TALKING POINT

Consulting the public: some recent findings

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Several students of health care systems¹⁻³ have emphasised the importance of public and consumer participation in the planning of health care. One of the major objectives of the 1974 reorganisation was stated to be the achievement of greater opportunities for the public to participate more fully in the affairs of the NHS.⁴ To this end the community health councils were created⁵ and the new planning⁶ and consultation⁷ procedures developed. It is too soon to say how successful these new arrangements have been but I hope that these findings, which arise from a study of a round of formal public consultations concerning hospital services,⁸ will interest those concerned in planning and conducting similar exercises in public consultation. I have not therefore discussed in detail the part played by local authorities and NHS staff in the consultations.

Public consultation

From July 1975 to May 1976 the Clwyd Area Health Authority in North Wales undertook a formal round of public consultations about the pattern of hospital services to be provided after the commissioning of a new 400-bed district general hospital. The new hospital is intended to serve a catchment population of about 170 000 and is expected to be commissioned during 1978. In accordance with the procedure for formal public consultation laid down in DHSS circular HSC(IS)207 the health authority published a consultation document⁹ setting out its proposals and the reasons underlying them. The authority proposed that the new DGH should be supported by a network of community hospitals to serve the non-acute hospital needs of local communities within what is a largely rural health district. To bring this about some of the existing hospitals are to be developed as community hospitals, and three are to be closed. The proposals were discussed fully with, and supported by, the medical profession in the district concerned, before being included in the consultative document.

In July 1975 the consultative document was sent to all the authorities, organisations, and individuals referred to in the DHSS/Welsh Office consultation circulars¹⁰ with an explanatory letter inviting comments. Thirty meetings were held between September and December 1975 with local authorities, hospital staff, and the general public. It had been agreed with the community health council that it would be responsible for arranging all public meetings and that AHA officers would always be in attendance to explain the health authority's proposals and to answer questions. The public were invited at all meetings to submit comments to the CHC and were informed that,

though there was no set time limit, it was hoped that these would be sent before the end of December 1975.

MAJOR FINDINGS

The three major findings of the consultations were the poor attendance at public meetings, delay in submission of comments, and bypassing the CHC.

Ten public meetings were held at different centres in the health district over a two-month period. Total attendances came to about 330: a figure in marked contrast to the total district population of 170 000. Furthermore, over 200 of those attended the only two meetings to have generated any real public or consumer interest, because of the proposal to close a nearby large hospital. In those parts of the health district where the AHA's proposals were envisaged to mean only minimal changes in hospital services for the local people attendances at the public meetings were very low—usually fewer than 20 people.

DHSS circular HSC(IS)207 recommends that AHAs should ask for comments from CHCs and others within a period of three months from the publication of a consultative document. Table I shows that in these particular consultations comments were received over a 10-month period. Local authorities supporting the proposals made their views known, with one exception, during the first

six months of consultation, whereas most of the authorities and interest groups opposed to the proposals submitted their comments later.

Table II shows to whom individual members of the public and "interest" groups submitted their comments. In only seven of the 73 submissions was the CHC included as a recipient.

Discussion

The reasons for low attendances at public meetings called to discuss public policy issues such as health are probably numerous and complex, and, as Klein has stated,¹¹ are due to such factors as the low level of public information and commitment in most policy areas. Poor attendance at meetings is not confined to NHS issues and has been commented upon by students¹² of public participation in local authority structure planning. The success of public meetings depends on their being extended beyond the conventional format—that is, booking a hall, placing a notice in the local paper, and hoping that people will turn up. For example, in local authority matters it has been found helpful to build meetings around existing groups and organisations rather than the so-called "public." Similarly arranged meetings for health would be equally rewarding, both in terms of numbers attending and in the quality of discussion. For example, the presentation of proposals at a meeting

TABLE I—Timescale of receipt of comments on Clwyd AHA's proposals*

Comments	Month comments received									
	1975						1976			
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Local authorities County council District councils Community councils Non-statutory "interest" groups	1 (1)	1	(2) 2	(1) (1) (2)	(2) (1)	(1)		1 3 7	(1) 8 25	3 6
Total Support for AHA Opposition to AHA	1 (1) 1	1	(2) 2	(4)	(3)	(1)		11	(1) 33	9

*Figures in brackets indicate support for the AHA's proposals.

TABLE II—Destination of comments regarding Clwyd AHA's proposals

Comments	Destination of comments:					Total
	AHA	Secretary of State	CHC	AHA + Secretary of State	AHA + Secretary of State + CHC	
Individual members of the public "Interest" groups	6 5	23 15	5 0	0 17	0 2	34 39
Total	11	38	5	17	2	73

arranged by organisations and groups concerned with the elderly could be geared to emphasising points of special interest or concern to that particular audience.

Table I shows that so far as these consultations are concerned the recommendation that AHAs should require comments within a period of three months when hospital closure is proposed was unsatisfactory. The time was too short. Most of the local authorities and interest groups opposed to the health authority's proposals did not submit their comments until the consultations had been in progress for about eight months. Furthermore, those community councils and "interest" groups which submitted comments do not have the support of full-time paid officials to study and research consultative documents sent to them for comment, in contrast to the county and district councils. Members of the public who decide to concern themselves with consultation or participation exercises do so generally in their own spare time. Consequently, it may take them some time to become familiar with what may be difficult and complex issues, and the accumulation of facts to build up a case can be a lengthy and time-consuming process. Sufficient time should be allowed for the public to make its views known, either as individuals or through "action" and "interest" groups. Not to do so would only lend support to the public suspicion that consultations are often no more than public relations exercises where authorities are not really interested in taking notice of anything the public might have to say.

Table II shows that those individuals and interest groups who submitted comments on the health authority's proposals largely bypassed the CHC, apparently preferring to bring their views directly to the attention of the Secretary of State, or the area health authority, or both. This is not surprising. Firstly, at the time these consultations were taking place (1975-6) the CHC concerned was still a "new" body, so that the public were largely unaware of its existence and of its

intended role in the NHS. Secondly, public participation in the consultations largely centred on opposition to those proposals concerned with hospital closure. So the public were primarily concerned with bringing their views to the attention of the Secretary of State, who was known to be responsible for taking the final decision on the matter. It will be interesting to see whether, in time, the CHC will become accepted by the public as the channel through which its views and protests on important Health Service issues are made known.

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References

- Logan, R F L, Pasker, P, and Klein, P. *British Journal of Hospital Medicine*, 1971, 5, 29.
- Lazar, E. *Hospital Administration in Canada*, February 1973, p 23.
- Lysander, N. *Hospital Administration in Canada*, November 1973, p 32.
- Hansard, House of Commons, 26 March 1973, col 932.
- DHSS, *Community Health Councils*, Reorganisation Circular HRC(74)4, 1974.
- DHSS, *Guide to Planning in the NHS*, March 1975.
- DHSS, *Closure or Change of Use of Health Buildings*, Circular HSC(IS)207, October 1975.
- MFCM (PART II) Report, D T Jones, *Public Consultation Within the Context of the National Health Service*, July 1977.
- Clwyd Area Health Authority, *A Plan for the Reorganisation and Development of Hospital Services in Clwyd North Health District on Completion of Stage One of the District General Hospital (Ysbyty Clwyd)*, Bodelwyddan, consultative paper, July 1975.
- Welsh Office, *Procedure for Consultation on the Closure and Change of Use of Health Buildings*, Service Planning Paper No 5, 1975.
- Klein, R, *British Medical Journal*, 1974, 4, 328.
- Stringer, P, and Plumridge, G, *Publicity and Communications in Structure Planning*, Interim Research Paper No 1, Department of the Environment, 1974.

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Health Services Act

Board proposes removal of 356 pay-beds

The independent Health Services Board has proposed that 317 pay-beds should be removed from the NHS in England, four in Wales (before 1 January 1978), and 35 in Scotland (before 1 April 1978).^{*} This will result in a total reduction in pay-beds in Great Britain of 10% to 3088.

Welcoming the report on behalf of the three health ministers to whom it was addressed Mr David Ennals said on 13 October: "In May the Government abolished 1000 of the 4400 pay-beds under the direct terms of the Act which they successfully carried through Parliament in 1976. Further progressive withdrawal is the job of the independent Health Services Board. They have made their own inquiries and their report confirms the Government's belief that in many parts of the country the present number of pay-beds is more than necessary to meet the demand for private practice and many pay-beds were not being

much used. We shall put their proposed reductions into effect, as the Act requires us to do."

In its covering note to the report the board stated that its "ability to propose further revocations at six-monthly intervals as required by the Act will depend on the availability of even more detailed information about the practice of private medicine in NHS hospitals and in private hospitals. In particular, considerably more information will be needed before the board can assess the scope for pay-bed reductions in hospitals where, *prima facie*, there appears to be a reasonable demand for the currently authorised pay-beds."

The Health Services Board also proposes the withdrawal of consulting room facilities for private non-resident patients in 101 hospitals in England and eight in Wales. At this stage, the board explains, it has only "revoked" authorisations for the use of consulting rooms at particular hospitals where it has been established beyond doubt that no use whatever has been made of those facilities either in 1975 or 1976. The board regard this fact as clear evidence of a lack of any reasonable demand,

and also infer . . . that . . . there is sufficient accommodation elsewhere to meet such demand, if any, for consulting rooms as is not directed towards that hospital."

The proposals affecting Scotland and Wales have been made after consultation with the board's Scottish and Welsh Committees.

In May this year the board reported on common waiting lists for NHS and private patients in NHS hospitals (Cmd 6828). This report is being considered by the Health Departments after consultation with interested bodies.

BMA comment

Commenting on the report, Mr A J Grabham, chairman, Central Committee for Hospital Medical Services, said: "We are studying this report urgently and are asking consultants in the affected areas to let us know their reactions to it. If we find any areas where the practice of private medicine is likely to be impaired as a result of these proposed closures, then we shall consider what legal steps may be necessary to correct the situation. We shall also watch with interest to see how many of these closed beds are in fact used by NHS patients from now on."

In brief . . .

Code on deputising services

Mr Roland Moyle told the annual meeting of the Society of Family Practitioner Committees on 13 October that the DHSS would shortly publish a new code for deputising services. The code would deal with the number of deputising doctors on duty and their competence; their supporting staff and transport; their communications; the priority of and response to calls; the continuity of care; and the records to be kept and information available from them. The DHSS has also proposed that professional advisory committees should be established in every area where a deputising service is set up. Family practitioner committees, Mr Moyle emphasised, would remain responsible for consenting to the use of deputising services. The Central Advisory Committee of the BMA Deputising Services has been consulted on the code and the General Medical Services Committee was due to consider it on 20 October.

District nurse training

A working party, chaired by Mr A J Carr, area nursing officer, Newcastle upon Tyne AHA(T), has been set up "to devise an improved syllabus for the district training of the enrolled nurse without prejudice to the implementation of the Briggs Report on Nursing." The working party would welcome any comments on this subject. These should be sent to the secretary, Panel of Assessors for District Nurse Training, Hannibal House, Elephant and Castle, London SE1 6TE.

^{*}Withdrawal of Authorisations for the use of NHS Hospital Accommodation and Services, Cmd 6963. London, HMSO, 1977.