would be to service, coordinate and focus the activities of individual health councils so that their remit is clear. In particular, the national body would disseminate information about good practice amongst Local Health Councils.

(d) **Appointments**

The national body would draw up a set of criteria and appointments procedures to inform and advise health boards in the appointment of local health council members. These criteria would ensure that members are from a wide cross section of the community and have the right kind of skills and experience. (see para. 7)
(e) **Training**

The national body would be responsible for ensuring that LHC members and staff receive adequate and appropriate training. (see para.8).

If the national body is to perform functions (a) to (e) well then it needs to be adequately financed, and structured in such a way as to allow a balance between national coordination and local responsiveness.

5.2 **Structure**

The SCC believes that the decision-making council of the national body should comprise the Chairperson of one LHC from each health board area (15 in all) plus five other independent members. One of these other members would be the national Chairperson and would be appointed by the Secretary of State. The others would be nominees of other organisations such as the new national health education organisation, the Scottish Consumer Council and academic bodies.

5.3 **Finance**

The national body should be independent of health boards and, like LHCs, financed by the Scottish Home and Health Department. It is envisaged that the body would receive approximately 25% of the current budget for Local Health Councils with the remaining 75% (given one LHC per health board) split between the fifteen Local Health Councils. (see para.6.2).
6. **Local Health Councils**

If the remit of LHCs set out in para.4 is to be adequately met then the present structure and finance of LHCs needs to be significantly altered.

6.1 **Structure**

At present there are around 45 Local Health Councils in Scotland. This has led to a fragmented system of consumer representation. The Scottish Consumer Council believes strongly that there should only be one Local Health Council per health board. There are a number of reasons for having only one health council per board;

(i) One health council per board area would be much more cost effective, with less being spent on overheads and more on the work programme and representing consumers.

(ii) Management would be faced with a more focussed and united consumer voice than previously.

(iii) Health-board wide consumer bodies would have a broader view of the kinds of service changes which may deprive one local community but benefit another.

(iv) There would be much less likelihood of variability in the quality of consumer representation in Scotland if there were 15 rather than 45 Local Health Councils.

The rationalisation of the local health council system, with one LHC per board, need not diminish the links health councils have with local communities. Firstly, the criteria for membership of LHCs would be such that members are representative of the wide geographical area they serve. Secondly, at present community councils have a statutory responsibility to comment on health matters and could feasibly provide a grassroots input into the workings of Local Health Councils. Finally, by improving the public's awareness of Local Health Councils (see para.9) links with the community could be enhanced.

6.2 **Finance**

The Scottish Consumer Council believes that LHCs should be independent of health boards and therefore should continue to be financed by the Scottish Home and Health Department. Finance should be allocated according to the population of the board area the LHC serves but with recognition of travelling costs in the larger, more remote areas.
7. **Appointments to the Local Bodies**

The members of Local Health Councils should be appointed by the health board according to the advice and guidance given to them by the national body concerning selection criteria and appointment procedures.

The selection criteria and appointment procedures drawn up by the national body would aim to achieve a cross-section of people, skills and experience on each LHC. It might, for instance, be decided that each local body should include members from a representative range of ages and social and ethnic backgrounds with:

- knowledge of the local area
- knowledge of the health needs of particular groups in the community
- research skills
- management skills
- involvement in community or voluntary work
- experience of publicity work

To promote accountability these criteria and appointment procedures would be public knowledge and the membership of each LHC would be monitored by the national body to ensure they were met.

Members would be drawn from local bodies and voluntary organisations and the public would be invited, through media advertising, to nominate themselves for membership.
8. Training

As already noted, if Local Health Councils are to perform their duties to the best of their ability then their members and staff need to be adequately and appropriately trained with each of them receiving core training. Ideally, the national body would be allocated additional funding to allow it to commission training, though it would be possible for a training/development officer to be established within the Scottish Home and Health Department.

Training for Local Health Council members would include:

- Principles and practice of consumer representation in the health service.
- Health law and administration (at national and regional levels).
- Measuring consumer satisfaction with health services.
- Representation and advocacy skills
- Communication and publicity skills

The training could take place at the national and regional level through training days, short but intensive residential weekends, evening courses and perhaps self-help study groups.

It is important that training takes account of the individual problems in each Health Council area arising from its' particular mix of rural and urban health demands.

The way in which training for School Boards has developed provides a good example to follow. With School Boards, the production of a national training manual and supporting materials has been central to their early development.
9. **Increasing Public Awareness**

At present Local Health Councils have a very low public profile. If they are to be accessible to the public then their profile needs to be considerably raised. There are a number of ways in which this may happen:

(i) The setting up of a national health consumer body would raise the public profile of the network of Local Health Councils.

(ii) Media advertising aimed at encouraging the public to become members of Local Health Councils would raise their profile.

(iii) The health board and/or national body should provide, by the hospital bedside and in GPs surgeries, a leaflet in plain English describing the role of the council.

(iv) Information about the role and activities of Local Health Councils should be generally available in places such as post offices, public libraries, community centres and offices of voluntary organisations. This could take the form of a nationally produced poster with an insert by the Local Health Council and/or leaflets distributed by the Local Health Council.

(v) The Local Health Council could distribute personalised pocket calendars etc and members and staff can give talks to local community and voluntary groups.
Summary

1. There must be a strong voice for users of the Scottish health service which is independent of management.

2. Consumer representation includes a variety of functions which need to be performed at both national and local level.

3. These functions would best be performed by one national consumer body and fifteen local consumer bodies, one for each health board.

4. The remit of Local Health Councils should cover four overlapping and interdependent roles:

   (a) 'Patients Friend'
   (b) Monitoring of Services
   (c) Setting standards
   (d) Representation and consultation.

5. Local consumer bodies should have the right:

   (a) to be the first body consulted by health boards about proposed changes to services and to have their views circulated to interested parties at the same time as those of the health board;

   (b) to have access to all premises where NHS and community care patients are treated, irrespective of the agency providing the service.

   (c) to attend formal complaints hearings as "patients' friends".

6. Local Health Councils should 'trawl' local community and voluntary organisations for lay members of GP and other service complaints committees.

7. Given that the legislation about boards' committees will be altered to allow a greater proportion of non-members to assist in their specialised functions then LHC members should be allowed to sit on these committees as consumer representatives.

8. Membership of Local Health Councils should represent a cross section of skills, experience and social and demographic factors. Nominations (including self-nomination) should be invited from the general public, community and voluntary organisations but not from health boards.
9. All Local Health Council staff members and staff should receive adequate and appropriate core training.

10. The national body should set out clear selection criteria and appointment procedures for the recruitment and appointment of LHC members and should provide guidance and advice to health boards concerning these matters.

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